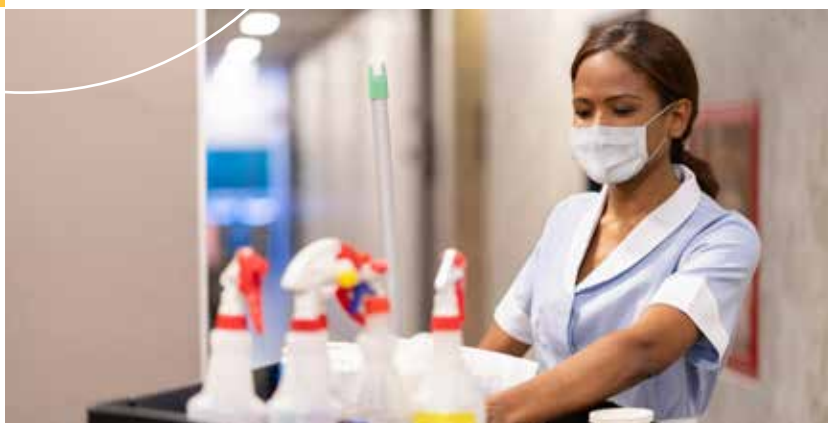




# **Listening to Californians with Low Incomes:** How They Experience the Health Care System and What It Means for the Future

FINAL REPORT

MAY 2021



**AUTHORS**

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## About the Authors

This report was written by Jen Joynt, independent health care consultant; Lucy Rabinowitz, MPH, principal research analyst at NORC; and Rebecca Catterson, MPH, senior research director at NORC. **NORC** at the University of Chicago is an objective nonpartisan research institution that delivers reliable data and rigorous analysis to guide critical programmatic, business, and policy decisions.

## About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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# Executive Summary

The COVID-19 pandemic has upended the lives of most Californians, and caused significant impacts to the physical, emotional, and financial well-being of all residents, especially those with low incomes. To better understand how the pandemic impacted the health and health care experiences of Californians with low incomes, the California Health Care Foundation (CHCF) and NORC at the University of Chicago, a national research organization, conducted a statewide survey of California residents who had received care since March 2019, with an oversampling of residents with low incomes (defined as below 200% of the federal poverty level).<sup>1-3</sup>

The survey, conducted in the summer of 2020, asked respondents about their health care concerns, experiences, and access before and during the COVID-19 pandemic. Survey findings were supplemented with qualitative findings from interviews conducted with 37 survey respondents with low incomes and with 10 health care experts.

*“Inequality is growing. We know that as a result of the pandemic, economic, health, and inequality otherwise, the gap has only widened. The pandemic served as this great magnifier of what was already there. I talk about it as a crisis within a crisis. . . . We should have known it was going to happen because it’s building upon decades, generations of inequities and injustices.”*

— Kiran Savage-Sangwan  
California Pan-Ethnic Health Network (CPEHN)

## KEY FINDINGS:

### Understanding the Impact of the COVID-19 Pandemic

The study found that the pandemic exposed and exacerbated inequities in health, mental health, and health care access for Californians with low incomes, particularly for Californians of color. In addition, the pandemic heightened and increased economic and employment inequalities, placing additional stress on people most likely to experience inequities. Specific findings from the research are presented below.

**Deteriorating mental health for many.** The pandemic exerted a significant impact on the mental and emotional health of many Californians with low incomes, especially those who already considered their mental health to be “fair or poor.” More than half of respondents with low incomes (53%) who rated their prepandemic mental health as “fair or poor” reported worse mental health since the start of the pandemic.

**Strong interest in care for mental health problems.** More than two-thirds of respondents with low incomes (68%) who wanted to see a provider during the pandemic wanted care for a mental health problem. This finding reveals both the extent of the pandemic’s negative impact on people’s mental health and indicates that the long-entrenched stigma associated with acknowledging and seeking care for mental health problems may be decreasing.

**Pent-up demand for health care.** Many Californians with low incomes have not received needed care or have delayed care since the start of the pandemic. This survey was limited to Californians who had received care since March 2019. However, only 24% reported a problem that they wanted to see a provider for since the start of the pandemic, suggesting many may have been delaying care. Furthermore, among those who wanted to see a provider, many did not receive care for their health problem.

**Telehealth a critical source of care.** Two-thirds of respondents with low incomes (65%) and three-quarters of respondents of color (76%) who received care

during the pandemic received care via telehealth (either phone or video). Among those who received care via telehealth, satisfaction was high, with 70% of respondents with low incomes and 82% of respondents of color with low incomes saying they would likely choose a phone or video visit over an in-person visit in the future.

**Experience of stress prevalent and debilitating.**

Californians with low incomes were more likely to experience pandemic-related stressors than those with higher incomes.<sup>4</sup> Ninety-six percent of respondents with low incomes experienced at least one pandemic-related stress. Stress was associated with worsening mental health during the pandemic.

**LOOKING FORWARD:**

**Implications for the Future**

Interviews with leading health care experts revealed six key themes for how California's health care system should respond to the lessons learned during the pandemic.

**Restructuring payment systems to address health care inequities.**

Experts recognized that addressing inequities in health and health care access will require changes to policy and to health care payment models. One expert stressed the importance of moving away from fee-for-service payment models toward value-based and place-based contracting to incentivize health care systems to proactively engage high-risk patients in their communities, and to coordinate care and services that address their physical, behavioral, and social needs.

**Expanding access to mental health care and promoting emotional well-being.**

The significant mental health concerns experienced by respondents highlights the urgency to increase access to care for mental health issues. Experts emphasized that mental health services should be integrated into primary care settings and be redesigned to reach people where they are (instead of waiting for them to engage with the system) and to promote mental well-being and prevention. In addition, the mental health workforce needs to be expanded and diversified to better meet the needs of people from different cultural backgrounds. Experts offered solutions including leveraging a community-based workforce to provide outreach to people experiencing mental health issues and expanding the use of nontraditional mental health services such as technology-based supports.

**Redefining access to health care.**

The research revealed the need to bring Californians with low incomes back into the health care system as soon as possible. Experts recommended leveraging primary care providers, the mass COVID-19 vaccination effort, and community health workers and *promotores de salud* to reengage patients in accessing care not only to address existing health issues but also for critical prevention, such as screenings for adults and children, and vaccinations for children. Experts also recommended that these measures should continue beyond the immediate term and serve as a starting point for reconsidering how California's health care system ensures convenient and comprehensive access to care, especially for those with low incomes and for people of color.

*"We need to make sure that there are incentives for more place-based, equity-driven coordination of care and services to address the medical, behavioral, and social needs of low-income, high-need patients. Right now, the current model of care, especially fee-for-service, drives structural inequity, and helps perpetuate structural racism and economic inequality."*

— Dr. Rishi Manchanda, HealthBegins

**Ensuring equitable access to telehealth.** The pandemic connected many more Californians to telehealth, and experts agreed that telehealth will continue to play a critical role in the health care system moving forward. However, they also noted that investment is needed to ensure that Californians with low incomes have sufficient technology, connectivity, and privacy for effective telehealth visits. While telehealth offers significant benefits, such as requiring less time and hassle to get care and expanding access to linguistically and racially/ethnically diverse providers, they emphasized that all patients should be able to choose whether they receive care in person or via telehealth.

**Breaking down data silos in health and social services.** The research demonstrated that many Californians with low incomes have needs for health care, mental health care, social services, and economic support. Patient needs can be more easily and safely addressed by establishing data systems and structures that enable health care providers to share health information about patients, both between health care delivery systems and between health systems and other types of providers such as jails and prisons or homeless service providers.

**Addressing social determinants of health.** The study emphasized the importance of social determinants of health, and their impact on the stress and deteriorating health experienced by many Californians with low incomes during the pandemic. Experts universally agreed that addressing these social determinants of health, including housing, food security, and employment, will be critical to reducing inequities in health but cautioned that there are no easy solutions. Many experts recommended expanding investment in housing and economic opportunities in communities disproportionately affected by inequities.

These implications for the future are described in greater length in the Conclusions section.

## Background

The COVID-19 pandemic has caused significant impacts to the physical, emotional, and financial well-being of all Californians, especially those with low incomes and people of color. To better understand how the pandemic impacted the health and health care experiences of Californians with low incomes, the California Health Care Foundation (CHCF) and NORC at the University of Chicago, a national research organization, conducted a mixed-methods study during the latter half of 2020. This mixed-methods study consisted of a statewide survey of Californians who reported seeing a doctor or other health care provider in the year before the start of the pandemic and subsequent in-depth interviews with selected respondents. Additional interviews were conducted with health care experts to identify the implications of the findings for the future of the health care system in California.

The overarching research questions that this mixed-methods study aimed to answer are as follows:

- ▶ How was the health and health care of Californians with low incomes impacted by the pandemic?
- ▶ How were impacts on Californians with low incomes different than on Californians with higher incomes?
- ▶ How else did the pandemic impact health and health care differently between groups?

*“COVID affects everything. It affects your finance, finance will affect your mental, and mental will affect your physical. One way or another.”*

— 57-year-old Asian resident,  
Southern California

## About the Study

### Survey

The California Health Care Foundation's Listening to Californians with Low Incomes Survey was conducted June 24 to August 21, 2020, using a combined probability-based sample and nonprobability sample to achieve an overall sample of 2,249 nonsenior adults (age 18 to 64) living in California. The foundational probability-based sample comes from the NORC AmeriSpeak Panel ( $n = 746$ ). The nonprobability sample is composed of a web sample from Dynata ( $n = 1,314$ ) to reach more respondents with low incomes, and a combined web and telephone sample from Davis Research ( $n = 189$ ) to reach Vietnamese and Cantonese speakers. A multistage weighting design was applied to ensure accurate representation of the California adult population. Survey respondents were limited to those who saw a doctor or other health care professional about their health since the COVID-19 pandemic or in the year before the pandemic (March 2019 through March 2020). Typically, 75% to 85% of Californians age 18 to 64 have seen a doctor in the last year.<sup>5</sup>

Survey respondents were asked whether they identified as Hispanic or Latino, and then asked about their racial identity. For the purpose of this report, all Hispanic and Latino respondents will be referred to as *Latinx*. All respondents who did not identify as Hispanic or Latino are reported on here with concise labels (Asian, Black, or White). *People of color* is used to aggregate non-White respondents where there was not a sufficient number of respondents to make observations by specific racial and ethnic categories. This report provides results for groups with a base sample size of 75 or greater. The margin of sampling error including the design effect for the full sample is plus or minus 3.7 percentage points. For results based on specific subgroups, the margin of sampling error may be higher. The complete survey methodology is available in Appendix A.

### Interviews

In addition to the survey, in-depth follow-up interviews were conducted with 37 survey respondents; 22 were conducted in English, and 5 each were conducted in

Spanish, Vietnamese, and Chinese. A semi-structured interview guide was used to derive additional insights and context for survey responses, which informed the findings in this report.

The interviewees were mostly female (68% and 32% male), came from diverse racial and ethnic backgrounds, and lived throughout the state (see Appendix B for detailed demographic information on interviewees). Interviewees were screened into different criteria based on the experiences they reported on the survey, including having a health issue, receiving care, and receiving a telehealth visit, so that the researchers could explore topics of interest in depth.

In-depth interviews were also conducted with nine subject-matter experts identified by the California Health Care Foundation as having important perspectives on the implications of the findings of this study for the future of California's health care system. Interviews were conducted with the following experts:

**Jacqueline Martinez Garcel, MPH**

CEO, Latino Community Foundation

**Liz Gibboney, MA**

CEO, Partnership HealthPlan of California;  
Member, CHCF Board of Directors

**Sandra R. Hernández, MD**

President and CEO, CHCF

**Rishi Manchanda, MD, MPH**

President and CEO, HealthBegins

**Louise McCarthy, MPP**

President and CEO, Community Clinic Association  
of Los Angeles County (CCALAC)

**Benjamin F. Miller, PsyD, MA**

Chief Strategy Officer, Well Being Trust

**Ian Morrison, PhD, MA**

Futurist; Former Member, CHCF Board of Directors

**Erica Murray, MPA**

President and CEO, California Assn. of Public  
Hospitals and Health Systems (CAPH)

**Kiran Savage-Sangwan, MPA**

Executive Director, California Pan-Ethnic Health  
Network (CPEHN)

# Health Status

The COVID-19 pandemic caused upheaval in the lives of most Californians. To understand the impact of the pandemic on the health of Californians, especially those with low incomes, respondents were asked about their health, mental health, and substance use problems before the pandemic. In addition, respondents were asked how their health, mental health, and substance use problems changed since the start of the pandemic.

**THE TAKEAWAY.** Californians with low incomes were more likely to report changes in their health status — both negative and positive — compared to those with higher incomes. More than one in three respondents with low incomes experienced worsening mental health. On the other hand, about one in five said their mental and overall health improved and credited changes such as more time for exercise and to spend with family. It's now critical to increase outreach to those who had fair or poor mental or overall health prepandemic, as they are more likely to have experienced further deteriorations during the pandemic.

## Mental Health Before and During the COVID-19 Pandemic

**Respondents with low incomes were more likely to report fair or poor mental health before the pandemic.** Respondents with low incomes were more than twice as likely than respondents with higher incomes to report fair or poor mental health before the pandemic (29% vs. 12%).

**Respondents with low incomes were more likely to report their mental health got worse since the start of the pandemic.** More than one in three respondents with low incomes (36%) reported “worse” or “a lot worse” mental health since the pandemic (Figure 1). However, one in five respondents with low incomes (20%) reported better mental health since the pandemic. In both cases, respondents with low incomes indicated more change in mental health than did those with higher incomes.

Figure 1. Change in Mental Health Since Start of Pandemic, by Income

Q: Since the start of the COVID-19 pandemic, how, if at all, has your mental or emotional health changed? Is it . . .

A lot better / Better



About the same



Worse / A lot worse



Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020. Differences between income groups were statistically significant at  $p < .05$ .

