CHCF

In Their Own Words:

What Californians with Multiple Health and Social Needs Say About Their Care

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About EVITARUS

EVITARUS is a public opinion, research, and strategic consulting firm that delivers actionable data and strategic insights to public policy, political, and corporate decision makers. Focused on research that provides communities with an opportunity to influence decisions that impact their lives, the firm's mission is to elevate and amplify the voices of people and ensure they are heard.

About the Author

Silvina Martinez is a public relations consultant specializing in health care and multicultural communications. A former newspaper reporter in Latin America and California and a medical interpreter herself, she works on health care initiatives and policies designed to expand access to care as well as educate and empower patients to take control of their health.

About the Foundation

The **California Health Care Foundation** is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

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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Alameda County
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Introduction

As the CalAIM (California Advancing and Innovating Medi-Cal) Enhanced Care Management and Community Supports programs approach their four-year anniversary, implementation partners have reported that these services are making a difference for their organizations and the Californians they serve. But what about the people themselves? This report focuses on an essential perspective: the voices of people CalAIM was designed to support. Their perspectives provide an example of how involving people with lived experience as equal partners in design and implementation increases the chance that these programs will actually meet their needs.

In partnership with CHCF, EVITARUS conducted in-depth interviews with 99 Californians with complex needs and eight focus groups with caregivers across Alameda, Fresno, Humboldt, and Los Angeles counties between October 2023 and November 2024. Participants met at least one of four criteria: experiencing homelessness or housing insecurity, living with serious mental illness, facing or recovering from substance use disorder, or living with functional impairments such as hearing loss or mobility or cognitive decline. See Table 1 in the appendix for demographics of the study participants.

The findings reveal universal needs among participants — the importance of trust, empathy, and respect. Participants value the providers who asked about their goals, shared their cultural background, and spoke their language. They appreciate integrated services that could address immediate needs like food and hygiene alongside longer-term needs such as housing applications and health care connections.

Many participants described challenges accessing timely services and navigating complex systems. For those experiencing homelessness, housing often took precedence over health care. Many sought "one-stop shopping" models or additional navigation support. Participants expressed frustration with eligibility criteria that require them to reach crisis before receiving help, and the burden of repeatedly sharing their stories with new providers.

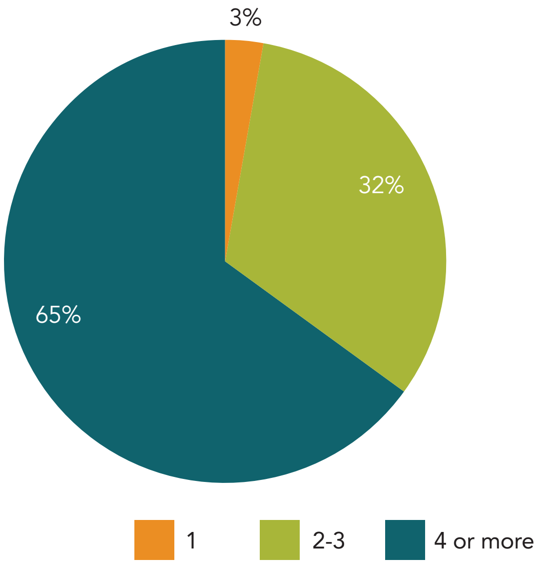
One approach that addresses these challenges: care managers. Participants consistently highlighted the value of care managers who coordinated appointments, arranged transportation, and helped them navigate systems. Many participants described this support as "lifesaving." These relationships, and the systems that enable them, form the foundation of CalAIM's person-centered approach to improving care for Californians with complex needs.

This report describes six key findings presented primarily through the voices of the participants themselves. Their insights are an opportunity for CalAIM's implementers to consider how to refine and strengthen their services and approach for people with complex needs. The report concludes with reflections from CHCF's CalAIM Implementation Advisory Group. These ideas are offered to help implementers who seek to improve care delivery for their clients.

