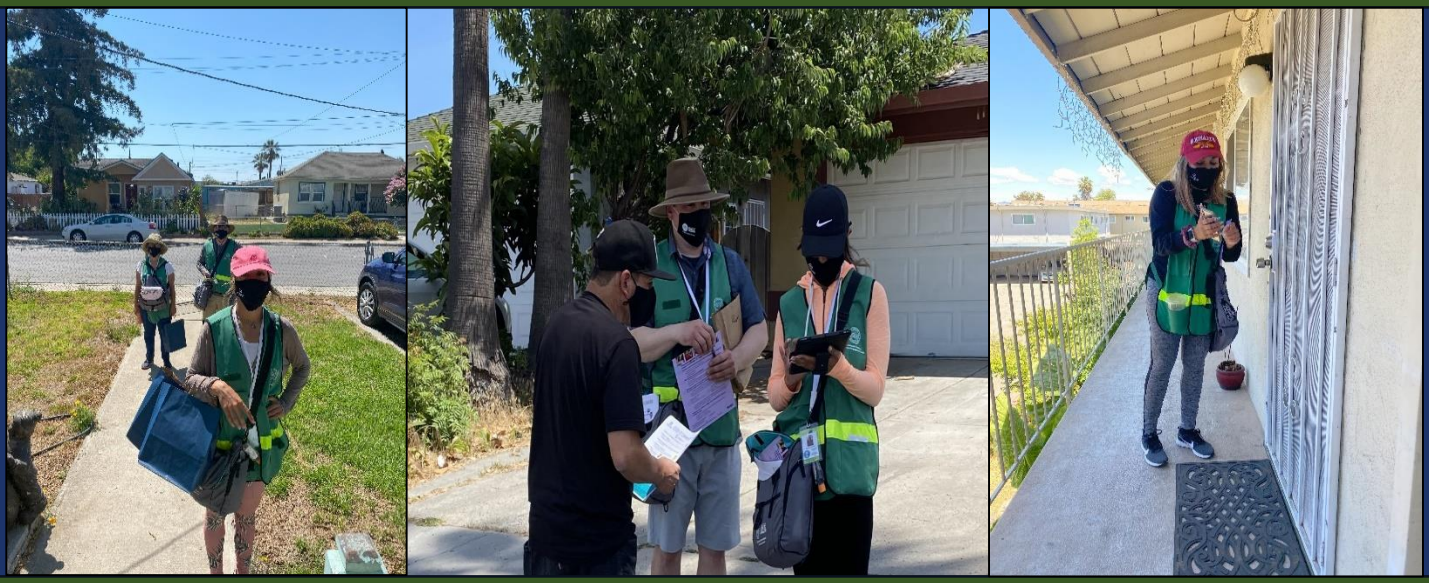

COVID-19 Community Resiliency & Recovery Efforts Report

COMMUNITY HEALTH PARTNERSHIP

Supporting our health centers

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ACKNOWLEDGEMENTS

This report has been prepared by various parties. Community Health Partnership (CHP) would like to thank the many individuals and agencies who helped to engage the communities hit hardest by COVID-19 to create and advance community-driven solutions for COVID-19 recovery response and emergency preparedness. The outreach efforts of partner community-based organizations (CBOs) and participation of community members in the focus groups, community surveys, and one-on-one interviews were critical to the success of this project.

CBO Partners

A special thanks to the CBOs who provided space, assisted with outreach, and/or helped facilitate focus groups:

- Amigos de Guadalupe
- Cassell Neighborhood Association
- Community Agency for Resources, Advocacy, and Services (CARAS)
- Community Health Partnership Community Health Workers
- Community in Action Team of Mountain View
- Community Solutions
- ConXion to Community
- LEAD Filipino
- Latinos United for a New America (LUNA)
- McLaughlin Area Tenants
- San José Mobile Home & RV Park Tenants Association
- Silicon Valley Small Business Development Center
- SOMOS Mayfair
- Sunrise Middle School
- Tropicana-Lanai Neighborhood Association
- Truc Vien Club
- Valley Palm Apartments
- Van Lang School
- Veggielution
- Vietnamese American Cultural Center
- VIVO - Vietnamese Voluntary Foundation

CHP Staff & Community Health Workers

CHP would like to express its deepest appreciation to the staff and community health workers who designed and conducted the focus groups, assisted with logistics, note-taking, and translation, distributed and collected community surveys, connected COVID-19 recovery resources to the community, and conducted one-on-one in-depth interviews.