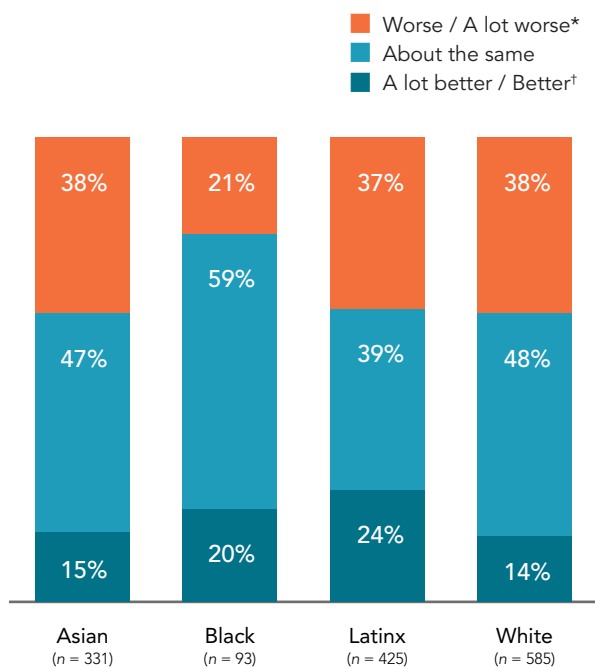
*“After COVID started, sometimes I felt like I did not want to do anything anymore. I went to talk to the doctor, and he increased the medication for my depression. However, there were still days when I wake up and I didn’t feel like I loved life like I used to.”*

— 58-year-old Asian resident, Bay Area

**Change in mental health since the start of the pandemic varied by race/ethnicity.** Among respondents with low incomes, 38% of Asian and White respondents and 37% of Latinx respondents reported worse mental health since the start of the pandemic (Figure 2). In contrast, 21% of Black respondents with low incomes reported worse mental health. Nearly one in four Latinx respondents with low incomes (24%) and one in five Black respondents with low incomes (20%) reported better mental health since the pandemic.

**Figure 2. Change in Mental Health Since Start of the Pandemic Among Respondents with Low Incomes, by Race/Ethnicity**

Q: Since the start of the COVID-19 pandemic, how, if at all, has your mental or emotional health changed? Is it . . .



\*Differences between Black respondents and other racial/ethnic groups were statistically significant at  $p < .05$ .

† Differences between Latinx respondents and White and Asian respondents were statistically significant at  $p < .05$ .

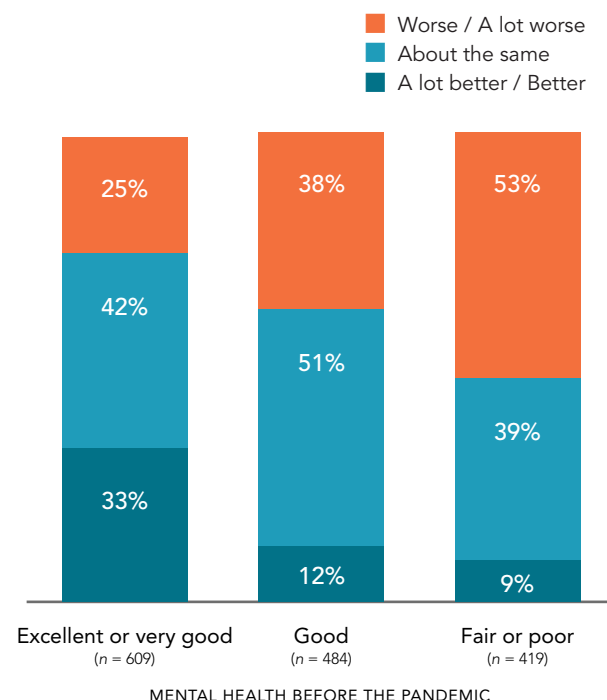
FIGURES 2 AND 3:

Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020 and who were considered low income at <200% of the federal poverty level (FPL).

**Respondents whose mental health was fair or poor before the pandemic were most likely to report worsening mental health.** Respondents with low incomes who reported fair or poor mental health before the pandemic were most likely to also experience worsening mental health since the start of the pandemic (Figure 3). More than half of respondents (53%) whose reported prepandemic mental health was “fair or poor” reported “worse” or “a lot worse” mental health since the start of the pandemic, compared to one-quarter of respondents (25%) whose reported prepandemic mental health was “excellent or very good” ( $p < .05$ ).

**Figure 3. Change in Mental Health Since Start of the Pandemic Among Respondents with Low Incomes, by Mental Health Before Pandemic**

Qs: How would you rate your overall mental or emotional health before the COVID-19 pandemic? AND since the start of the COVID-19 pandemic, how, if at all, has your mental or emotional health changed? Is it . . .



Notes: Differences between proportions of respondents who answered “fair or poor” and “excellent or very good” are statistically significant at  $p < .05$ . Segments may not sum to 100% due to rounding.



Interviews with those who came into the pandemic struggling with mental health revealed a number of reasons for worsening mental health during the pandemic, including loneliness due to quarantine, social distancing, and isolation, and an abrupt decrease in access to the in-person care they had previously relied on for their mental health needs, including peer and community support groups. A few mentioned they had increased their substance use as a coping mechanism for dealing with the uncertainty and instability caused by the pandemic.

*“It’s not just regular stress; it starts to deviate into mental health stress. It’s physical on the body. . . . For the portion of the population that I am included in that does have mental health issues already, it’s a double whammy. And to be separated and have loneliness and have that feed into the mental health disease that’s already there just waiting to be fed.”*

— 24-year-old Latinx resident, Central Coast

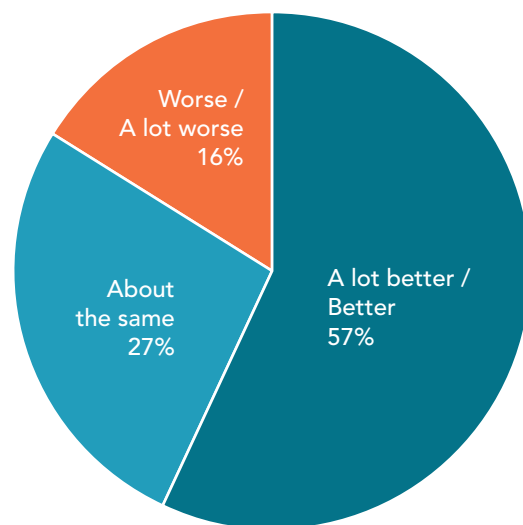
## Substance Use Before and During the COVID-19 Pandemic

Respondents with low incomes were more likely to report a problem related to using alcohol, drugs, or other substances both before and during the pandemic than respondents with higher incomes. Nearly 1 in 6 respondents with low incomes (16%) reported a problem with using alcohol, drugs, or other substances before the pandemic, compared to about 1 in 10 respondents with higher incomes (9%,  $p < .05$ ). Since the start of the pandemic, 6% of respondents with low incomes reported a new problem with alcohol or drug use, compared to 2% of respondents with higher incomes ( $p < .05$ ).

**The majority of respondents with low incomes who experienced a problem with alcohol or drug use before the pandemic reported their problems got better since the start of the pandemic.** Among respondents with low incomes who reported problems with using alcohol, drugs, or other substances before the pandemic, more than half (57%) reported that their problems had gotten “better” or “a lot better” since the start of the pandemic (Figure 4). Only 16% reported that their alcohol or drug problems got “worse” or “a lot worse.”

**Figure 4. Change in Substance Use Problems Since the Pandemic Among Respondents with Low Incomes**

Q: Since the start of the COVID-19 pandemic, is your problem with using alcohol, drugs, or other substances . . .



Note: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020 and who were considered low income at <200% FPL and who said they had a problem with using alcohol, drugs, or other substances before the pandemic.

*“I’ve been drinking a lot more, feeling a lot more depressed. I just feel bad sometimes. I go to therapy every now and then . . . the place is closed now.”*

— 25-year-old Latinx resident, Los Angeles

## Overall Health During the COVID-19 Pandemic

Looking at overall health since the start of the pandemic, respondents with low incomes were more likely to experience improvements in their health than those with higher incomes. One in 5 respondents with low incomes (21%) reported their health was “better” or “a lot better” since the start of the pandemic, compared to 1 in 10 respondents with higher incomes (10%) (Figure 5).

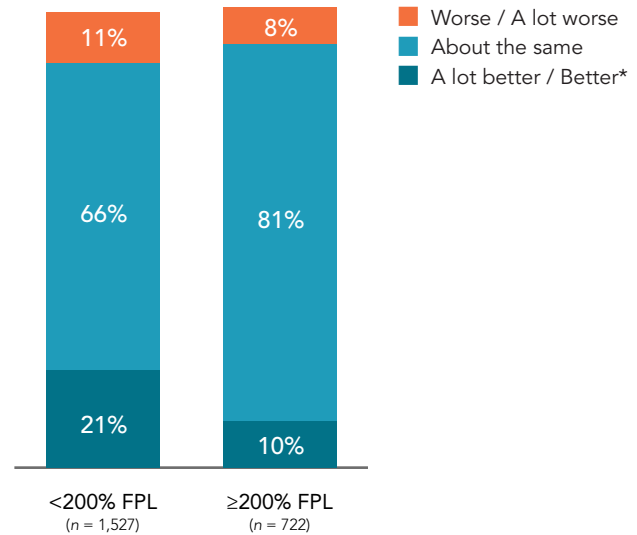
Interviews offered context and personal stories about why some respondents with low incomes experienced improvements in their health and mental health since the start of the pandemic. For some, the pandemic provided an opportunity to take a break from their regular fast-paced, busy workweek and focus on healthy behaviors. A number of participants described the upside of the pandemic-related restrictions, including having more time for sleep and exercise since they were no longer spending time commuting to work, as well as being able to focus on recovering from previous health issues.

Participants also described how working from home and flexibility in work hours allowed them to spend more time with their families. A few participants also reflected on the fact that the slower pace of their lives enabled them to think more deeply about their goals and purpose in life, including exploring or furthering new career and education opportunities.

Health care experts expressed some optimism that the slowed pace of pandemic life allowed some Californians to improve their physical and mental health. For Californians with low incomes, the challenges of their day-to-day lives, including traveling long distances to work, working long or late shifts, and spending money on commuting, can contribute to physical and mental health issues. For some of these individuals, the experience of having more flexible or reduced hours due to the pandemic may have contributed to improved health. However, the stresses associated with reduced income and household finances remain a concern in the long term.

Figure 5. Change in Overall Health Since the Pandemic, by Income

Q: Since the start of the COVID-19 pandemic, how, if at all, has your health changed? Is it . . .



\*Differences between the respondent groups was statistically significant at  $p < .05$ .

Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020. Segments do not sum to 100% due to rounding.

*“Well, I lost 20 pounds so I’m happy about that. I got off of my blood pressure medication, I’m happy about that. . . . I just want to be the healthiest me that I can be for as long as possible. I want to live a really long life; I want to be really influential on other people and their families and children. I want to help people in my neighborhood, people outside my neighborhood.”*

— 44-year-old Black resident, Bay Area

Erica Murray (CAPH) said, “I’m heartened that [some Californians with low incomes took] the opportunity to focus on healthy behaviors that the normal pre-pandemic environment might not have allowed for.”

#### LOOKING FORWARD:

### Supporting Vulnerable Populations

The pandemic exposed the vulnerability of certain populations, especially those who already had fair or poor physical or mental health, as they were more likely to suffer negative health impacts from the pandemic. Many health care experts noted that Californians with low incomes were already disproportionately impacted by chronic conditions associated with living in under-resourced neighborhoods, such as unhealthy air quality and substandard housing conditions, and that the pandemic exacerbated these issues. In addition, because of historically low investments in resources and health care services in these areas, this population has limited access to primary care services, in terms of both proximity and appointment availability, which negatively impacts physical and mental health.

Dr. Sandra R. Hernández (CHCF) recommended holding Medi-Cal accountable for providing its enrollees — Californians with low incomes — with comprehensive access to high-quality primary care, including primary mental health care. The program should focus on building up its primary care network and creating incentives for its providers to deliver thorough primary and preventive care to their patients.

## Health Care Access

The emergence of the COVID-19 pandemic drastically impacted access to health care. As the health care system became overwhelmed, nonessential medical procedures and appointments were halted. In addition, new safety precautions and fear of contracting the virus created obstacles to seeking care in person.

To understand the impact of these changes on Californian’s receipt of care, respondents’ interest in seeing a health care provider for various health issues during the pandemic were examined. The results help to elucidate who wanted care, who received care, and who did not receive care.

**THE TAKEAWAY.** *Respondents with low incomes were more likely to experience an issue they wanted to seek care for than respondents with higher incomes, and mental health care was their biggest need. More than two-thirds of respondents with low incomes who wanted to see a provider were interested in mental health care, and a quarter of these respondents said their mental health issue was new. Yet 42% of respondents with low incomes who wanted mental health care reported they did not receive care. Health care experts emphasized the need to increase access to mental health care and recommended integrating behavioral health into primary care. Growing and diversifying California’s mental health care workforce, including adding more community-based supports and providers like community health workers and promotores, were also noted as critical to expanding access to mental health care for Californians with low incomes.*

## Need for Care

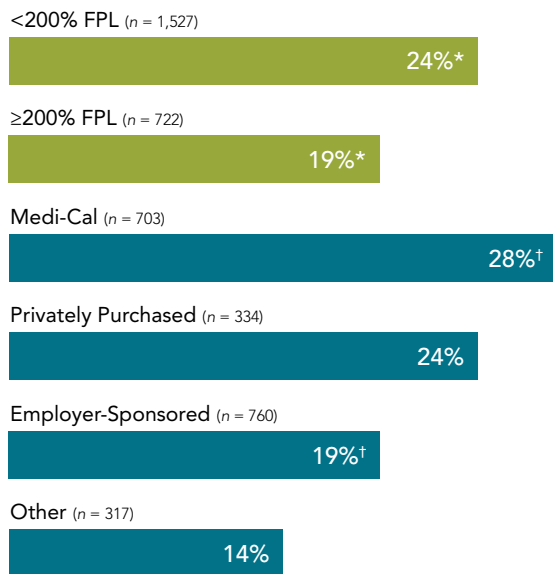
During the pandemic, respondents with low incomes were more likely than those with higher incomes to report having an issue they wanted to see a provider for. One in four respondents with low incomes experienced a health problem they wanted to see a provider for during the pandemic (24%), compared to one in five respondents with higher incomes (19%) (Figure 6). Respondents covered by Medi-Cal

were more likely to want to see a health care provider (28%) than those with employer-sponsored coverage (19%).