Key Finding #1: Most Participants Experience Several Complex Needs Simultaneously

Most participants experience several complex needs simultaneously, which has a compounding effect on their ability to take care or their health. Eight in ten participants (83%) reported having a chronic health condition in addition to the four health and social needs used for recruiting. Many participants also reported recent or prior experience with incarceration (44%), recent hospitalization, or a recent pregnancy (12% of female participants). Looking across all eight of these complexities, virtually all

Figure 1. Participants by Number of Complexities



Note: Complexities include current homelessness, substance use disorder, serious mental illness, functional impairment (including cognitive decline), chronic health conditions, incarceration, recent pregnancy, and transition between health care settings (asked of 65 participants). No participant reported all eight complexities.

Source: Listening to Californians with Complex Needs, in-depth interviews conducted by EVITARUS (October 2023 to November 2024).

participants (97%) reported experiencing two or more complexities, and about two in three (65%) reported experiencing four or more complexities. See Figure 1.

Experiencing several complex needs simultaneously has implications for the number of systems participants need to navigate and the types of support they need in order to reach stability and achieve good health.

Key Finding #2: Trust with Providers and Staff Is Crucial

Participants said trust with providers and staff helps them manage their health more effectively. They emphasized the need for fair treatment and providers who share their ethnic and cultural background.

Feeling Respected and Empowered

Over half the participants stressed the importance of being respected and empowered as patients and not looked at as just a "case number." "They [providers] don't ask you about your goals. They get you in and out, like fast food service. Nobody sitting and talking to you. Half the time, they haven't even read your chart," said a 67-year-old Black man in Alameda County. Some participants reported having positive experiences with providers who reinforced their humanity, respected their sense of agency, and saw them as a person.

> *"I feel like it is different when you've got somebody that you can relate to compared to somebody that is just trying to teach you something that they read out of a book or that they haven't lived or something. Then, it is like he don't judge you and . . . he's really for the people."*
>
> — 33-year-old Black man, Fresno County

Empathetic, "More Caring Care"

Over half of participants also said they want to receive "more caring care." They prefer and are more likely to trust and engage with providers who demonstrate compassion and empathy, especially participants who were previously disengaged with the health care system and other systems of support. Many participants said they would like providers and caregivers with lived experiences that are similar to their own. A 44-year-old Latina in Los Angeles with a history of cancer, substance use, and chronic illness said she found empathic care when a street nurse found her while she was homeless. "She was able to get help through recommendations, she knocked on my door and she saw me. She said you look cold, you are sleepy. . . . When I saw that she was good, she gave me clothing and

I felt wow, she is really willing to help me. It made me feel special," she said.

> *"More of an understanding instead of a condescending mental health system. Don't just mark us down on paper. So maybe fewer people per case load or something — [don't] shuffle us through — remember us, remember our story when you see our face. . . . There's a lot of us who could really use a lot of recognition and assistance in our problems instead of here it is."*
>
> — 63-year-old White woman, Humboldt County

Experiencing Judgmental and Rude Treatment

After years of homelessness, substance use, and incarceration, a 32-year-old man in Humboldt County said things have been getting better; he has been in transitional housing and sober for more than five months. The man, who identifies as White and Native American, started using heroin at 16 and lived on the streets for most of his adult life. His journey has included jail time, rehabilitation, violation of probation, and long hospital stays. "A lot of the staff at the hospital are really judgmental of homeless drug addicts," he said. "They get tired of the same junkies and tweakers coming in all the time, which I understand, but sometimes a junkie or tweaker comes in and they really need help."

One day the participant went to the hospital with a fever of 102.7°. He said he could barely move and the woman who treated him prescribed antibiotics for him to pick up from the pharmacy. "It was like midnight or something, and she was like, 'Okay, I'm going to get you signed out here.' . . . The doctor came in and took my temperature and looked at the nurse and was like, 'What are you doing? If you sent this guy out of here, he would have been dead tomorrow.' That's just an example of how homeless people and drug addicts get treated sometimes in the health care industry."

The man said he knew about various types of training when people start a job. "But maybe certain jobs like that, they could include something like awareness of certain people and their problems," he said.

Fair Treatment

One in five participants stressed the need to experience fair treatment and to eliminate discrimination. Some respondents reported experiences of racism, while others reported being discriminated against based on their type of insurance, substance use, homelessness, mental health condition, and/or history of incarceration. Some perceived the attitude of hospital and emergency room staff as judgmental, rude, and demeaning, which led them to either avoid these settings altogether or leave before being treated.