- Patricia Diaz, Community Engagement Director
- Robin Hayes, Program Coordinator III

- Melissa Trujillo, Program Coordinator III
- Lien Phan, Program Coordinator II
- Ana Cervantes, Community Health Worker
- Ana Jimenez, Community Health Worker
- Cherrilynn Pirir, Community Health Worker
- Gloria Crisanto Peralta, Community Health Worker
- Mai Doan, Community Health Worker

Starling Advisors

CHP wishes to express warm thanks and appreciation to Melissa Mendez with Starling Advisors for her extensive consultation. Ms. Mendez prepared, analyzed, researched, and finalized the report. The process of preparation of the report involved collaborating with CHP, analyzing notes of 47 focus groups, 493 community surveys, and 23 interviews, and research.

Investment Partners

CHP would also like to give special thanks to the California Governor's Office of Emergency Services (CAL OES) Listos California Target Grant Program, the County of Santa Clara Public Health Department (PHD), California Commission on the Status of Women and Girls (CCSWG), Applied Materials Foundation, and the City of San José for their financial support.

EXECUTIVE SUMMARY

From August 2022 to January 2023, Community Health Partnership (CHP) conducted 47 focus groups with 513 community members in three regions of Santa Clara County that were hit hardest by the COVID-19 pandemic – East San José, South County/Gilroy, and North County/Mountain View. Focus groups were conducted in Spanish, Vietnamese, and English and focused on different key aspects of the pandemic: 1) challenges, 2) coping and resiliency, and 3) recovery. In addition to participating in focus groups, 493 (96.1%) community members also responded to a community survey that included demographic questions and several basic questions about the impact of the pandemic and where they received information from. Twenty-three focus group participants also completed one-on-one interviews with CHP staff after the completion of the focus groups to provide additional details on their personal experiences. The aim of these information-gathering activities was to gain a better understanding of the impact of the COVID-19 pandemic on vulnerable populations in Santa Clara County and to gather community input on local emergency preparedness gaps and solutions. Thanks to these activities, this report offers:

1. Community-driven solutions for COVID-19 recovery efforts and recommendations for how Santa Clara County can better prepare for future public health emergencies.
2. Recommendations for how to incorporate community representatives into local emergency response planning.

Findings from project activities gleaned valuable information about the impact of COVID-19 on socially vulnerable Santa Clara County residents, especially those with access and functional needs. Some of the most common challenges experienced during the pandemic across the different communities included economic hardship, a difficulty applying to and receiving COVID-19 aid, mental health issues, low access to health care services, children's education challenges and barriers to online learning, use of technology, and misinformation and confusion surrounding the virus and assistance that was available. Many focus group participants received some type of COVID-19 relief or aid. Food assistance, stimulus checks, and rental assistance were common services that people obtained. While some aid was relatively easy to obtain, participants experienced major difficulties in accessing rental assistance and other financial aid. Many also reported receiving no aid, either because they were unaware or misinformed of the aid that was available, ineligible, or otherwise denied assistance. People learned about these services through various means, including from a community health worker/promotora, a clinic or hospital, their child's school, the county, the media (e.g., TV, news, radio, social media), a CBO, and word of mouth.

Focus group participants were also asked to name some things that got easier over time, things that became more challenging over time, and things that should be prioritized in the event of another emergency. The most common things that got easier over time were adhering to recommendations and guidelines (e.g., wearing masks, using hand sanitizer, social distancing), online learning, and getting comfortable with technology. By contrast, what became more difficult over time was paying for goods that had become more expensive/overall financial struggles. Many suggestions were provided to help the community better prepare for future disasters. Focus group participants emphasized the importance of having equal access to accurate and timely information; safety-net services like food, housing/shelter, and health care; community networks and groups; supports for community-based outreach staff;

simplified COVID-19 assistance application processes; and community-based educational workshops and trainings on emergency preparedness and response for a variety of disasters.