Among respondents with low incomes, White (29%) and Latinx respondents (27%) were more likely to report wanting to see a health care provider than Black (18%) or Asian respondents (9%) (see Figure 7).

**Figure 6. Experienced a Health Problem Since the Start of the Pandemic, by Income and Insurance**

Q: Since the start of the pandemic, have you experienced any health problem, including mental health or substance use, that you wanted to see a health care provider for?



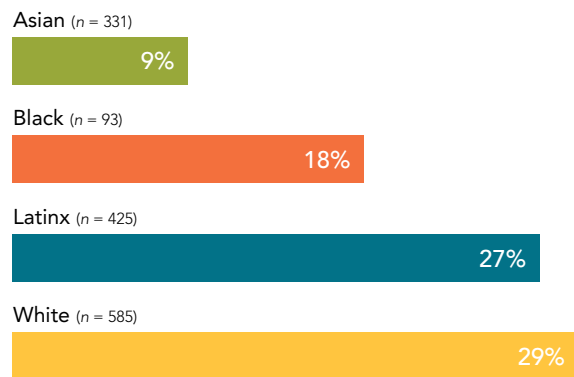
\*Differences between these groups were statistically significant at  $p < .05$ .

† Differences between these groups were statistically significant at  $p < .05$ .

Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020.

**Figure 7. Experienced a Health Problem Since the Start of the Pandemic, Among Respondents with Low Incomes, by Race/Ethnicity**

Q: Since the start of the pandemic, have you experienced any health problem, including mental health or substance use, that you wanted to see a health care provider for?



Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020 and who were considered low income at <200% FPL. Differences between racial and ethnic groups were statistically significant.

**A mental health problem was the most common issue for respondents with low incomes who wanted to see a provider during the pandemic.** More than two-thirds of respondents with low incomes (68%) who wanted to see a provider during the pandemic wanted care for a mental health problem, compared to just over half of respondents with higher incomes (53%) (Figure 8).

The second most common health issue reported by respondents with low incomes was a nonurgent physical health problem (42%).

One in three respondents with low incomes (33%) who reported wanting to see a provider for a health issue wanted care for a problem with alcohol or drug use, compared to less than one in five respondents with higher incomes (18%).

For respondents with low incomes who wanted to see a provider for a mental health issue since the start of the pandemic, a quarter (25%) reported their mental health issue was new since the start of the pandemic, compared to 22% of those with higher incomes ( $p < .05$ ).

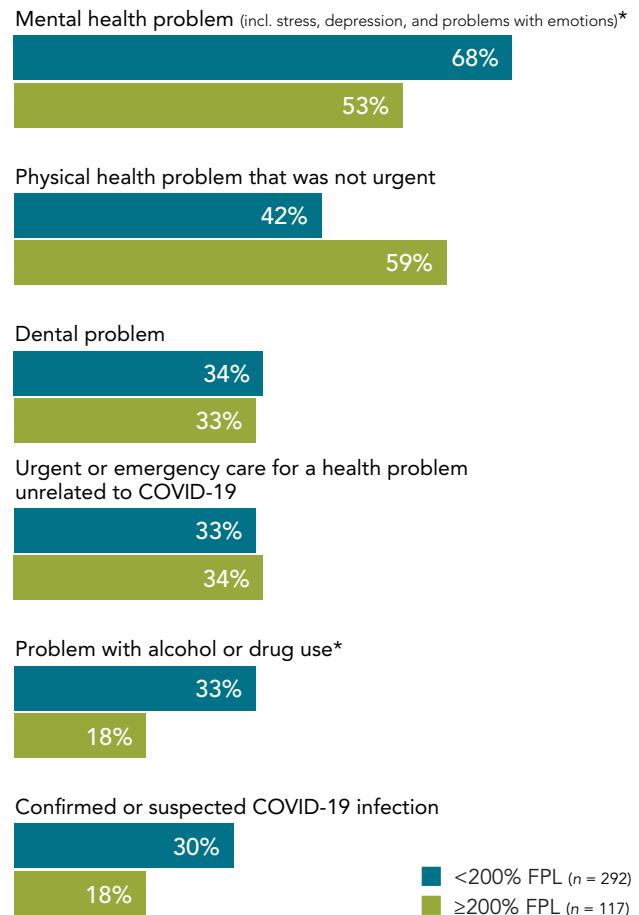
Regarding the significant prevalence of mental health concerns revealed by the survey, health care experts were optimistic that the pandemic and changing norms may help reduce the stigma around acknowledging and seeking help with mental health issues.

*“We’ve always had a barrier around stigma and people for various reasons not seeking [mental health] services. . . . I don’t know how much this really has to do with COVID, but sort of the normalization of mental health issues in our society. And I think that’s a positive thing.”*

— Kiran Savage-Sangwan, CPEHN

**Figure 8. Type of Health Problems Experienced Since the Start of the Pandemic, by Income**

Q: Was the problem you wanted to see a provider for . . .



\*Differences between groups were statistically significant at  $p < .05$ .

Note: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020 and who reported they wanted to see a provider for any issue during the pandemic.

*“Many people are grieving what they’ve lost over the course of the year and have had their anxiety or depression exacerbated.”*

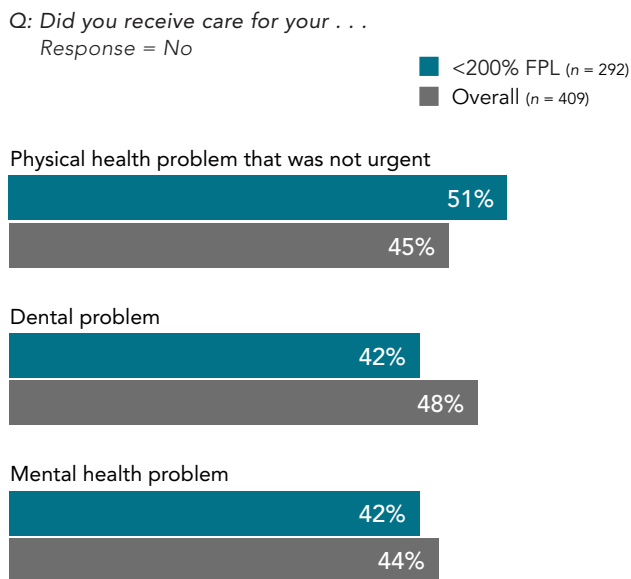
— Dr. Sandra R. Hernández, CHCF

## Care Received During the Pandemic

Many respondents with low incomes who reported wanting to see a health care provider since the start of the pandemic did not receive care.<sup>6</sup> Half of respondents with low incomes (51%) did not receive care for a physical health problem that was not urgent, and 4 in 10 (42%) did not receive care for their mental health issue (Figure 9).

**Interviews with respondents detailed varying reasons for not receiving care for health problems during the pandemic.** Some noted fears of contracting the virus during an in-person visit and planned to wait for an opportunity to get vaccinated before seeking in-person services again. Others noted specific challenges of accessing care during the pandemic, including limited physician availability, and difficulty arranging childcare while children were attending remote school from home.

**Figure 9. Did Not Receive Care for Health Problems Since the Start of the Pandemic, by Income**



Note: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020 and who reported they wanted to see a provider for any issue during the pandemic.

*“Before, I was going to the mental health wellness center almost every day, going to classes, learning how to budget, pay bills. They were teaching me. They were also walking me through my childhood traumas and talking to my counselor. Not anymore.”*

— 38-year-old Latinx resident,  
San Joaquin Valley

*“I didn’t want to go because we were during COVID time now. I was afraid for the doctor and for myself.”*

— 57-year-old Asian resident,  
Southern California

*“I did have a thought to see a psychiatrist, but then I thought there might be a vaccine soon. The pandemic might be over soon. I just tried to comfort myself so that I can feel better this way.”*

— 26-year-old Asian resident,  
Los Angeles

## Delaying Care

In addition to those who did not receive care for the problems they wanted to see a provider for, **many respondents indicated they had delayed care during the pandemic.** They planned to wait until the end of the pandemic or the availability of vaccines to seek care.

**The financial strain of the pandemic also led many respondents with low incomes to delay care.** One-third of respondents with low incomes (33%) delayed seeking care since the pandemic began in order to manage health care costs. One-third of respondents with low incomes (32%) used self-care or home remedies instead of seeking care from a provider. Thirty-six percent of respondents with Medi-Cal coverage delayed seeking care, compared to 24% of those with employer-sponsored coverage ( $p < .05$ ).

**Many respondents of color with low incomes delayed care due to difficulty affording health care costs since the start of the pandemic.** Thirty-seven percent of Asian respondents with low incomes, 35% of Black respondents, and 33% of Latinx respondents delayed seeking care since the pandemic began, compared to 26% of White respondents with low incomes (Figure 10).

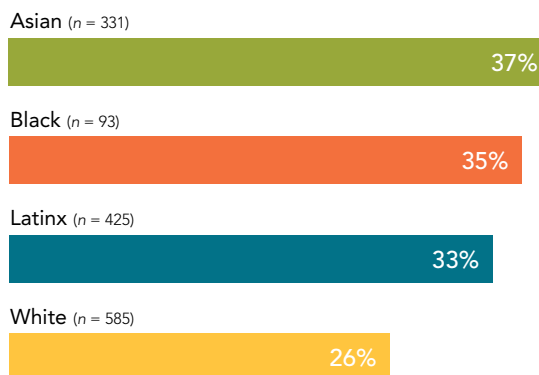
### LOOKING FORWARD:

## Critical to Get Californians with Low Incomes Back into Care

Health care experts raised concerns about the large numbers of Californians, especially those with low incomes and those who have been marginalized, who delayed or have not received care since the start of the pandemic. Several health care experts noted how the messaging regarding pandemic public health safety measures scared people away from seeking care, and that messages about how and when to seek care safely, or alternatives such as telehealth, have not reached many Californians with low incomes.

Figure 10. Delayed Seeking Care to Manage Health Care Costs During the Pandemic, by Race/Ethnicity

Q: Did you delay seeking care to manage health care costs since the start of the COVID-19 pandemic?



Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020 and who were considered low income at <200% FPL. Differences between White respondents and all other racial/ethnic groups were statistically significant at  $p < .05$ .

*“When we met with the state Department of Public Health, they said, ‘You’ve got to get your people in for care.’ And we said, ‘But you keep telling them to stay home.’ We need better messaging.”*

— Louise McCarthy,  
CCALAC

**Health care experts agreed that getting Californians with low incomes back into the system after the pandemic will be critical to treat chronic health issues, provide preventive care, ensure children are on schedule for vaccinations and checkups, and address new health issues and those that deteriorated during the pandemic.** Jacqueline Martinez Garcel (Latino Community Foundation), noted that primary care providers need to engage in outreach to let their patients and communities know it is safe to come back and get care. She also recommended investing in community health center networks and creating community driven opportunities to reach out to communities hardest hit by the pandemic and that are underserved by local health facilities. Working with nonprofits led by people of color would be a good place to start.

**Several health care experts discussed leveraging the mass vaccination effort to reengage patients, especially to get immunizations and screenings.** Dr. Sandra R. Hernández (CHCF) said, “We need to get the message out that we are open for primary care and prevention, for immunizations, and for screening. While we are spending all of this money on vaccine education, we should also be messaging that there are other lethal diseases that we’re trying to prevent, and childhood diseases are among them.”

**One expert raised the issue of immigration concerns causing California immigrants to delay care.** While the new federal administration has rolled back many public charge rules that presented barriers to engaging immigrant communities in care, education directed at these communities about these changes has been limited. Dr. Sandra R. Hernández recommended engaging providers and public health advocates to actively address immigration-related concerns about accessing care to ensure that immigrant Californians get the care they need.

Dr. Rishi Manchanda (HealthBegins) recommended putting the onus of getting people back into the system on the system itself and noted how structural factors impact the ability of the system to meet the needs of Californians with low incomes. He said, “Instead of ensuring that people come to the health care system, how do we get the health care system to the people? The payment and financing structures that we have right now make that impossible for many, even for the most social mission-oriented organizations.”

#### LOOKING FORWARD:

### **Need to Increase Access to Mental Health Care**

**Health care experts recognized the need to shift the mental health care system from a crisis-response system to one oriented toward prevention and ongoing support for positive mental health.** The pandemic exacerbated the need for ongoing mental health support to help people weather the uncertainty and anxiety associated with the pandemic, and the mental health system is not prepared to provide this kind of support as it is currently structured. Drawing on informal mental health services, peer and community supports, and an invigorated mental health workforce would help to reorient the mental health care system toward proactively addressing people’s mental health needs.

*“I think it’s important to point out that postpandemic, we will have a significant increased demand for mental health services. We don’t have a good primary behavioral health system that allows people to access care when they need it. What we have is largely an emergency-based system, and even that was overwhelmed prepandemic.”*

— Dr. Sandra R. Hernández, CHCF



**Experts also highlighted existing access barriers due to an insufficient mental health care workforce, and the need to build a culturally competent workforce to meet the diverse needs of Californians with low incomes.**

*“[T]he recruitment that needs to happen to build up a network of mental health providers that has availability and the cultural competence to care for these communities. . . . This part of the safety net was already strained to begin with due to a constant lack of investment.”*

— Erica Murray, CAPH

Experts recommend deploying less medicalized approaches to mental health care, including peer support and community-based mental health prevention and treatment activities. Dr. Rishi Manchanda (HealthBegins) recommended leveraging a community-based workforce to help reach people experiencing mental health issues and to reduce the stigma associated with seeking care for those issues. He said, “Tapping into community-based workforce, including CBOs, . . . [can] help normalize understanding of mental health to address the concerns out there that prevent some people from actually being able to disclose, and discuss, and feel open about it. And that means actually just investing in community-based workforce, as well as the lay community — natural helper folks who are out there.”

Another expert suggested the integration of cultural practices valued by different communities alongside “westernized approaches” to care as a way to build connections between communities and health care systems, and to reduce negative perceptions related to seeking care for mental health concerns.

While many experts agreed that the stigma around seeking care for mental health issues has been reduced, they cautioned that there is a deeply entrenched structural stigma surrounding the delivery of mental health care.

**One promising development during the pandemic has been the use of telehealth for mental health care, which can help improve access and leverage the capacity of a limited workforce.** Louise McCarthy (CCALAC) noted, “Our no-show rate for mental health visits is way down. . . . With telehealth, they can hop on the phone with a counselor. We’ve destigmatized mental health care enough that picking up the phone actually is improving their access.”