> *"The moment you say bipolar 1, even in the medical profession, people switch. I think that there is no compassion. Very rarely if you have extreme or, let's say, worse conditions than other conditions, people lose compassion. I can see that with severe mental health to severe substance use disorder. I don't know, I think that the school systems need to do better in order to teach these people who are working in communities. It's just like, why isn't cultural competency taught?"*
>
> — 33-year-old Multiracial woman, Humboldt County

Culturally Resonant Care

About one in six participants emphasized the importance of care that acknowledges, respects, and incorporates their cultural background, beliefs, and values. Many said they prefer service providers and staff who share their ethnic and cultural background. They believed working with such providers could increase understanding, avoid judgment, and address their unique needs. A 30-year-old Black woman in Fresno County said, "I feel like if you're my color, you've been through the same thing that I've been through — you kind of understand me more."

Participants who identified as Native American reported positive experiences with substance use treatment centers that were culturally specific and integrated traditions such as basket-weaving and beading into traditional group therapy methods.

> *"It helps having a Native American provider if you're Native American, because they know a lot about culture and everything as well. When I was going to Two Feathers [substance use disorder recovery], it helped me reconnect with my heritage, because while you're talking to them, you guys would bead necklaces together or go to like workshops for bear grass weaving and basket weaving."*
>
> — 18-year-old Native American woman,
> Humboldt County

For some participants, the lack of providers with similar backgrounds had often discouraged them from seeking care. In the absence of such providers, a few participants suggested providing cultural competency training for all staff.

Participants with non-English language preference reported difficulties accessing health care and services due to language barriers and inadequate communication from providers. They emphasized the need for bilingual providers and in-language support. Some reported problems with the quality of interpretation and highlighted the fact that translations from a native language to and from English are not always accurate and can lead to misinformation.

> *"For me, it's important [to have somebody speaking Spanish with me], because I can understand better. Things are more clear, because there are things that I can't understand. . . . Sometimes I am so frustrated that I don't even look at it [Spanish-written materials]."*
>
> — 58-year-old Latina, Los Angeles County
> Translated from Spanish

Key Finding #3: Meeting Basic Needs Comes Before Addressing Health Concerns

For many participants, fundamental needs of daily living, including safe housing, employment, and access to food, take priority over addressing physical or mental health concerns.

Housing: A Priority Need

Having a safe, stable place to live emerged as a priority over health for nearly every participant who is or had been homeless. They said not having the right housing placement exacerbates their physical and mental health problems and poses unique barriers to accessing care and services. Some expressed a concern about the safety of housing offered to them. A few participants in recovery said they prefer to be unhoused rather than be housed with active substance users. Others, especially women, reported experiencing sexual assault, trauma, and PTSD associated with being placed in mixed-gender housing placements.

> *"When you are on your own and you are homeless, you look for warmth, food, a shower, your primary needs. That is what you are focused on. That takes a lot of time. A shower might take you an hour or two hours by the time you wait in line and take a shower. Then it might be closed, the shower truck might be gone. It may have broken down. You are constantly trying to meet those simple primary needs, and then you are neglecting the long-term needs . . . because your primary needs take priority."*
>
> — 68-year-old White man, Alameda County

Meeting Needs After Homelessness and Incarceration

A Black participant from Alameda County said getting support has always been a challenge for him. The 65-year-old has diabetes, high blood pressure, breathing and sinus problems, and arthritis in one knee. He used to be homeless and two of his children passed away. He also went to jail several times. The last time, he said he a had a nervous breakdown and decided he wanted a better life. He said, "I got tired of not feeling like a person. Have you ever woke up on Christmas in jail?"

Life after homelessness and incarceration has come with new needs and little help, he said. When he was last released from prison, coming back to the community posed new challenges. "When you get out, you don't have nothing to go to," he said. "Even though they try to set you up with a program before going home, the support is just not there." He added that this is why when people get out of jail they go right back. "If you came from stealing, you are going to steal to survive."