Based on these findings, the following solutions for COVID-19 recovery efforts and recommendations for preparing for future emergencies have been proposed:

1. *Ensure equitable COVID-19 relief application processes by only enforcing requirements that guarantee a fair process and by removing application barriers.*
2. *Ensure crisis communication is timely and targeted, and take steps to combat misinformation.*
3. *Improve access to health care by increasing health coverage enrollment assistance activities.*
4. *Increase community-based workshops and trainings to help improve residents' access to emergency planning and response information.*
5. *Prepare the community for future disasters through community-building activities.*
6. *Prioritize long-term recovery efforts and activities.*

Additionally, to incorporate community-centric ideas into local emergency response planning, county emergency management personnel should strive to use a whole community approach by building and maintaining partnerships with community leaders, leveraging the expertise of CBOs, and increasing visibility into emergency response planning activities and opportunities for community members to get involved.

INTRODUCTION

In 2022, CHP was one of 19 nonprofit community-based organizations (CBOs) who received a grant award from the Listos California Target Grant Program, funded by the California Governor's Office of Emergency Services (CAL OES). The purpose of this grant program is to support organizations throughout California that serve socially vulnerable populations located in areas at moderate to high risk from natural hazard. Beginning June 1, 2022, CHP provided disaster education, training, and resources to diverse populations in San José and Gilroy in Santa Clara County to increase the community's disaster preparedness, response, recovery, and mitigation capabilities. Through this CAL OES grant and other related work with the County of Santa Clara Public Health Department (PHD), California Commission on the Status of Women and Girls (CCSWG), Applied Materials Foundation, and the City of San José, CHP distributed surveys to community members and conducted focus groups in East San José, South County/Gilroy, and North County/Mountain View. These data-gathering efforts aimed to gain a better understanding of the impact of the COVID-19 pandemic on vulnerable populations in Santa Clara County and gather community input on local emergency preparedness gaps and solutions.

Purpose of the Report

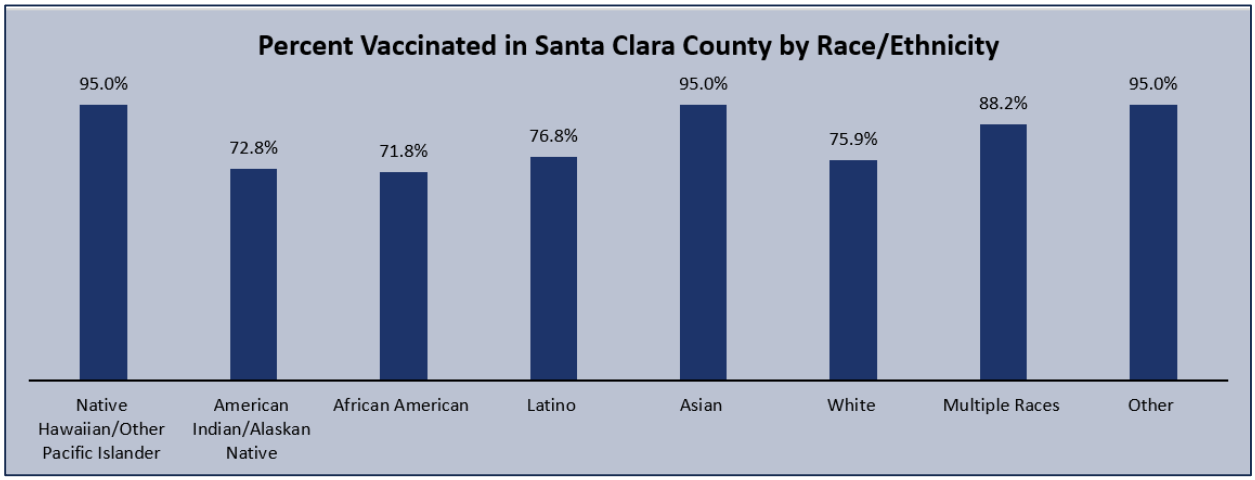
CHP prepared this COVID-19 Community Resiliency & Recovery Efforts Report to summarize findings from the information-gathering activities that took place within three target communities in Santa Clara County that were severely impacted by the COVID-19 pandemic.

This report has two key aims:

1. Provide community-driven solutions for COVID-19 recovery efforts and recommendations for how Santa Clara County can better prepare for future public health emergencies.
2. Offer recommendations for how to incorporate community representatives into local emergency response planning.