*“[Imagine] you’re a kid in school and you reach out to your guidance counselor and you say you’re having thoughts of suicide. The first intervention you might get is a police car showing up at your school to pick you up. How horrible is that as a kid, when you’re finally disclosing how you feel and then the police are the first intervention? Especially if you’re a kid of color. . . . [Or] you’re at your pediatrician’s office and they ask, ‘How are you feeling?’ You say, ‘I’ve been a little anxious.’ They say, ‘Oh, I know this person who specializes in anxiety. You should go talk to them.’ It sends a signal that you’re different and we’re going to treat you as such, so you need to go do something else. Structural stigma is pervasive.”*

— Dr. Benjamin F. Miller, Well Being Trust

Another expert noted that many younger Californians have been using apps and online tools for mental health support during the pandemic, including meditation, nutritional guidance, and support groups. The availability of digital supports such as these might help reduce the stigma of seeking help for mental health.

## Telehealth

Telehealth emerged as a critical source for accessing health care during the COVID-19 pandemic, due to restrictions on in-person services as well as individual concerns about exposure to the coronavirus.

**THE TAKEAWAY.** *Telehealth (both phone and video visits) was an essential source of care for respondents with low incomes and people of color during the pandemic. Phone visits played a particularly important role for those with low incomes, constituting half of all telehealth visits for this group. Satisfaction was high for both phone and video visits among those with low incomes who received telehealth during the pandemic, with 70% saying they would likely choose either a phone or video visit over an in-person visit in the future. Interviews with respondents and experts stressed the importance of ensuring equitable access to both in-person visits and telehealth going forward, with patients able to choose based on their preferences and clinical needs.*

### Use of Telehealth

Telehealth<sup>7</sup> was an important source for care for respondents with low incomes and respondents of color. Two-thirds of respondents with low incomes (65%) and three-quarters of respondents of color (76%) who received care during the pandemic reported that they had a telehealth visit (Figure 11).

**More than half the care received by respondents with low incomes who received telehealth was by phone (53%).** Forty-one percent of respondents with low incomes who had a telehealth visit received a video visit, and 7% received both a phone and a video visit (Figure 12).

**Figure 11. Telehealth Visit, by Race/Ethnicity and Income**

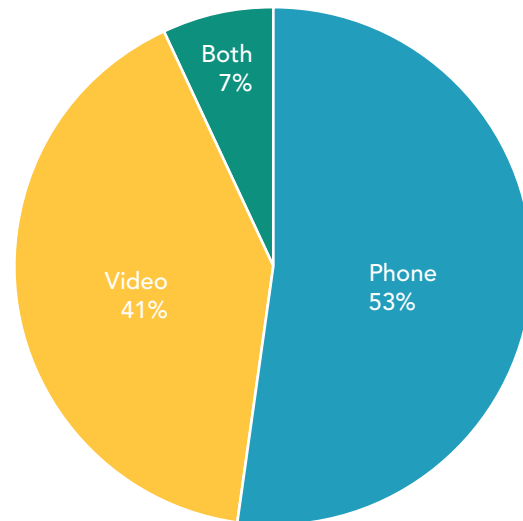
Q: How did you receive care?  
Response = By phone or video (vs. in person)



Notes: Sample limited to California residents age 18 to 64 who saw a doctor or other health care provider between March 2019 and summer 2020 and who reported having received any care during the pandemic. *People of color* is used to aggregate non-White respondents where there was not a sufficient number of respondents to make observations by specific racial and ethnic categories.

**Figure 12. Telehealth Visits for Respondents with Low Incomes, by Type**

Q: How did you receive care?  
Response = By phone, video, or both



Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020, were considered low income at <200% FPL, and saw a provider during the pandemic via telehealth (total n = 130). The proportion represents the average proportion of care received by each mode for respondents with low incomes who reported receiving care via telehealth. Segments do not sum to 100% due to rounding.

## Satisfaction with Telehealth

**Respondents with low incomes report high levels of satisfaction with telehealth visits.** Two-thirds of respondents with low incomes (67%) were “very satisfied” or “somewhat satisfied” with the overall experience of their phone visit during the pandemic, and nearly two-thirds (64%) were “very satisfied” or “somewhat satisfied” with the overall experience of their video visit (Figure 13).

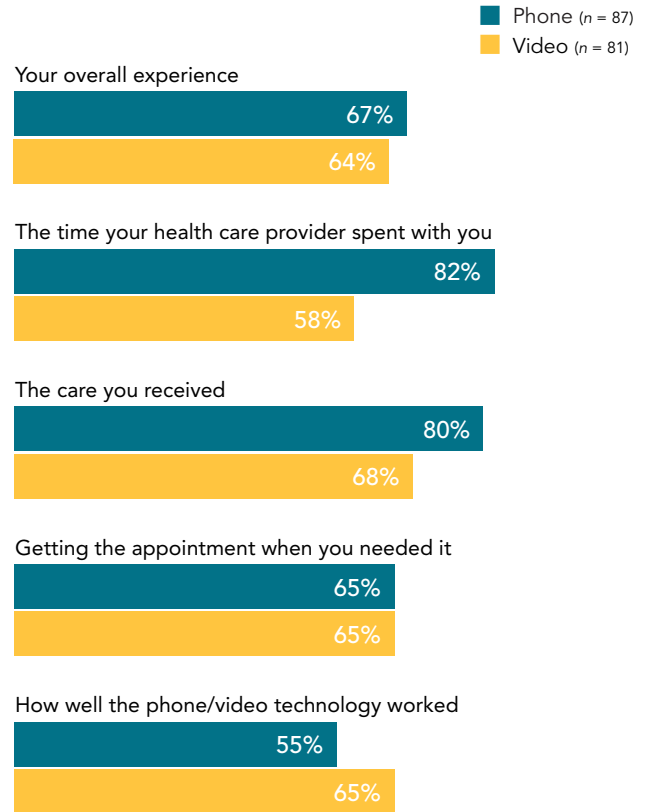
Regarding how well the technology worked, 65% of respondents with low incomes were “very satisfied” or “somewhat satisfied” with the technology during video visits, and 55% were “very satisfied” or “somewhat satisfied” with the technology during phone visits.

*“You don’t have to step out of your house. It’s super easy. It’s just the 15 minutes, that’s all it takes. Nowadays everyone is on screens all day, so that makes it very accessible. The doctors will be able to see more patients, too, because there is less walking back and forth in-between. I worry a little bit about the information you can extract in person . . . if that same nuanced information can come across in a video visit.”*

— 32-year-old Asian resident, Bay Area

**Figure 13. Satisfaction with Telehealth Visits Among Respondents with Low Incomes**

Q: Thinking about the care you received by phone or video since the start of the COVID-19 pandemic, would you rate your satisfaction level as “very” or “somewhat” satisfied with . . . ?



Note: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020, were considered low income at <200% FPL, and saw a provider via telehealth during the pandemic.

The majority of respondents with low incomes were just as or more satisfied with telehealth visits than they were with their last in-person visit. Half of respondents with low incomes (50%) were “more satisfied” with their video visit than their last in-person visit, and more than one-third (36%) were “just as satisfied” (Figure 14). Only 14% were “less satisfied” with their video visit than their last in-person visit. Similarly, high percentages of respondents with low incomes were “more satisfied” (46%) or “just as satisfied” (38%) with their phone visit than with their last in-person visit.

*“It’s better to visit a doctor by video unless the doctor needs to exam you in person for a particular reason. It’s better by video. But if I have pain in my ears, in my nose, of course, it’s better to visit a doctor in person because the doctor needs to exam your ears or nose, or even inside your throat. . . . For an annual checkup, it can be done by phone or by video. The lab order can be mailed to me. I can do the blood work. This can save my time to visit the doctor’s office.”*

— 26-year-old Asian resident, Los Angeles

## Future Interest in Telehealth

Most respondents with low incomes who received telehealth during the pandemic would likely choose a telehealth visit in the future. Seventy percent of respondents with low incomes agreed that in the future, whenever possible, they would likely choose a phone or video visit over an in-person visit, compared to only 52% of those with higher incomes (Figure 15). Sixty-four percent of respondents with low incomes agreed that they had an easier time keeping their appointment for a phone or video visit than they did keeping appointments for in-person visits in the past,

Figure 14. Satisfaction with Telehealth Visits Compared to Last In-Person Visits Among Respondents with Low Incomes (<200 FPL)

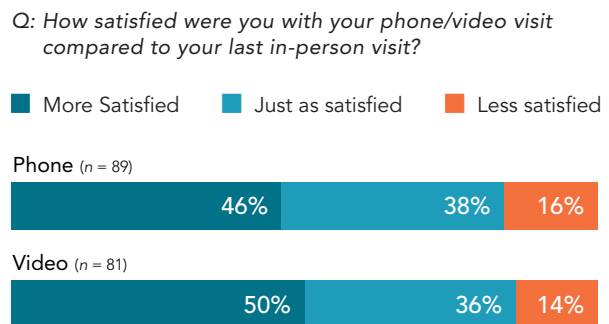
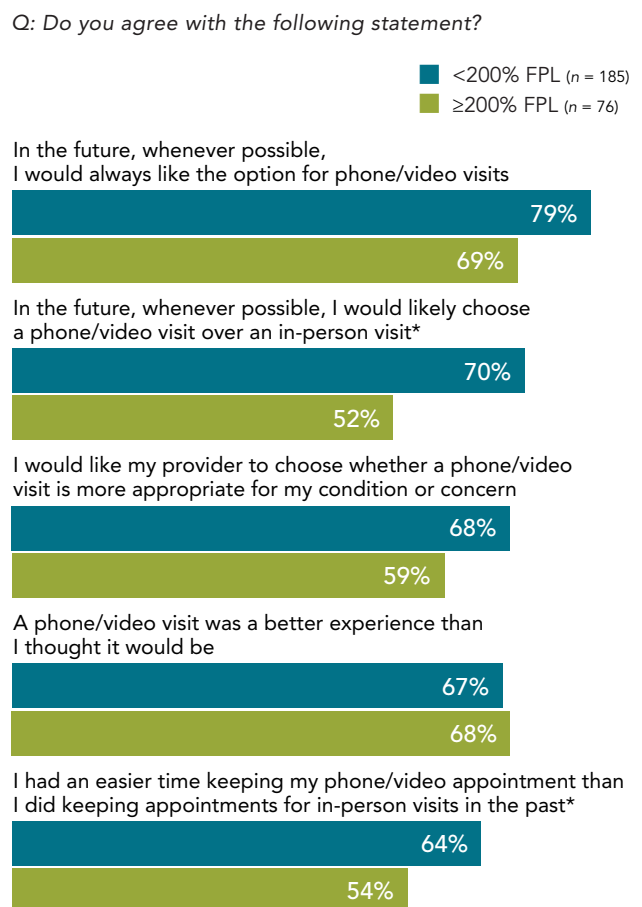


Figure 15. Satisfaction with and Future Interest in Telehealth, by Income



\*Indicates statistically significant differences between groups at  $p < .05$ .

FIGURES 14 AND 15:

Note: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020 and who saw a provider during the pandemic via telehealth.

compared to 54% of those with higher incomes. These results indicate that telehealth can be an important avenue for accessing care for those with lower incomes.

**Respondents of color also expressed high levels of interest in telehealth for future visits.** Among respondents of color with low incomes, more than four in five (82%) would likely choose a phone or video visit over in-person visit in the future if possible (Figure 16). Further, 85% would always like the option for telehealth visits in the future, whenever possible.

Sixty-nine percent of respondents of color with low incomes agreed with the statement: “I had an easier time keeping my appointment for a phone or video visit than I did keeping appointments for in-person visits in the past.”

**Interviews with respondents reveal a more nuanced perspective on their future interest in telehealth.** For the most part, interview participants appreciated the convenience of a telehealth visit, including not having to travel long distances to an appointment, take time off of work, or endure long wait times to see a provider. Interviewees also described their comfort with using the technology, and the lack of technological challenges during their visit.

At the same time, interviews with respondents revealed some concerns related to telehealth visits. Several participants described drawbacks related to privacy, both finding private spaces in their homes to take appointments and concerns about security and privacy when sharing personal information over the internet. Some respondents also said that they did not have access to the necessary technology for video visits. A few respondents felt that there was a lack of engagement from providers during telehealth visits.

Looking forward, many interviewees recognized the convenience of having a phone or video visit for certain types of health care needs, including follow-up appointments and visits for health issues that do not require in-person examination. Among these interviewees, some expressed a strong preference for video visits, while others preferred phone visits.

**Figure 16. Satisfaction with and Future Interest in Telehealth Among Respondents of Color with Low Incomes (n = 113)**

Q: Do you agree with the following statement?

In the future, whenever possible, I would always like the option for phone/video visits

85%

In the future, whenever possible, I would likely choose a phone/video visit over an in-person visit

82%

I would like my provider to choose whether a phone/video visit is more appropriate for my condition or concern

74%

A phone or video visit was a better experience than I thought it would be

73%

I had an easier time keeping my phone/video appointment than I did keeping appointments for in-person visits in the past

69%

Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020, were considered low income at <200% FPL, and saw a provider during the pandemic via telehealth. *People of color* is used to aggregate non-White respondents where there was not a sufficient number of respondents to make observations by specific racial and ethnic categories.

*“I do like that it is convenient. You are there. You can have it anywhere you are at. But that is the double-edged sword. You don’t know who is listening to what and getting what information. You could be at McDonalds using the free Wi-Fi, and if you have to tell them the last four of your social to get into the appointment. And then, guess whose identity just got stolen?”*

— 38-year-old Latinx resident, San Joaquin

Some respondents expressed a strong preference for in-person visits, citing reasons like having a better personal connection with their doctor and ensuring that their health concerns that require in-depth assessment can be addressed. Nearly all interviewees indicated they would prefer in-person care for certain health issues, such as when a physical exam is required or blood pressure needs to be checked.

#### LOOKING FORWARD:

### Telehealth Will Continue to Play a Key Role in the Health Care System

**A key takeaway from interviews with survey respondents is that a mix of in-person visits and telehealth — both phone and video — would work best for most patients.** As noted above, many interviewees liked the idea of using telehealth for routine health care issues and follow-up appointments, while still ensuring access to in-person visits for more complicated issues and for those who prefer them.