"When you leave the penitentiary, they take you to the bus station and they stand right there until you get on the bus. . . . You've got to pay for your ticket, and you've got to eat, so by the time you get to where you're going, you might have $120. And even if you've got $120, if you are going to try to get a room, how are you going to pay rent with $120?"

Employment and Economic Assistance

A majority of participants reported that they delayed accessing health care to address other priority needs such as paying rent and buying food. This was further emphasized among participants with children. Respondents said they were focusing their energy on trying to find a job and figuring out how to make ends meet with their limited financial means.

> *"If I get the work in and then I'm making so much money — welfare cuts you off and how do you expect somebody to survive if you guys are taking food stamps — I got like five kids, like I've got to feed them, I got to pay phone bills, cable, PG&E, water, if I'm sitting in the house, all that is separate and I just don't feel like welfare cuts it out. . . . I've definitely got down with stealing to make sure my kids had socks and shoes, anything I got to do for my babies I'm gonna do."*
>
> — 31-year-old Black woman, Fresno County

Access to Social and Community Services

More than half of respondents reported that social services such as financial assistance and food stamps are insufficient to meet their needs. Participants released from prison said they were not given enough support to reenter the community, working parents expressed the need for more child-care services, and people experiencing homelessness shared that they did not have a place to shower or cook, or to get help finding and applying for housing. Participants living in Humboldt County described years-long wait lists for housing. Nearly all participants living in rural areas said they do not have reliable public transportation to travel for services that are not available in their area. Seniors receiving financial assistance reported that they do not receive enough money to cover monthly expenses, particularly prescription medications, rent, and food.

> *"The toiletries, too. Being able to have stuff to wash and clean. That's kind of hard to come by sometimes, too. . . . They used to have places that, once a week or so, mobile showers that you can go in and at least take a shower. I haven't seen any of those in so long. It seems like ever since COVID I haven't seen anything like that."*
>
> — 63-year-old White woman, Los Angeles County

Key Finding #4: Need for Fewer Barriers to Care

Participants expressed the need to have more preventive services, timely care, and increased access to mental health supports and dental care. Caregivers said they need more support to take care of people with complex needs.

The Importance of Preventive Services

One in three participants emphasized the importance of preventive care to avoid falling into a crisis or seeing their condition deteriorate before being able to see a provider. They favored more flexible eligibility requirements to qualify for and access available health care and services. Participants with substance use disorders said strict criteria prevent them from accessing needed recovery programs. Some participants said they often feel compelled to exaggerate symptoms or misreport their condition to be prioritized.

> *"Sometimes you aren't homeless enough, and sometimes they want you to literally be on the street. I had a situation where I wouldn't have been able to get into the homeless shelter, because even though I [faced] impending homelessness, I technically wasn't homeless."*
>
> — 24-year-old White nonbinary person, Humboldt County

Need for Timely Care

About 6 in 10 participants said that long wait times and lack of follow-up have prevented them from getting the health care they need. Caregivers of people with serious mental illness said such delays can cause severe complications, as these patients need treatment during or immediately after an acute episode. Participants in rural areas reported months-long wait times for health appointments coupled with hours-long travel required to get to these appointments.

A 33-year-old Multiracial woman with severe allergies in Humboldt County shared that after a year of waiting to start immunotherapy, her appointment was canceled. At the time of her interview, she was still on a waiting list. "What is really difficult is you are constantly waiting for services, and oftentimes that is all you are doing, just waiting," she said. "You keep calling back and they are like, 'I'm sorry, we still don't have a provider.'"

> *"Two months later, I go in and see her, and she said she wanted to tell me about the test results. I said, 'I was wondering. There must be nothing wrong. You didn't call me.' She said, 'Oh, yeah, there is something wrong. You have cirrhosis of the liver.' I just went smooth out. I said, 'You know what? You just now calling me two months later?'*
>
> — 66-year-old Creole woman, Alameda County

Availability of Mental Health Support

Many participants wanted help with depression or anxiety but did not know how to go about getting counseling or medication. Other participants discussed lacking opportunities for gathering and socializing with people who are facing similar challenges. Caregivers noted the importance of access to counseling for the seniors they care for, who are struggling with cognitive impairments and mobility loss.