Background

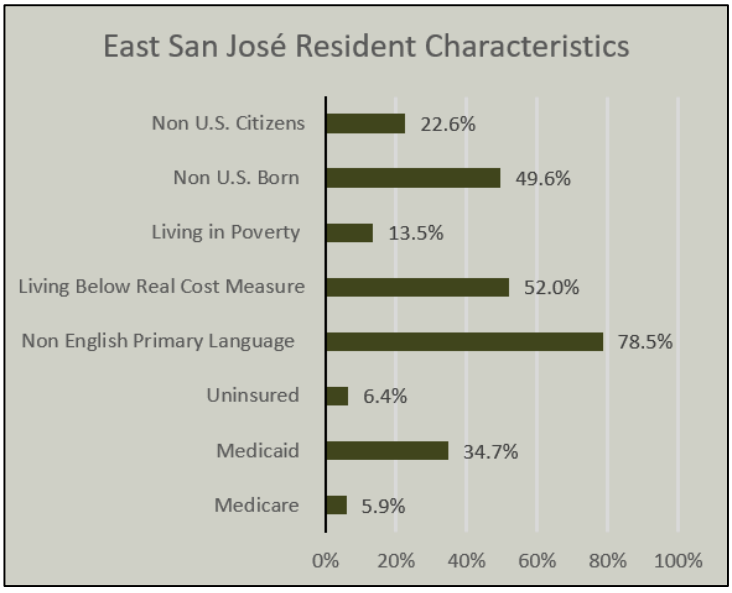
Preexisting health and economic disparities were exacerbated around the nation by the COVID-19 pandemic, including within Santa Clara County. According to the most recent COVID-19 case and death data for the county, Latino residents make up almost one third (31.2%) of all cases and deaths (31.4%), yet they only make up 26.5% of the population.[1] Vaccination rates vary among different racial and ethnic groups, with the most recent data showing that only 5% of Asians and Native Hawaiian/Other Pacific Islanders remain unvaccinated while 28.2% of African American, 27.2% of American Indian/Alaskan Native, 24.1% of White, and 23.2% of Latino residents remain unvaccinated.[2]



CHP conducted information-gathering activities in the most diverse and underserved areas within three regions of Santa Clara County – East San José, South County/Gilroy, and North County/Mountain View.

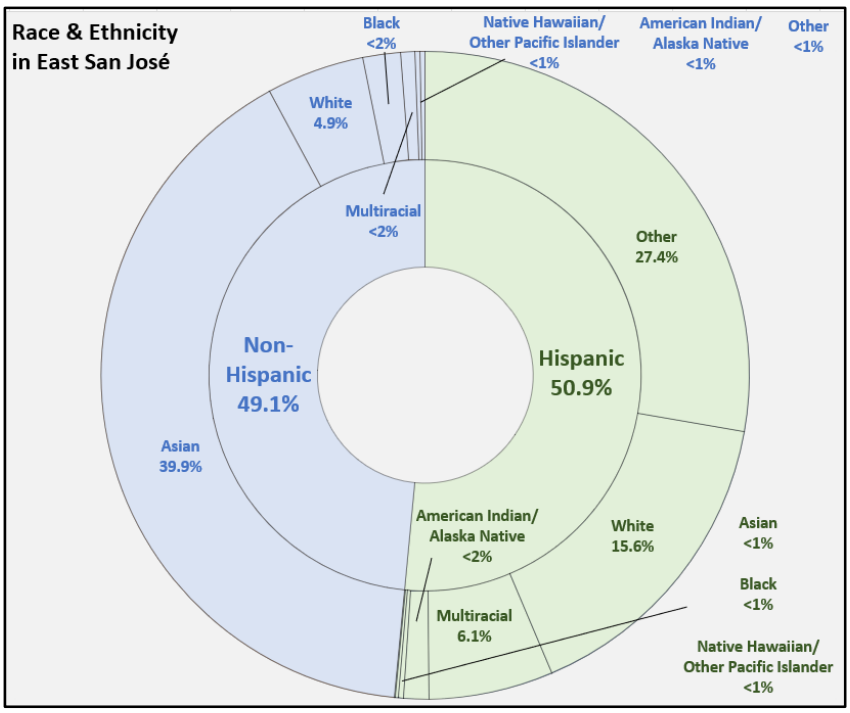
East San José

The majority of focus groups took place in the city of San José, particularly the East San José region, as 37 of the 47 (78.7%) focus groups were conducted there. San José overall is highly diverse, but the eastern region of the city of San José has even more diversity. In 2020, the San José City (East Central/East Valley) Public Use Microdata Area (PUMA) had a population of 110,000 people, of which 22.6% were not U.S. citizens. That year, almost half (49.6%) of residents in the region were born outside of the country. The largest ethnic groups in East San José are Asian (Non-Hispanic) at 39.9% of the