This takeaway was echoed in interviews with health care experts, who emphasized the need to ensure equal access to both telehealth and in-person care for Californians with low incomes. Because the availability of telehealth as an option for care has been rapidly expanded during the pandemic, Dr. Sandra R. Hernández (CHCF) recognized the need for evaluation to understand where telehealth works well and where its effectiveness as a mode of care delivery might be more limited.

**Experts also emphasized the importance of ensuring that all people, especially those with low incomes, always have a choice of how they receive care.** To accomplish this, Californians with low incomes need equitable access to providers, as well as resources to assist them in choosing how they want to receive care. In the absence of individual choice and broader system changes focused on equity, telehealth could become the next frontier for disparities in care.

### Across the board, health care experts agreed that telehealth has an important role to play in increasing access to care for Californians with low incomes.

Many health care experts described telehealth as a “game changer” or “completely transformative” for providing access to care for this population. Mental health and patient monitoring were two areas of health care for which experts were especially excited about the potential for the expanded and continued use of telehealth. Experts pointed out that a key benefit of telehealth visits is that they reduce the ancillary costs of seeking health care, including taking time off work, traveling to providers’ offices, and finding child or family care.

*“This is about equity. It’s unfair that someone who’s publicly insured can’t enjoy the same benefits as someone with a higher income for whom it’s easier to get away from work to make that appointment. It’s also critical that we all recognize that this is real, actual, honest-to-God care. It took a bit for some folks, including the consumer advocates, to warm up to telehealth, to realize that this is care. It’s not a lesser substitute. It’s the real thing.”*

— Louise McCarthy, CCALAC

### Importantly, telehealth has the potential to expand access to racially/ethnically diverse providers, including providers who speak different languages.

The opportunity for accessing in-language care via telehealth was raised as an important aspect of providing culturally competent care overall, and reducing the disparity in access to care between English speakers and those with limited English proficiency. Kiran Savage-Sangwan (CPEHN) noted that telehealth can help “in terms of cultural concordance, and opportunity to be able to expand the network of providers that folks can see. So you don’t have to be in Los Angeles to see a Korean-speaking therapist in Los Angeles.”

*“Telehealth will make it possible for people to see a physician or other support members of that primary care team that speak their language. . . . I’m sure with the tech progress we made in the last decade, we can figure out how to build in an interpretation tool so that people can connect in the language of preference. . . . telehealth provides the opportunity to deal with the shortage of physicians and health care providers who speak the first or second language of 40% of the population in California.”*

— Jacqueline Martinez Garcel  
Latino Community Foundation

**Health care experts emphasized the importance of ensuring that Californians with low incomes have sufficient technology, connectivity, and privacy for effective telehealth visits.** Suggested solutions for safeguarding equity included screening patients for access to digital devices and the internet in the care setting, providing necessary patient technology as a health plan benefit, and advocating for universal broadband as a public utility in California. Some experts also recommended expanding Medi-Cal coverage to pay for the devices needed to engage in telehealth.

Experts argued that the continuation of sufficient provider reimbursement for care delivered via telehealth is critically important to support the ongoing and expanded use of telehealth. During the pandemic, adjustments to providers’ covered services and rates for providing telehealth care were made to incentivize providers to continue providing care even amid restrictions on in-person care. Continuation of these rates, rather than a return to lower payments for telehealth services, would help enhance providers’ capability to provide telehealth to this population.

Beyond addressing the digital divide between Californians with low incomes who may not have access to technology to support telehealth and those with higher incomes who do, Dr. Rishi Manchanda (HealthBegins) urged the health care system to design and deploy telehealth to better serve those with low incomes. He said, “The digital divide issue has to be elevated. But I also think that it means that the models of telehealth, much like the models of care in brick and mortar, have to be redesigned with the end user in mind. . . . Instead of saying, Can telehealth services designed for higher-income patients help low-income patients?, it’s Can we build a telehealth platform and payment model that meets the needs of low-income patients?”

## Experiences of COVID-19-Related Stress

The conditions caused by the COVID-19 pandemic have disrupted many people’s daily lives, leading to unprecedented levels of stress and anxiety. Respondents were asked to report which of the following stressors they have experienced as a result of the pandemic:

- ▶ Concern about the health or well-being of a loved one
- ▶ Affording basic needs, such as food, rent, and utilities
- ▶ Children out of school or childcare unavailable
- ▶ Stress in your relationship or marriage
- ▶ Death of a loved one
- ▶ Other stress

**THE TAKEAWAY.** *Californians with low incomes were more likely to experience multiple pandemic-related stressors than those with higher incomes. Experiencing multiple stressors was associated with worsening mental health during the pandemic. Respondents with low incomes were also more likely to experience negative changes in family income and employment during the*

pandemic. Health care experts emphasized the need to address social determinants of health, such as poor living conditions and financial and job insecurity, that contribute to the high levels of stress experienced by Californians with low incomes.

**Respondents with low incomes reported more stress than those with higher incomes.** Ninety-six percent of respondents with low incomes experienced at least one stress on the list, compared to 86% of those with higher incomes (Figure 17). Slightly more than half of respondents with low incomes (53%) experienced two or more stressors, compared to only 40% of those with higher incomes. Twice as many respondents with low incomes reported four or more stressors (10%) compared to those with higher incomes (5%).

*“My life has made a 180-degree turn. The pandemic has affected my household economically. The fact that my kids take classes here at home is frustrating for me and frustrating for them. I think that also affects health, because stress isn’t healthy for anyone, neither kids not adults. . . . I had an accident a year ago that hurt my back badly. I’ve realized that because of stress, because of lack of work, because of the lack of money, my pain is more intense. I also get too stressed out and I have gained weight. COVID has affected my personal life in many, many ways and the life of my family.”*

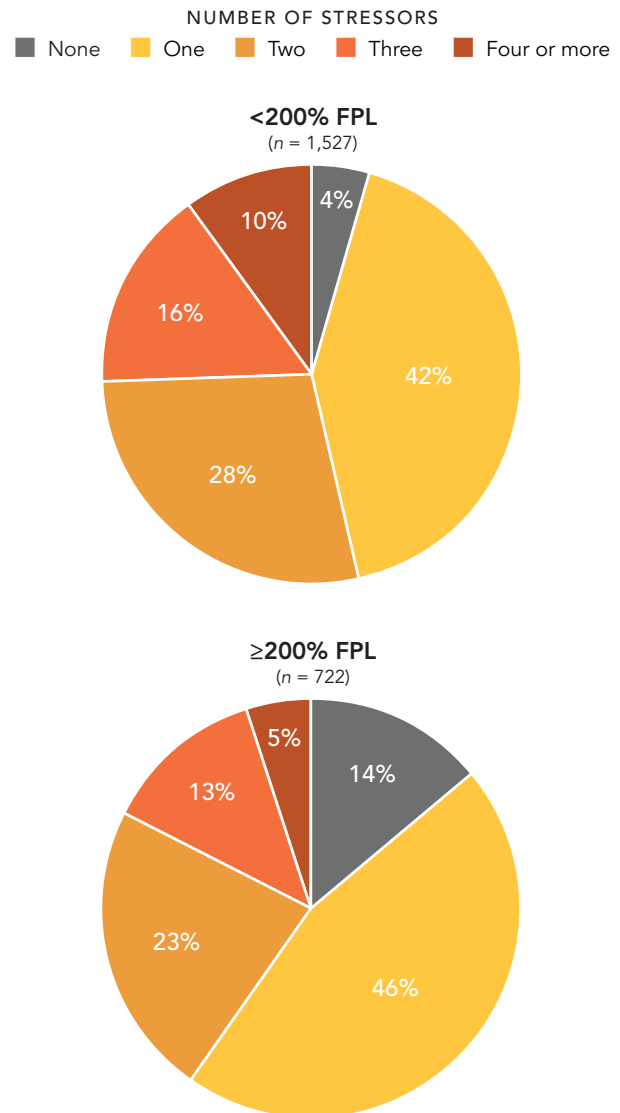
— 46-year-old Latinx resident, Inland Empire

**Figure 17. Number of Pandemic-Related Stresses Experienced, by Income**

Q: Which of the following stresses, if any, have you experienced as a result of the COVID-19 pandemic? Please select all that apply.

Responses:

- Concern about the health or well-being of a loved one
- Affording basic needs, such as food, rent, and utilities
- Children out of school or childcare unavailable
- Stress in your relationship or marriage
- Death of a loved one
- Other stress



Notes: Sample limited to California residents age 18 to 64 who saw a doctor or other health care professional between March 2019 and summer 2020. Differences between income groups are statistically significant at  $p < .05$ . Segments may not sum to 100% due to rounding.



**Respondents with low incomes were also more likely to experience certain stressors than those with higher incomes.** Respondents with low incomes were more than twice as likely to experience the death of a loved one (10%) than those with higher incomes (4%) (Figure 18). Half of respondents with low incomes reported stress related to affording basic needs (50%) compared to one in five respondents with higher incomes (18%). More than half of respondents in both income groups reported stress related to concern about the health of a loved one.

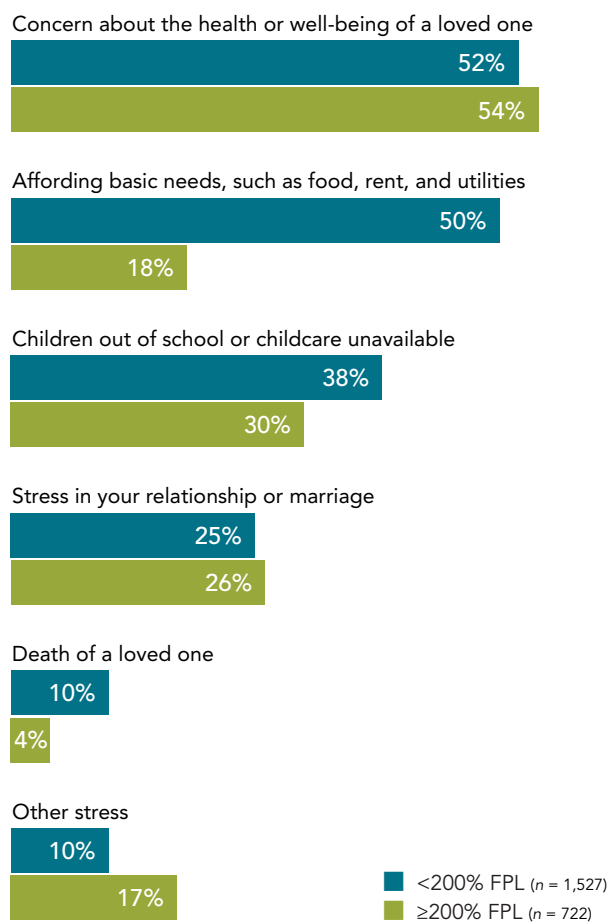
**Stressors experienced during the pandemic varied by race and ethnicity.** Black respondents with low incomes were most likely to report having experienced the death of a loved one, with one in five (21%) reporting this, compared to 11% of Latinx, 8% of White, and 2% of Asian respondents with low incomes (Figure 19, page 26). Three in five Asian (60%) and Black respondents with low incomes (59%) reported stress related to affording basic needs, such as food, rent, and utilities, compared to 49% of White and 47% of Latinx respondents with low incomes.

**Stressors also varied by language spoken.** Respondents with low incomes who spoke Vietnamese were most likely to experience stress related to concern about the health or well-being of a loved one (87%), compared to 57% of those who spoke Spanish or were bilingual (Spanish and English), 54% of those who spoke Chinese, and 51% of those who spoke English. (Figure 20, page 26.)

Almost three-quarters of respondents with low incomes who spoke Chinese (73%) reported stress related to affording basic needs, compared to 51% of Spanish/bilingual speakers and 48% of English speakers ( $p < .05$ ). English speakers were less likely to report children out of school or childcare unavailable (38%) compared to Spanish/bilingual speakers (44%) and Vietnamese speakers (49%). Chinese speakers with low incomes were much less likely to report the death of a loved one (1%) compared to all other groups (7% of Vietnamese speakers, 11% of English, and 12% of Spanish/bilingual).

**Figure 18. Pandemic-Related Stresses Experienced, by Income**

Q: Which of the following stresses, if any, have you experienced as a result of the COVID-19 pandemic? Please select all that apply.



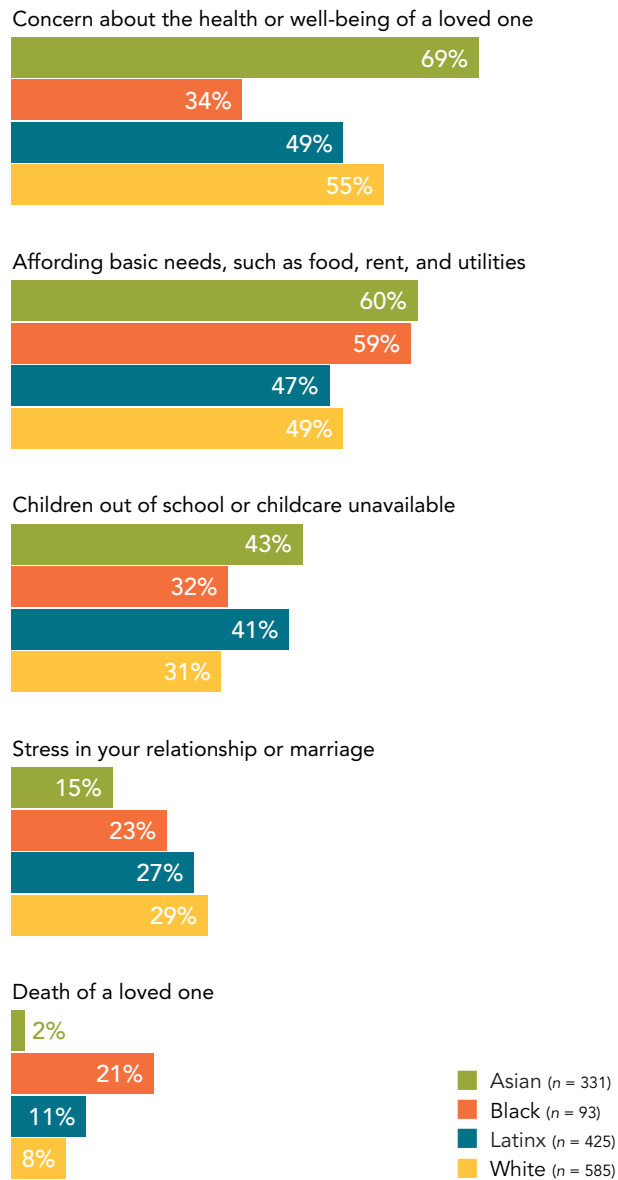
Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020. Differences between groups who reported “death of a loved one” and “affording basic needs, such as food, rent, and utilities” are statistically significant at  $p < .05$ .