> *"Between really sticking to the therapy and asking for another and taking the medication as prescribed, that is helping me maintain my sanity to a level to where my health has improved now."*
>
> — 65-year-old Asian American woman,
> Alameda County

The Search for Mental Health Support

A 33-year-old Latina in Fresno said that the last time she had stable housing was when she was in foster care. "Once I turned 18, they are like you can just go ahead and live your life on the street and whatever you do is up to you," said the participant, who had been diagnosed with depression and bipolar disorder at age 12.

The participant had lived in tents and parks and tried shelters but said they were always filled. Once she found a job in security, she started living in her car, wherever she could park it. Since then, she has been trying to find mental health support. "I've been looking for counseling for like two years now, and every time I've gotten denied. I went through my primary care physician and every time it [has] always been excuse, after excuse, after excuse of why they can't see me," she said. She explained that they wanted to give her medication, which she said she was forced to take while in foster care and made her feel worse. "I'd tell them that I don't want to go on medication, I just want to talk to somebody."

Access to and Coverage of Dental Care

Limited access to dental care was a significant concern for nearly half of all participants. Older adults stressed that without proper dental treatment, they are unable to consume food; many reported that they required dentures or implants but were waiting for appointments or could not afford to pay for them without insurance coverage. Many participants with substance use disorders said that dental care is an urgent need for them, as they had lost teeth or were wearing ill-fitting dentures. Respondents living in Humboldt County emphasized the poor access to dental health care in their area. One participant reported that there are only one or two clinics in Eureka that accept Medi-Cal patients, and these clinics offer only one treatment per appointment. Residents have to make appointments many months in advance or travel multiple hours to seek care outside the region.

> *"I have gotten the dentures before, and they hurt my mouth. I can't eat with them. I need to eat. I can't eat healthy foods that I need to eat because I don't have any teeth. That's a health problem."*
>
> — 68-year-old Black woman, Alameda County

Increased In-Home Services for Older Adults

Seniors and their caregivers said there is a critical need for care and services in the home, including increased in-home supportive services (IHSS). Caregivers of hospice patients reported needing supplemental support, particularly after hours and overnight, to give them an opportunity to rest and recharge. An Asian participant over 75 years old in Los Angeles said, "I said to them I need to have homecare attendants, and they asked me what I need the homecare attendants for. I said for me I can't go to shop and I need the attendants to help me to shop. Also, I need the homecare attendants to cook."

> *"We need people to help us and yet, even though it is our friend who is our home attendant, they won't be coming for that many hours. I think that they can only help us for 50 hours every month and then if you need to go to see the doctor, then it would take many hours away because it's only two of us. . . . As long as the home care attendants can help us many more hours, then they can help us to accompany us to see the doctor because sometimes you have to wait for many hours at the doctor's office and if you don't pay them they are not going to be with us."*
>
> — 73-year-old Chinese woman, Los Angeles County
> Translated from Cantonese

Support for Caregivers

Both professional caregivers and those caring for loved ones reported needing more support, including more allocated hours, adequate compensation, and structured training on caring for people with complex needs. They highlighted the burden of performing tasks they are not trained for and covering costs such as groceries, medications, transportation, and other out-of-pocket expenses. Others shared that the stress they were under posed a challenge to their own mental health. A caregiver of a man paralyzed from the neck down in Humboldt County said, "There is just a lot of things that nurses are supposed to do, but that we end up doing, but haven't had the proper training for it."

> *"I think that the mental health system should offer mental health training to caregivers. Because looking from the outside in, you may see that person is not wanting to do nothing, when in fact they may be in depression. And you cannot diagnose it if you have not experienced it or you're not a mental health professional.*
>
> — Female caregiver, Alameda County

Key Finding #5: Desire for One-Stop Shopping

Participants with complex needs favor an integrated model of care that would allow them to access several types of care and services in one place. They believe such an approach would result in improved continuity and coordination of care.

One-Stop Shopping

More than 6 in 10 participants said that being able to access multiple types of care and services in one location would provide a much-needed answer to the multifaceted and complex nature of their living circumstances and health needs. A 66-year-old Black woman in Alameda County said about the organization where she receives services, "It feels good not to be hopping around here and there . . . because I don't have to go to a doctor over here and then a dentist over here and then I have to go to the dermatologist over here. Everything is just right there."