[1] County of Santa Clara Public Health Department, COVID Cases and Deaths Dashboard (2023). Retrieved June 5, 2023, from https://covid19.sccgov.org/dashboard-cases-and-deaths

[2] County of Santa Clara Public Health Department, COVID Vaccinations Dashboard (2023). Retrieved June 5, 2023, from https://covid19.sccgov.org/dashboard-vaccinations



population, Other (Hispanic) at 27.4% of the population, White (Hispanic) at 15.6% of the population, multiracial (Hispanic) at 6.1% of the population, and White (Non-Hispanic) at 4.9% of the population. Half (50.9%) of the population in East San José is Hispanic while 31% of the population is Hispanic in the city of San José as a whole. East San José also has a greater poverty rate than the city as a whole, as 13.5% of the population in East San José is living below the poverty line compared to 8.3% in the whole city.[3] However, the Real Cost Measure, which takes into account geographical differences in the cost of living, is a more accurate measure of the number of families in the area who are unable to meet basic needs. According to the United Way Bay Area Real Cost Measure, 52% of household in this region (San José City - East Central/East Valley) live below the Real Cost Measure, the highest percentage in any region in Santa Clara County.[4] Hispanics are the most common racial or ethnic group living in poverty, followed by Asians and Other.[3]

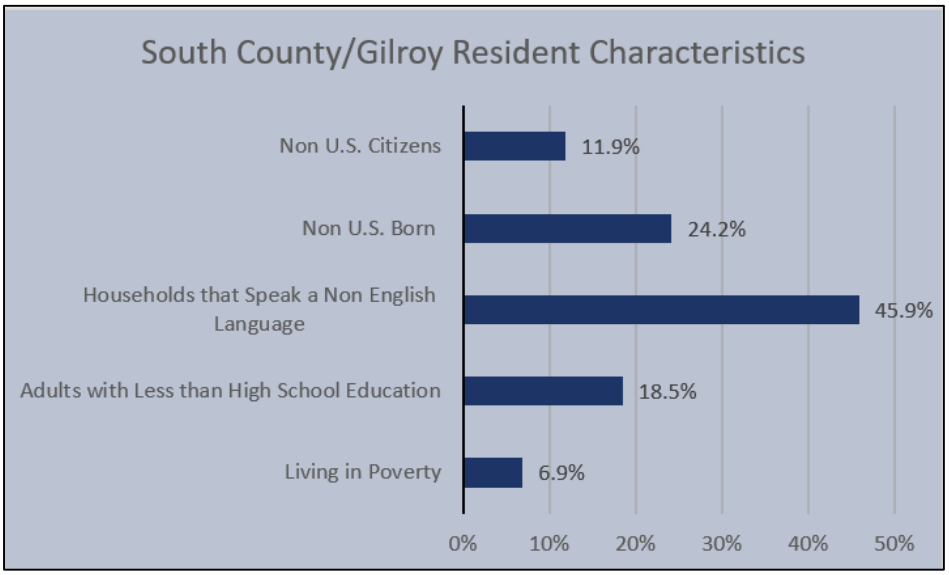
Additional social vulnerability factors exhibited by the populations living in East San José include low English proficiency and low health coverage. Many residents in the region lost employment during COVID-19, as the most common job groups are in industries that were negatively impacted by the pandemic lockdown. The top five most common job groups are janitors and building cleaners, personal care aides, cashiers, construction laborers, and cooks, in that order. The vast majority (78.5%) of households in the San José City (East Central/East Valley) PUMA report a non-English language as their primary shared language. The most common primary languages spoken are Spanish (41.8%), Vietnamese (17.3%), and Tagalog (including Filipino) (6.8%). Also, many community members in the region are uninsured or underinsured, as 6.4% of residents have no health insurance, 34.7% have Medicaid, and 5.9% have Medicare.[3]

[3] Data USA, San José City (East Central/East Valley) PUMA, CA (n.d.). Retrieved April 17, 2023, from https://datausa.io/profile/geo/san-jose-city-east-centraleast-valley-puma-ca