*“We were just feeling more stressed, so you know, more tired and a little bit more confusion because you don’t know exactly what to do, and you don’t have a clear idea of how to organize your everyday life.”*

— 35-year-old White resident, Central Coast

**Figure 19. Pandemic-Related Stresses Experienced Among Respondents with Low Incomes, by Race/Ethnicity**

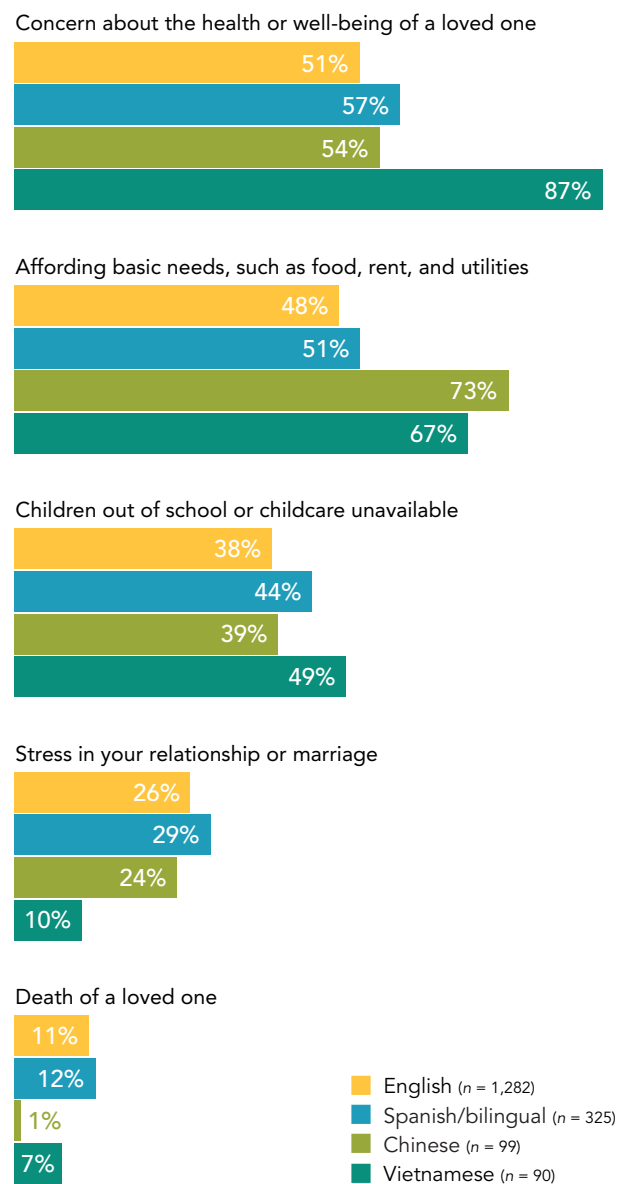
Q: Which of the following stresses, if any, have you experienced as a result of the COVID-19 pandemic? Please select all that apply.



Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020. Differences between groups were statistically significant for all statements except "children out of school" at  $p < .05$ .

**Figure 20. Pandemic-Related Stresses Experienced Among Respondents with Low Incomes, by Language**

Q: Which of the following stresses, if any, have you experienced as a result of the COVID-19 pandemic? Please select all that apply.



Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020. Differences between groups were statistically significant ( $p < .05$ ) for the following items: concern about the health of a loved one (Vietnamese compared to English, Spanish/bilingual, and Chinese), affording basic needs (Chinese compared to English and Spanish/bilingual, English compared to Vietnamese), children out of school (English compared to Spanish/bilingual and Vietnamese), stress in relationships (Chinese compared to Vietnamese), death of a loved one (Chinese compared to Spanish/bilingual and Vietnamese), and other stress (English compared to Spanish/bilingual and Chinese, Spanish/bilingual compared to Vietnamese, and Chinese compared to Spanish/bilingual and Vietnamese).

Interviewees expanded on the stresses they experienced since the start of the pandemic. Many expressed concerns about their family members and friends, as well as anxiety about being exposed to the virus and complying with social distancing and masking requirements. Interviewees with children described the stress of supervising kids in remote learning, especially when there were schoolwork problems that they were unable to address on their own.

*“My older children have distance learning. That’s been stressful because everything that they need, I have to help them with.”*

— Latinx 34-year-old resident, Central Coast

**Interviewees also discussed their coping strategies for dealing with pandemic-related stress.** Many discussed how they tried to focus on the “here and now” or taking it “one day at a time” as a way to handle the shifting circumstances and restrictions related to the pandemic. Prayer and drawing on personally held spiritual beliefs were important mechanisms through which interviewees managed stress. Self-care activities like meditation, exercise, drinking tea, and connecting with family or friends virtually were also common. Many interviewees spoke about taking walks outside as a mechanism to alleviate stress. Picking up new hobbies, such as crafting or gardening, and immersion in studies or schoolwork were also mentioned as important ways that interviewees managed their elevated stress levels during these times.

*“I notice that the days that I don’t take care of myself I physically feel much worse. So I try to make self-care a daily practice so that I feel better on all aspects — physical, mental, emotional, spiritual.”*

— 26-year-old White resident, Central Coast

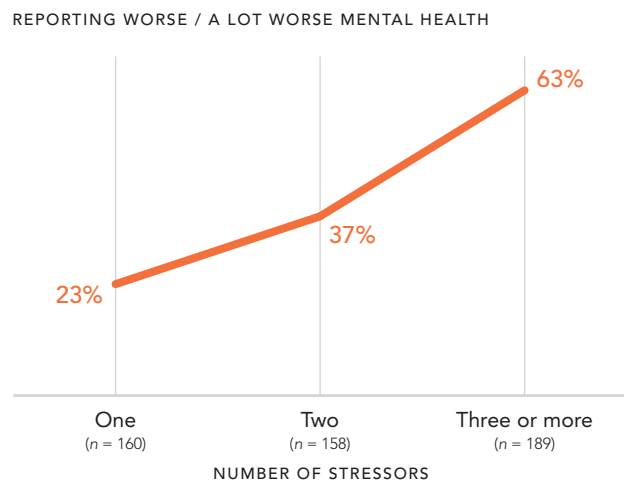
## Impact of Stress on Health

The connection between stress and health is well established in research.<sup>7</sup> This study corroborates this connection, as experiencing pandemic-related stress was associated with deteriorating mental health during the pandemic.

**More stressors experienced by respondents were associated with worse mental health.** As the number of reported stressors increased from one to three or more, so did the proportion of respondents with low incomes who reported “worse” or “a lot worse” mental health since the start of the pandemic (see Figure 21). Among respondents with low incomes who experienced one stressor, 23% reported “worse” or “a lot worse” mental health, compared to 63% among those who experienced three or more stressors.

**Figure 21. Number of Pandemic-Related Stresses Experienced and Reports of Worse Mental Health During the Pandemic Among Respondents with Low Incomes**

Q: Which of the following stresses, if any, have you experienced as a result of the COVID-19 pandemic? AND Since the start of the COVID-19 pandemic, how, if at all, has your mental or emotional health changed? Is it worse or a lot worse?



Note: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020, were considered low income at <200% FPL, and reported any COVID-19-related stressors and who reported that their emotional health got “worse” or “a lot worse” since the start of the COVID-19 pandemic. The increases in proportions of respondents who reported “worse” or “a lot worse” mental health was statistically significant ( $p < .05$ ).

**Stress in relationship or marriage was the stressor most associated with “worse” or “a lot worse” mental health.** More than half of respondents with low incomes (56%) who reported stress in their relationship or marriage during the pandemic also reported “worse” or “a lot worse” mental health since the start of the pandemic. Half of respondents with low incomes (50%) who reported the death of a loved one also reported “worse” or “a lot worse” mental health.

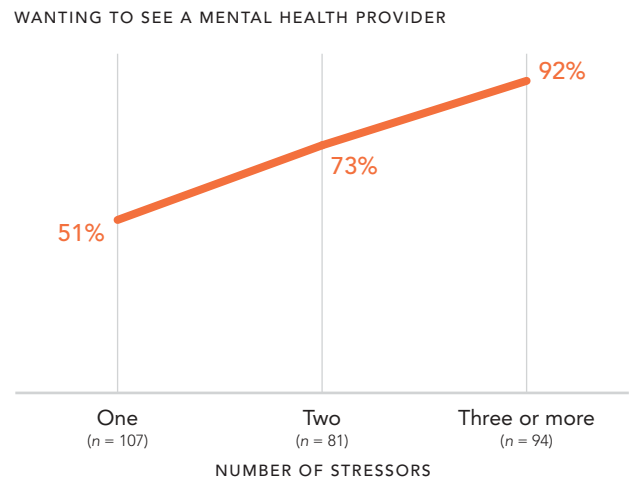
*“It’s affected my friendships; it’s affected my family because if anyone gets the sniffles, I want them to stay away from me because I have a weak immune system. . . . I care for a family of seven now. All I live on is food stamps. During the pandemic, the stress got too much, and me and my husband separated. And I became homeless. Before the pandemic, getting my Section 8 voucher was moving along, but then it stopped.”*

— 38-year-old Latinx resident,  
San Joaquin Valley

**Experiencing stress is associated with wanting to see a provider for a mental health concern.** Among respondents who wanted to see a provider for a health problem during the pandemic, experiencing more COVID-19-related stressors was associated with wanting care for a mental health problem (compared to a different type of health problem). Half of respondents with low incomes (51%) who experienced one COVID-19-related stressor reported wanting to see a provider for a mental health concern. This proportion increased to 73% for those who experienced two stressors and to 92% for those who reported three or more stressors (Figure 22).

**Figure 22. Number of Pandemic-Related Stresses Experienced and Wanting to See a Provider for a Mental Health Concern Among Respondents with Low Incomes**

Q: Which of the following stresses, if any, have you experienced as a result of the COVID-19 pandemic? AND Was the problem you wanted to see a provider for a mental health problem (including stress, depression, and problems with emotions)?



Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020 and who were considered low income at <200% FPL and who wanted to see a provider for any reason and who experienced any COVID-19-related stress. Increases in the proportions of respondents with low incomes who wanted to see a provider are statistically significant ( $p < .05$ ).

*“I know some of the ins and outs of my disease and what triggers it and what doesn’t. And when I am alone and in quarantine or we are having these long stay-at-home orders, it drives you almost to the brink of madness.”*

— 38-year-old Latinx resident,  
San Joaquin

Many interviewees described how pandemic-related stress negatively impacted their health. For a few interviewees, the stress from the pandemic exacerbated existing mental health concerns and caused them to rely more heavily on medications and mental health supports than before the pandemic started. Others described how the stress caused physical problems, such as loss of sleep, headaches, and weight loss or gain.

*“I usually take Xanax once or twice a year. But since the pandemic started in March, I was taking Xanax maybe twice or three times a week — that’s how bad it was. . . . I have very severe anxiety. And also, bipolar.”*

— 58-year-old Asian resident, Southern California

## Income and Employment Impacts of the Pandemic

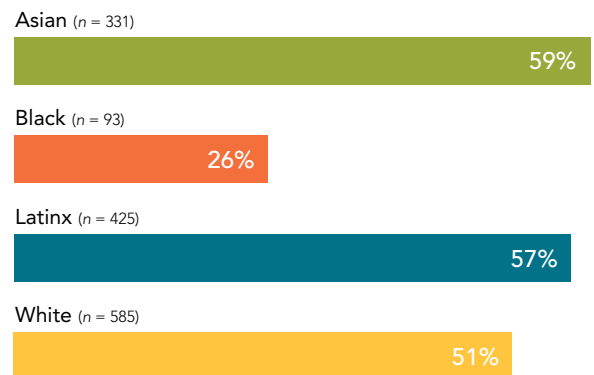
A key factor contributing to stress for many Californians with low incomes was the potential or actual loss of employment or income due to the pandemic. The survey found that many respondents with low incomes experienced negative changes in their employment and income.

**Respondents with low incomes were more likely to experience changes in family income compared to those with higher incomes.** More than half of respondents with low incomes (53%) reported a change in family income due to the pandemic compared to 39% of those with higher incomes ( $p < .05$ ). Among respondents with low incomes who reported any change in family income, 43% experienced a decrease in income, 18% were laid off, 9% were furloughed, and 7% experienced a reduction in salary.

**Asian and Latinx respondents with low incomes were more likely to experience changes in family income than respondents of other races/ethnicities.** Among respondents with low incomes, Asian (59%) and Latinx (57%) respondents were most likely to report any change in family income as a result of COVID-19, and Black (26%) respondents were least likely to report any change in family income (Figure 23).

**Figure 23. Change in Family Income Among Respondents with Low Incomes, by Race/Ethnicity**

Q: Have you experienced any change in family income as a result of the COVID-19 pandemic?



Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020 and who were considered low income at <200% FPL. Differences between Black respondents and all other groups were statistically significant at  $p < .05$ . Differences between White and Asian respondents were also statistically significant at  $p < .05$ .

*“I don’t work enough hours to make enough money. There is nothing I can do. It’s only me working, and I take care of my children. When I have money, I can get more things. Now I just have to make do with what I have.”*

— 52-year-old Asian resident, Southern California

**Most interviewees expressed stress related to employment or financial concerns.** Interviewees detailed experiences of personal or family member job loss, changes in employment, and reduced work hours. These experiences increased stress and anxiety for many interviewees as they navigated periods of unstable income and searched for jobs in new markets or roles available during the pandemic. Those who had not experienced reductions in income or employment were concerned that they would at some point. Among almost all interviewees, stress related to employment was high due to the uncertain nature of the economy and job market.