> *"A good quality of life for me is to have a system . . . where [there's] either a mobile team or you can go to a facility, get time to spend in there, have counselors, mental health specialists, doctors, nurses who are trained to know how to help you, work with you, diagnose you, and then when you leave, you not only feel better, but you also want to give back."*
>
> — 56-year-old Black man, Humboldt County

Integrated Care Managers

For many participants, the next best thing to having multiple services in one location is having one care manager they can rely on and who can help them access and coordinate all the services and care they need. Participants with a dedicated care manager or social worker said they felt supported, had help coordinating their various services and health care appointments, and were better able to follow through with treatment plans. For some, a strong relationship with a primary care provider helped them integrate and coordinate their care.

Finding Multiple Resources in One Place

A 34-year-old Latina in Los Angeles said that she was using drugs and living in tents under a bridge at age 19 when she got pregnant. "It was hard not really knowing where we were going to rest our heads sometimes," she said.

Over the years, the young mother found that support to address her complex needs was scattered in different places and difficult to access. Despite the challenges, she eventually secured money from one program, food from another, and training to get a job somewhere else.

It was not until she located a mobile medical clinic in her area that she found care, services, and resources in one place. "[They] pretty much always come through with any type of resources, whether it be gas cards or medical help or dentistry or transportation rides for where we needed to be at [a] certain time for my kids' needs or our needs. They've been right there like a rock, so I appreciate them a lot." She said she hoped this would allow her to address her own health problems, including high cholesterol, kidney problems, gallstones, and flare-ups that often take her breath away. While she suffers from depression and anxiety, the woman said she has been afraid to seek therapy. "I thought [if I asked for help] I would get in trouble, [that] they would take my kids away from me," she said.

> *"It would be helpful to have a case manager designated for everything, not just for mental health or not just for physical health*

> *or anything like that. If you had like a main guy who just did it all and made the referrals to everything, because it does come hand in hand. You can't just do one without the other. . . . So if you could have a coordinator like that, that would be really cool."*
>
> — Female caregiver, Humboldt County

Key Finding #6: More Help Navigating the Health Care System

While participants see one-stop shopping as the ideal, they welcome any support in navigating the complexities of the health care system.

Need for Readily Accessible Information About Resources

A majority of participants said they need readily accessible information about resources. They reported not knowing what resources are available to them, how to access information about those resources, and where to obtain them. Some said they only became aware of needed resources through word of mouth or by "luck." They favored a single source of information rather than having to call multiple numbers.

> *"He has very limited Social Security income, and the whole process of learning how to get him qualified for Medi-Cal, how to get his share of costs down, how to get enrolled in IHSS, that was a really difficult process for us. And just to figure out how that system works was a big challenge. So I think that this whole process would have been easier if there was some way to provide more support in navigating the system and informing you about all of the resources that are available."*
>
> — Female caregiver, Los Angeles County

Care Managers: A Link to Resources

A 45-year-old Multiracial participant in Oakland lost everything from a fire in his apartment building. He had to jump out the window, shattering his knees and heels, and hurting his feet. He could not walk but continued to go to substance use classes, as he was trying to rebuild his life. In the middle of it all, a kidney stone sent him to the hospital for surgery, leaving him with a catheter for three weeks and nobody to follow up with him after the discharge. "I feel like ain't nobody helping me, so I get back into depressed mode," he said.

After seeing that a friend with similar issues had a care manager who would come by to help him and let him know what was available to him, the man asked his doctor for a care manager but had not gotten one. "Well, because like all the different things that are available . . . and it's like, how do I know what to ask for if I don't even know what's available to me? Like, why didn't you ask? Because I didn't know. There's a lot of things that I'm like sitting in the dark. . . . It's like, 'Why you didn't ask?' I didn't know. I don't know everything that's available to me. That's why I want a case manager."

Participants appreciated the critical role of community-based organization staff, who help them navigate the complex health care system. They rely on these navigators to connect them with the right care and support.

"They're already in the system, they know the ins and outs. I'm not trying to reinvent the wheel and run around, when I can go to someone that has the information that can guide me . . . and probably recognize some problems that I haven't even endured yet."