*“My mom had lost her job during COVID. That was really stressful on our family because she was the only source of income. So whenever we go to the grocery stores, I have a lot of social anxiety saying, like, ‘No we can’t buy this thing, no we can’t buy that thing. We have to stick to a budget.’”*

— 18-year-old White resident, Sacramento

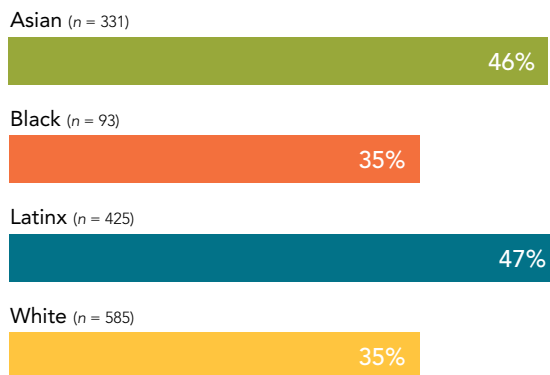
**High proportions of Californians continued to work outside the home during the pandemic.** Approximately 4 in 10 respondents with low incomes (43%) and with higher incomes (40%) continued to work outside the home during the pandemic ( $p < .05$  for differences between groups).

**Working outside the home varied by race and ethnicity.** Among respondents with low incomes, Latinx (47%) and Asian (46%) respondents were more likely to continue working outside the home than Black and White respondents (35% each) (Figure 24).

Interviewees who worked outside the home during the pandemic described additional stress and anxiety related to worries about catching the virus, exposing household members to the virus, or losing their jobs due to exposure to the virus.

**Figure 24. Working Outside the Home During the Pandemic Among Respondents with Low Incomes, by Race/Ethnicity**

Q: During the COVID-19 pandemic, did you work in a job where you continued working outside of the home?



Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020 and who were considered low income at <200% FPL. Differences between groups were statistically significant at  $p < .05$ .

**LOOKING FORWARD:  
Need to Address Underlying Factors That Put Californians with Low Incomes at Greater Risk for Deteriorating Health**

**Health care experts emphasized the importance of social determinants of health, including economic security and housing, and their impact on the stress experienced by Californians with low incomes.** Many individuals and families with low incomes were already in a vulnerable economic situation before the pandemic. A number of experts referenced the high cost of living in California, and the lack of robust financial assistance provided through the safety net to Californians with low incomes, as hurdles to economic prosperity. Even in the case of the federal relief provided throughout the pandemic, Kiran Savage-Sangwan of CPEHN noted, “the stimulus payments are not even going to pay one month of your rent.”

Experts also discussed that stress related to the uncertainties faced by Californians with low incomes on a regular basis exacerbates the specific uncertainties associated with the pandemic. Jacqueline Martinez

Garcel (Latino Community Foundation) said, “The stressors come from all the uncertainty that people experience, from housing to food security to community violence that may erupt at any given point. All of that [has] combined to low-income people experiencing [these] multiple stressors at a moment in time when there is a universal vulnerability [from the pandemic].”

**Health care experts discussed how low-income communities were often the hardest hit by the pandemic, with many factors making them more vulnerable both to infection from the coronavirus and to negative economic impacts from the pandemic.** Experts mentioned that many people with low incomes live in dense housing environments with multiple generations, where one or more people had to continue working outside the home during the pandemic, increasing the entire household’s exposure to the virus and the fear and stress related to that exposure.

*“From all of our COVID data, we know who’s dying, we know who’s losing their jobs. So it’s clear that those [individuals and families] would face the trauma and the stress of those things. We have little to no safety net, when we think about how we’re going to support people who lose their jobs, or who lose their homes, or have childcare needs.”*

— Kiran Savage-Sangwan, CPEHN

**Structural racism was also noted by a number of health care experts as contributing to health inequities and to the stress of Californians with low incomes.** Louise McCarthy (CCALAC) noted the “long-lasting effects of redlining, bad education policy, and just a lack of affordable housing and living and an affordable wage.”

*“I think we know that [a] big contributing factor to these [negative] outcomes that we see is the long-standing inequities in our health care system, and more broadly, structural racism throughout our society.”*

— Kiran Savage-Sangwan, CPEHN

Another expert tied structural racism to the fee-for-service model of care. Dr. Rishi Manchanda (HealthBegins) said, “The current fee-for-service model of care perpetuates structural racism. And it does so by actually asking a low-income person, in particular, in Black and Latino communities, to take time away from their job, or second or third job, to sit in a waiting room for three to four hours, to take the two or three hours it takes to get there through public transport, and spend that time just checking in with a nurse practitioner or doctor for 12 to 15 minutes, to talk about their entire medical plan. [This] can represent an existential threat to their job, and to their livelihood, to take that amount of time away.”

Given how entrenched inequality and social determinants of health are, experts cautioned that there are no easy solutions to improving health and health care. Widespread investment to address the social determinants of health, including economic opportunities and housing stability, will be critical to addressing the conditions in which Californians with low incomes live and operate.

*“We really do need to address those root causes and when we think about equity, it’s really about power and access to resources. And so, there’s no sort of small fix here, it’s about a fundamental shift in who has the ability to make decisions about how our policies and how our institutions are structured and how they function.”*

— Kiran Savage-Sangwan, CPEHN

Dr. Rishi Manchanda (HealthBegins) recommended moving from a fee-for-service model to value-based contracting with incentives focused on ensuring equitable access for people with low incomes and communities of color and reducing health inequities. He said, “Unintentionally, our health care systems that serve Medi-Cal patients may actually be, by default, harming patients by asking them to come to us, rather than us going to them. Value-based, place-based contracting is where I hope we go in the next five years to accelerate the way in which incentives are aligned to dismantle that form of structural racism.”

### Health Care Costs: Impact on Health

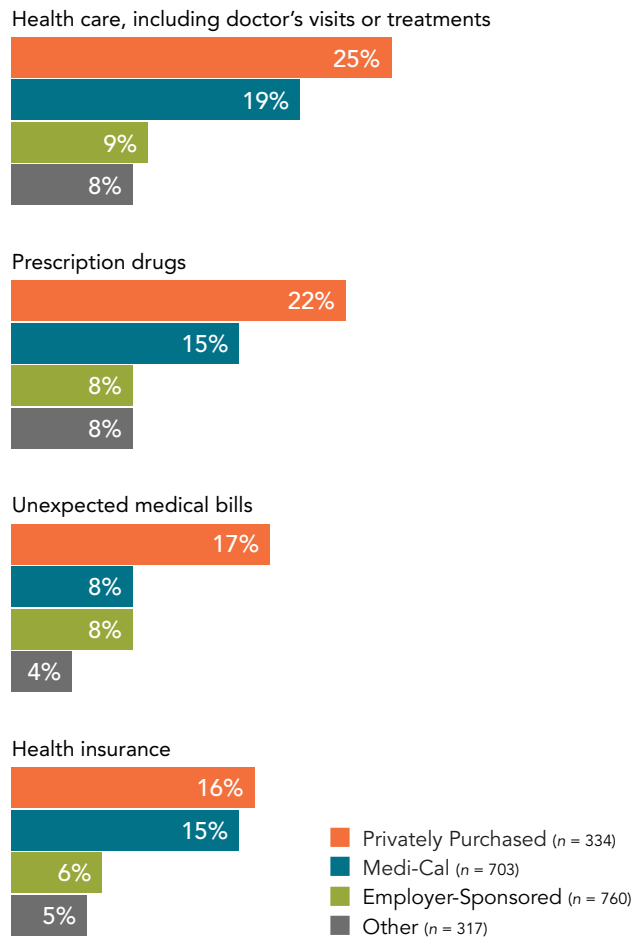
As described above, the pandemic has had a significant impact on the finances of many Californians, especially those with low incomes. Respondents with low incomes and those with Medi-Cal coverage were more likely to report difficulty affording health care costs, and this had negative impacts on physical and mental health.

**Respondents with Medi-Cal coverage were more likely to report difficulty affording health care costs than those with employer-sponsored coverage.** Since the start of the pandemic, 19% of respondents with Medi-Cal reported difficulty affording health care including doctor’s visits or treatments, compared to only 9% of those with employer-sponsored coverage (Figure 25). Fifteen percent of respondents with Medi-Cal coverage reported difficulty affording prescription drugs and health insurance since the start of the pandemic.

**Since the start of the pandemic, respondents with Medi-Cal coverage cut back on essential expenses and delayed care in order to manage health care costs.** Thirty-eight percent of Medi-Cal enrollees cut back on essential expenses such as food, gas, transportation, or utilities in order to manage health care costs. Thirty-six percent delayed seeking care, and 32% used self-care or home remedies instead of care from a provider.

**Figure 25. Difficulty Affording Health Care Costs During the Pandemic, by Insurance Type**

Respondents who had difficulty affording each item since the start of the COVID-19 pandemic



Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020. Differences between Medi-Cal and all other insurance groups who had difficulty affording health care, including doctor’s visits or treatments, since the start of the pandemic is statistically significant at  $p < .05$ .

**Having difficulty affording health care costs resulted in negative impacts on mental health, especially for those with low incomes and Medi-Cal.** Among respondents who reported they could not afford various health care costs, close to half of respondents with low incomes (46%) reported “worse” or “a lot worse” mental or emotional health as a result of not being able to afford these costs, compared to 39% of those with higher incomes (not a statistically significant



difference). Respondents with Medi-Cal coverage (64%) were much more likely to report that their mental or emotional health was “worse” or “a lot worse” as a result of having difficulty affording health care costs, compared to those with different coverage types (37%) (Figure 26).

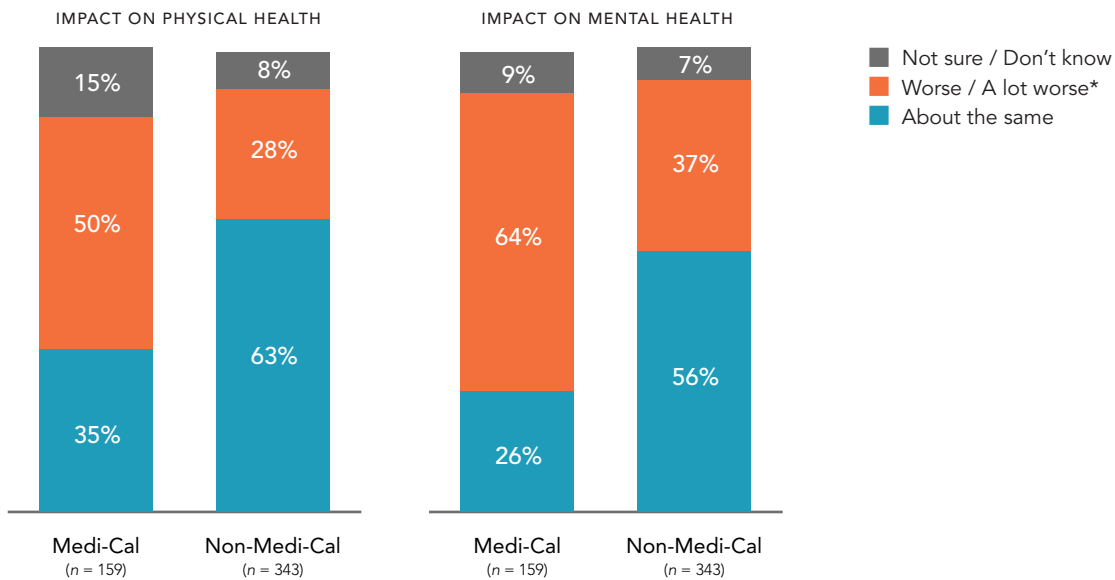
**Health care affordability concerns also negatively impacted the physical health of respondents with low incomes and Medi-Cal enrollees.** Respondents with low incomes were more likely to report “worse” or “a lot worse” physical health as a result of not being able to afford health-related costs compared to higher-income respondents (though these differences were not statistically significant). Half of survey respondents (50%) covered through Medi-Cal reported “worse” or “a lot worse” physical health as a result of not being able to afford health-related costs, compared to 28% of those with different coverage types.

### LOOKING FORWARD: Need for Improved Communication from Medi-Cal

Health care experts noted that respondents’ health care cost concerns are likely tied to a near-constant level of financial stress, combined with the lack of clear information about their Medi-Cal coverage benefits. They noted that some Medi-Cal enrollees delay or avoid seeking health care out of fear of out-of-pocket costs, when it is likely that the care would be covered by Medi-Cal. They emphasized that poor communication by the Medi-Cal program to enrollees about their benefits likely contributed to this delay in care. Health care experts suggested that enrollees need clear, understandable, in-language information about Medi-Cal, including how to use their coverage and its benefits. This kind of information should be communicated at multiple levels including by health plans, county and state government, navigators and community based organizations. Information should also

**Figure 26. Impact of Difficulty Affording Health Care Costs on Physical and Emotional Health, by Insurance Type**

Q: How, if at all, did your physical / mental or emotional health change as a result of not being able to afford health care costs?



\*Differences between groups were statistically significant at  $p < .05$ .

Notes: Sample limited to California residents age 18 to 64 who saw a health care provider between March 2019 and summer 2020 who reported difficulty affording any of the health care costs on the survey either before or during the COVID-19 pandemic. Segments may not sum to 100% due to rounding.

be communicated by the Department of Health Care Services in clear, succinct language through multiple channels.

In addition, the pandemic created confusion for all Californians about coverage of costs for COVID-19 tests and care. This was especially true for those with low incomes.

Finally, experts raised concerns that some Californians who may have become eligible for Medi-Cal during the pandemic have not yet enrolled. Louise McCarthy (CCALAC) noted that enrollment in food stamps has increased since the start of the pandemic, indicating increased financial stress among those with low incomes. At the same time, however, enrollment in Medi-Cal has not grown, perhaps suggesting a gap in ensuring that newly eligible people receive Medi-Cal coverage.

## Conclusions: Key Considerations for the Future

The COVID-19 pandemic shined a light on the persistent inequities and disparities in the health of Californians with low incomes, especially people of color, and the health care system that serves them. Our research revealed that Californians with low incomes were often more likely to have fair or poor health before the pandemic and to experience negative health impacts from the pandemic. Significant impacts from the pandemic including worsening mental health for many, pent-up demand for care for a broad range of health care issues, as well as a prevalent experience of stress.

Addressing these health inequities and disparities will require significant payment, policy, and practice changes to break down the siloed systems of care that adversely impact health equity. Specifically, health care experts recommended taking action in six key areas.