— 67-year-old Black man, Alameda County

Turning Discharge into a Warm Handoff to Other Services

Two in five participants said they need better discharge instruction and follow-up. This applies to hospital stays as well as transitional care, rehabilitation, and incarceration. They shared that the discharge process is often rushed, leaving them without adequate support or necessary information to manage their recovery effectively. Many participants said they would have appreciated being connected to needed services (e.g., step-down facilities, therapy, housing navigation) before being discharged.

Limited health literacy, digital literacy, and language barriers often compound these difficulties, forcing participants to rely on informal support from friends and family. Lack of follow-up is particularly challenging for those with chronic conditions requiring regular care.

"I had to go home with . . . 60 stitches inside me. I had internal bleeding. [My doctor] just threw [me] back to the wolves, 'Here['s] some medication, there you go.' Now, if you had sat me down and said, 'Hey, go call this number, this man might help you get physical therapy or help you figure out how you are going to be able to walk around or how are you going to survive, how you are going to be able to get this medication.'"

— 35-year-old Black man, Fresno County

Providing Information to Those with No Access to Digital Services

One in three participants said that information about care and services should not assume digital literacy and access to digital services. Many participants with limited computer literacy reported struggling to make appointments, receive reminders about appointments, and complete application forms online. In addition, many said they would like to have classes to help them use technology. A caregiver in Alameda County said, "You have the elderly. You have older people who don't know nothing about that kind of [digital] stuff. They can't see, they can't hear. They don't know nothing about a computer or nothing. What about that group of people?"

"Yes, I can go online. But if you ask me to look at information to apply for some services, I don't know. But I can read news and if you teach [me] something simple . . . but if you ask me to download things, to check out information, I don't know how to do that."

— 73-year-old Chinese woman, Los Angeles County
Translated from Cantonese

Implementers' Reflections

CHCF convened a CalAIM Implementation Advisory Group to help shape and interpret research on CalAIM's launch and rollout. These providers and managed care plan leaders from across the state reflected on the key findings of this report. They also shared examples of what they see working in the implementation of CalAIM, as well as what could be improved.

Patient's Goals Come First

Sometimes well-intentioned providers from the health care and social service systems prioritize their own goals (e.g., controlling diabetes or reducing readmissions), rather than asking the person they are serving what would improve their health and well-being. Katelyn Taubman, a community health worker (CHW) at Inland Housing Solutions, reflected, "If the medical system could just understand that the patients' needs are important, that their autonomy is important. If a client prioritizes a new bed, or getting into a housing unit, they're not going to go to the doctor." She stressed the importance of "meeting the patient where they are" and assisting with what the patient says are primary needs. "So then, the next time when we say, 'Can I go to your primary care doctor with you?' they're way more likely to do that."

Staff Who Reflect the Community Are Essential to Outreach and Navigation

Debbie Toth, the CEO at Choice in Aging, reinforced that "diversity is really important. We heavily focus on having the people that we hire reflect the people that we serve, not just in race or ethnicity but also lived experience." Nancy Wongvipat Kalev, senior director at Health Net, shared the power of the community health worker "to act as that cultural bridge and start building that trusted relationship." Kalev and other implementers said the CHW benefit provides funding to hire the needed staff. Health Net also provides CHWs with an extra per-member incentive for each enrollment in CHW services and for linking the member to a primary care provider, Enhanced Care Management (ECM) service, or Community Support service.

Finally, implementers discussed how essential community health work is to providing system navigation that people with complex needs seek. Taubman, who started in Community Supports and moved over to providing ECM, shared her "knowledge of how important community health work is. I didn't realize what an important role that was in ECM until I started doing it. It's really the glue that holds everything together."

Training and Other Measures to Reduce Care Manager Turnover

People with complex needs shared that it is disruptive to start over with a new care manager. Implementers emphasized that reducing turnover must be addressed collectively. In addition, Taubman offered that training can help. "Trauma-informed care training is huge. I don't think most agencies [have] always offered that type of training, and if it's not available, it's no wonder that people are not staying." Implementers also suggested that data exchange improvements prevent people from retelling traumatic events repeatedly, risking retraumatization. These improvements also reduce administrative workload for care managers, which affects job satisfaction.