## Restructuring Payment Models in Health Care

Experts recognized that addressing the inequities in health and health care access will require changes to policy and to health care payment models. Rather than fee-for-service payment models that reward provision of individual services and care in traditional health care settings, policymakers and payers should think creatively about value-based and place-based contracting and payments. Health care systems and providers should be incentivized to proactively engage patients in their communities, and coordinate care and services that address their physical, behavioral, and social needs. In addition, payment for health care and incentives need to be structured to address structural racism and ensure that patients of color receive high-quality care.

*“Equity has to be at the center, not just the way we talk about health care, but the way we deliver health care, the way we pay for health care, and the way in which we hold health systems and payers accountable to deliver care, to make sure that outcomes are delivered well.”*

— Dr. Rishi Manchanda, HealthBegins

## Integrating Behavioral Health into Primary Care Delivery Systems

Experts recommended integrating mental health care into the primary care delivery system to increase access to care and to continue to reduce the stigma around seeking help for a mental health concern. Experts offered specific solutions for addressing the siloed nature of mental and physical health, including removing restrictions on billing for services on the same day, enhancing payments to providers for outcomes that demonstrate a reduction in health disparities, and expanding payment to be inclusive of community-based care.

Experts also recommended expanding the use of nontraditional mental health services such as peer and technology-based supports and shifting from a crisis-response mental health system to one that promotes mental well-being and prevention consistently in primary care. Erica Murray (CAPH) said, “We need to structure a system that encourages health, which means ongoing regular maintenance and attention to daily mental health.”

Finally, experts recognized the need to expand the mental health workforce to better reflect the diversity of California’s individual communities, and to better utilize telehealth to provide access to mental health providers who speak other languages.

*“Health systems are often a leading perpetrator of structural stigma because the way that they’ve created silos and continue to treat mental health as its own isolated thing, which reinforces this false dichotomy that mental health isn’t foundational to your health. So the key here is integration. You bring the mental health services to the places that people are, you make it about their experience. There’s continuity and comprehensiveness built into your equation.”*

— Dr. Benjamin F. Miller, Well Being Trust

## Redefining Access to Health Care

In response to the research findings related to the prevalence of mental health care concerns and the large numbers of Californians who delayed care during the pandemic, experts recommended redefining California’s approach to health care access. They recommended creative strategies to reach into communities rather than waiting for people to come to the health care system, such as deploying community

health workers and *promotores de salud* to meet people where they are and engage those unable or less willing to actively seek out care.

*“Interventions need to be home and community based. Bring care to them. I think asking people to go, to do, to see, to want, to try, is not even going to come close to helping. You got to go to where they are because you might find that in the changing of the bandage or the checking the blood pressure or whatever it is you’re doing, that this person doesn’t have a bed. You got to bring care to people, and you got to bring care to people in ways that actually meet their needs.”*

— Dr. Benjamin F. Miller, Well Being Trust

Such broadening of access will only work, however, if payment is supportive of this type of community-based care. As it stands, payment is often tied to particular types of health care providers and to brick-and-mortar health care delivery settings. Health care systems and payers need to be incentivized to transform primary care in innovative ways. This includes providing health care access to people where they live, work, and gather, rather than just in a community health center or physician’s office.

In the near term, experts recommended using creative strategies of community engagement to get people with low incomes to access care that they may have delayed during the pandemic. One expert noted that there is an opportunity to leverage the COVID-19 vaccination effort as a touch point to reconnect people with the health system, provide age-specific recommendations for screenings or preventive care that might have been missed in the past year, and even make appointments on the spot.

*“A lot of people are touching the delivery system right now through the COVID-19 vaccination effort. . . . As we’re spending all of this money for messaging, we should use the opportunity to say ‘Here are vaccines your kids should regularly get. They’re not eligible right now for a COVID-19 vaccine, but they need these vaccines eventually.’”*

— Dr. Sandra R. Hernández, CHCF

## **Investing in Equitable Access to Telehealth**

During the pandemic, the use of telehealth — both phone and video — accelerated at a rapid rate and penetrated many communities that had never used technology to access their health care. Californians with low incomes were satisfied with their telehealth experiences, and experts agreed that telehealth will play a critical role in the health care system moving forward.

Experts also agreed that telehealth can, in many ways, increase equitable access to care. However, they emphasized that it is critical to ensure that the introduction of telehealth as a more significant component of the system of care is done thoughtfully so that it does not exacerbate inequities. To prevent this, investment is needed to ensure that Californians with low incomes have the devices, bandwidth, and privacy for effective telehealth visits.

*“What we really ought to be doing is redesigning care processes to add more digital in the mix. This could include discharge to the home with monitoring, including evaluation post-treatment, including using telemonitoring and telehealth solutions to do home-based infusion for managing cancer.”*

— Ian Morrison

## **Breaking Down Data Silos in Health and Social Services**

Patient needs can be more easily and safely addressed by establishing data systems and structures that enable health care providers to share health information about patients. This is especially true for those with complex medical needs or unmet social needs who often touch different delivery systems. This type of exchange of data is an important consideration both between health care delivery systems and between health systems and other types of providers such as jails and prisons or homeless service providers.

Liz Gibboney (Partnership HealthPlan) expressed optimism about the future of this type of health information exchange: “So in five years, I think we’ll be much farther along and sharing and utilizing data in a much easier and efficient way, and that will lead to better decisionmaking and more timely decisionmaking about health status and interventions. I think the public health system will be in a much better place and better positioned for the next crisis, the next pandemic. I think technology’s only going to get more pervasive in its role in health care.”

## Addressing Social Determinants of Health

Experts universally agreed that addressing social determinants of health, including making significant investments in services targeted at ensuring safe and secure housing, food security, and employment, will be critical to reducing inequities in health. However, they cautioned that there are no easy solutions and that it is made all the more complex because solutions often rely on the interplay of state and federal policies, such as childcare supports or unemployment benefits, that impact the lives of people with low incomes.

*“Fixing [the system] has to do with raising minimum wage and economic opportunity on the one hand, and stressing affordable housing solutions. And a lot of this has got nothing to do with health care, but that would make a big difference in this.”*

— Ian Morrison

Experts acknowledged that all these changes will require a true transformation in how health care and other social services are structured, financed, and delivered in California. Right now, health care, mental health care, and social services are provided by a network of local, state, and federal providers, whose systems of payment and care are siloed from one another. These silos, both within health care and across social services, perpetuate inequity, especially for people with low incomes and people of color.

These changes cannot be made in isolation but need to be part of a broader effort to engage communities and individuals in solutions that directly impact them. Listening to Californians with Low Incomes began with the goal of understanding the perspectives of Californians with low incomes and learning about their health and health care needs, their experiences with the health care system, and their health care goals. To effectively remake California’s health care system to better serve all Californians, especially those with low incomes, a necessary first step is to engage with these communities and to listen to their experiences, goals, and desires.

*“This work requires deep listening, humility, and partnership. A system that is truly designed around the needs of low-income patients and communities of color needs to be designed in partnership with them.”*

— Erica Murray, CAPH

## Appendix A. Survey Methodology

The California Health Care Foundation Listening to Californians with Low Incomes Survey was conducted June 24 to August 21, 2020, using a combined probability-based sample and nonprobability sample to achieve an overall sample of 2,249 adults age 18 to 64 living in California. The foundational probability-based sample comes from NORC at the University of Chicago's AmeriSpeak Panel<sup>8</sup> ( $n = 746$ ). The nonprobability sample is comprised of a web sample from Dynata<sup>9</sup> ( $n = 1,314$ ) to reach more respondents with low incomes and a telephone sample from Davis Research<sup>10</sup> ( $n = 189$ ) to reach Vietnamese and Cantonese speakers. Surveys were administered using a web-based questionnaire in English ( $n = 2,000$ ) and Spanish ( $n = 60$ ), and both web-based surveys and telephone interviewing for Chinese ( $n = 99$ ) and Vietnamese ( $n = 90$ ) speakers. Sampling, data collection, weighting, and tabulation were managed by NORC in close collaboration with CHCF researchers.

The sample was designed to complete a sufficient number of interviews with respondents of demographic groups (e.g., by race, Latinx ethnicity, and California region) that would allow accurate representation of the California adult population in the overall sample. AmeriSpeak was selected as the foundational sample for this study for its probability-based survey platform, and its unique in-person recruitment that attains response rates, on average, 5 to 10 times higher than other probability panels.<sup>11</sup> The AmeriSpeak Panel of California residents was stratified by income level and differentially sampled by strata to reach relatively more respondents with low incomes than respondents with higher incomes. The AmeriSpeak Panel is a nationally representative panel sample recruited using NORC's National Frame based on both area probability sampling and address-based sampling methods to achieve coverage of approximately 97% of the US population.

To achieve sufficient interviews for important and hard-to-reach subgroups for the study, samples from Dynata and Davis Research were utilized. While these opt-in samples come from a nonprobabilistic source, NORC

used its TrueNorth calibration procedure to combine the samples into a unified set of data that seeks to reduce potential bias in the study outcomes from inclusion of nonprobability sample. The TrueNorth method involves using the AmeriSpeak probability sample to calibrate the surveys from the nonprobability sample. TrueNorth utilizes the advanced techniques of small area estimation.<sup>12</sup>

To qualify for the study, all respondents needed to confirm through screening that they were adults age 18 to 64, currently residing in California, and had seen a doctor in the past year. Households at all income levels qualified for the study based on the aforementioned screening criteria; however, respondents who reported their household income was below 200% of the federal poverty level (FPL) were sampled at a higher rate.<sup>13</sup>

All selected panelists from AmeriSpeak and Dynata were sent an invitation email including a link to complete the survey online. Sample selected from Davis Research were also called, and interview data collected by phone. All qualified respondents were offered incentives for their participation. During the fielding, AmeriSpeak respondents were sent scheduled reminder emails to take the survey.

A series of data quality checks were run on the final data, which resulted in 73 completes being removed from the data. A multistage weighting design was applied to ensure accurate representation of the California adult population. The first stage of weighting included corrections to the AmeriSpeak sample for sample design and a demographic adjustment to balance the sample to match known adult population benchmarks based on the US Census Bureau's February 2020 Current Population Survey. Parameters included age, gender, educational attainment, race/ethnicity, rural status, poverty threshold, and region in California. AmeriSpeak sample records were combined with Dynata and Davis sample records, and True North combined weights constructed. Next, to reduce the possibility that single cases would affect

the data too much and to keep variance relatively low, the weights were truncated at the tails of the weight distribution such that no one category of a sociodemographic weighting variable differed more than five percentage points from its benchmark.

The margin of sampling error including the design effect for the full sample is plus or minus 3.7 percentage points. For results based on specific subgroups, the margin of sampling error may be higher. Note that sampling error is only one of the many potential sources of error in this and any other public opinion poll.

**Table A1. Estimated Margin of Error, by Base Sample Size**

BASE SAMPLE SIZE	ESTIMATED PERCENTAGE								
	10%	20%	30%	40%	50%	60%	70%	80%	90%
	MARGIN OF ERROR (+/- PERCENTAGE POINTS)								
<b>2,249</b>	2.25	3.00	3.44	3.67	3.75	3.67	3.44	3.00	2.25
<b>1,000</b>	3.40	4.50	5.20	5.50	5.60	5.50	5.20	4.50	3.40
<b>500</b>	4.80	6.40	7.30	7.80	8.00	7.80	7.30	6.40	4.80
<b>250</b>	6.80	9.00	10.40	11.10	11.30	11.10	10.40	9.00	6.80
<b>150</b>	8.80	11.70	13.40	14.30	14.60	14.30	13.40	11.70	8.80
<b>100</b>		14.40	16.50	17.60	18.00	17.60	16.50	14.40	
<b>75</b>		16.70	19.10	20.40	20.90	20.40	19.10	16.70	

Note: Sampling error is only one of the many potential sources of error in this and any other public opinion poll.

## Appendix B. Interviewee Criteria and Demographics

Thirty-seven survey respondents with low incomes were chosen for follow-up in-depth interviews. Interviewees represented a range of backgrounds and were selected based on their reported experiences during the pandemic. Interviewees could and often did meet multiple criteria for selection. Additional demographics of interviewees are reported in the tables below.

**Table B1. Interviewee Experiences**

Had a health issue	20
Received care	22
Received telehealth	19
Worked outside the home	16

**Table B2. Interviewee Residence**

Los Angeles	13
Bay Area	6
Central Coast	4
Inland Empire	4
Other Southern California	7
San Joaquin	2
Sacramento	1

**Table B3. Interviewee Race/Ethnicity**

White	8
Black	5
Asian	12
Latinx	11

**Table B4. Interviewee Insurance Coverage**

Medi-Cal	19
Privately Purchased	8
Employer-Sponsored	7
Other	2
Uninsured	1



## Endnotes

1. The survey was limited to Californian residents age 18 to 64 who had received health care between March 2019 and the time of the survey, which was conducted June 24 to August 21, 2020.
2. In 2020 the FPL was \$12,760 for a single person and \$26,200 for a family of four.
3. Sixty-eight percent of the sample were residents with low incomes.
4. Respondents were asked if they experienced any of the following COVID-19-related stresses: Concern about the health or well-being of a loved one; affording basic needs, such as food, rent, and utilities; children out of school or childcare unavailable; stress in your relationship or marriage; death of a loved one; other stress.
5. California Health Interview Survey.
6. Other data were collected on confirmed or suspected COVID-19 infections, urgent or emergency care for a health problem unrelated to COVID-19, and problems with drug or alcohol use; however, too few respondents indicated a need for this type of care, so no significant comparisons or conclusions can be drawn.
7. For this survey, *telehealth* denotes care delivered either by phone or by video. Because respondents could have selected multiple issues for which they saw a provider and multiple modes of care received for each issue, the proportion of respondents who reported that they received any care by any of the modes was examined.
8. ["Panel Design: How AmeriSpeak Households Are Sampled,"](#) AmeriSpeak.
9. ["About Dynata,"](#) Dynata.
10. [Davis Research.](#)
11. [28 Questions to Help Buyers of Online Samples](#) (PDF), Esomar, last revised July 2012.
12. ["TrueNorth,"](#) AmeriSpeak.
13. Respondents confirmed if they had seen a doctor in the year before or since the start of the COVID-19 pandemic.