Sustainable Partnerships Build Trust Within the Community

Trust-based partnerships are the foundation of the integrated care and one-stop shopping that Californians with complex needs value. But implementers noted there is still work to do on cross-sector collaboration and partnership.

"The issue of trust is a problem across the board, starting with providers and managed care plans," said Alex Fajardo, executive director of El Sol

Neighborhood Educational Center. He added that managed care plans often see providers as vendors rather than as partners, which undermines collaboration. "A trusted relationship has to start at that level, built on mutual respect and a shared commitment to improving outcomes for the community. Without trust, it's difficult to create the kind of integrated, people-centered systems that our communities need."

Conclusion

As CalAIM's Enhanced Care Management and Community Supports approach their four-year anniversary, this research provides critical insights directly from people whom the programs aim to serve. The voices of Californians with complex needs reveal both the promise and ongoing challenges of California's efforts to transform care delivery.

The research highlights the interconnected nature of health and social needs, with many participants prioritizing the role of housing, employment, and economic stability in their well-being over traditional health care. Their perspectives reinforce CalAIM's core premise that addressing social drivers of health is essential to improving health outcomes for those with complex needs. It also reinforces the importance of Enhanced Care Management as a key to system navigation.

As California continues to refine and strengthen CalAIM implementation, these findings offer a roadmap for building on early successes while addressing challenges that take longer to overcome. That said, such a roadmap is no substitute for involving people with lived experience directly in program development and refinement. By focusing on the expertise and lived experiences of those with complex needs, CalAIM's implementers can create a more responsive, person-centered system that truly meets people where they are and helps them achieve better health and quality of life.

Appendix: Study Demographics and Methodology

Demographics

Table 1 shows the demographics of study participants.

	PARTICIPANTS (#)
Gender Identity	
Female	52
Male	45
Nonbinary	1
Transgender	1
Age	
18–34	19
35–49	17
50–64	23
65+	40
Race/Ethnicity	
American Indian and Alaska Native	10
Asian, Native Hawaiian, and Pacific Islander	8
Black or African American	40
Latino/x	25
Multiracial	7
White	20
Some Other Background	6
Preferred Language	
English	87
Spanish	8
Chinese	4
Insurance Status and Coverage	
Uninsured	2
Medi-Cal	83
Medicare-Medi-Cal	8
Other	6

Notes: *Ns* are unweighted. Participants could select all racial/ethnic categories that they considered part of their identity. No participants had private insurance, CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), or coverage provided by the Indian Health Service.

Source: Listening to Californians with Complex Needs, in-depth interviews conducted by EVITARUS (October 2023 to November 2024).

Methodology

This report is based on research conducted by EVITARUS between October 9, 2023, and November 7, 2024. EVITARUS conducted 99 semi-structured, hour-long, in-person interviews with people with complex needs, as well as 8 focus groups among caregivers of those with complex needs. A total of 41 caregivers participated in the focus group research. For purposes of the research, complex needs were defined as one or more of the following:

- Homelessness or housing insecurity
- Serious mental illness
- Substance use disorder
- Functional impairments or cognitive decline — with a special focus on those age 65 years or older

To qualify for the study, participants had to be eligible for Medi-Cal, or eligible for both Medicare and Medi-Cal.

Research participants were recruited through community-based implementation partners across four counties that represented distinctive geographic regions of the state. Implementation partners identified potential interviewees by using a recruitment and screening questionnaire designed and developed by EVITARUS to assess the complexity of interviewees' health needs as well as demographic characteristics. These and other protocols were designed to provide a balanced sample of participants, including by health and behavioral health conditions, targeted age cohorts, gender identity, ethno-racial identity, and health insurance status/eligibility

The interviews were conducted in person by professional interviewers trained in the semistructured interview protocol developed by EVITARUS. Each interview lasted approximately one hour, was recorded with the permission of the participant, and was transcribed to facilitate data analysis. The interview process was standardized, with interviewers using a discussion guide that contained the same set of questions for each person interviewed. In addition, interviewers were allowed some flexibility to probe further for clarification or follow up on a particular line of thought. Each interviewee received a financial honorarium in recognition of their time and participation.