[4] United Ways of California, The Real Cost Measure in California 2023 (2023). Retrieved June 13, 2023, from https://public.tableau.com/app/profile/hgascon/viz/TheRealCostMeasureinCalifornia2023/RealCostDashboard

South County/Gilroy

Five focus groups, or 10.6% of all groups, were conducted in South County/Gilroy. In 2020, the city of Gilroy had a population of 55,227, of which 11.9% were not U.S. citizens and 24.2% were born outside of the U.S. More than half (57.6%) of the population is Hispanic, and the largest ethnic groups are White (Hispanic) at 36.9% of the population, White (Non-Hispanic) at 26.8% of the population, and Asian (Non-Hispanic) at 10.5% of the population.[5] Almost half (45.9%) of the households in the area speak a language other than English.[6] About 18.5% of the adult population did not graduate high school or obtain a GED.[7] In this region, the most common employment sectors are health care and social assistance, retail trade, and construction. Hispanics are the most likely racial or ethnic group to be living in poverty, followed by Whites, and 6.9% of the total population is living in poverty.[8] The income disparities are significant, even within census tracts, and while the median household income is $159,127 in the wealthiest area of Gilroy, it is only $66,176 in the poorest area.[9] Focus group participants from South County/Gilroy tended to have an even lower income than the median income in the poorest area of Gilroy, as 21.4% of participants reported no income. More than half (57.1%) reported an income below $50,000, with 33.3% below $19,999 and 23.8% between $20,000- $49,999. Only 4.8% reported an income greater than $50,000, and 16.7% provided no answer. Finally, Gilroy has experienced the highest case rate of COVID-19 in Santa Clara County since the start of the pandemic (20,962 cases out of a population of 55,525 as of May 12, 2023).[10]



[5] Data USA, Gilroy, CA (n.d.). Retrieved April 17, 2023, from https://datausa.io/profile/geo/gilroy-ca

[6] US Census Bureau, QuickFacts Gilroy city, California (2022). Retrieved April 19, 2023, from https://www.census.gov/quickfacts/gilroycitycalifornia

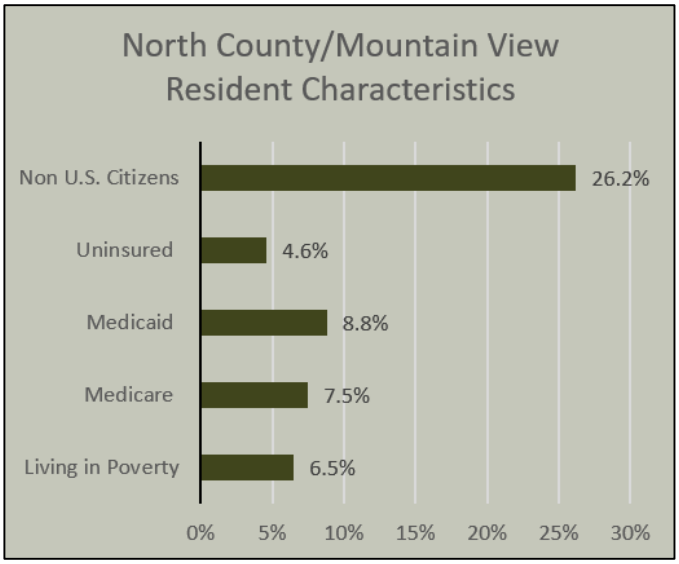
[7] UCLA Center for Health Policy Research, AskCHIS Neighborhood Edition, Less than high school (18+) Gilroy (2019). Retrieved April 27, 2023, from https://askchisne.ucla.edu/ask/_layouts/ne/dashboard.aspx#/

[8] Data USA, Gilroy, CA (n.d.). Retrieved April 17, 2023, from https://datausa.io/profile/geo/gilroy-ca

[9] Chalhoub, Erik, Covid-19 highlights health care inequality in Gilroy (2021). Retrieved May 1, 2023, from https://gilroydispatch.com/covid-19-highlights-health-care-inequality-in-gilroy/

[10] County of Santa Clara, COVID-19 cases by city of residence (2023). Retrieved May 12, 2023, from https://data.sccgov.org/COVID-19/COVID-19-cases-by-city-of-residence/59wk-iusg

North County/Mountain View



Another five focus groups, or 10.6% of all groups, were conducted in North County/Mountain View. The city had a population of 80,104 in 2020, with 26.2% of the population not being U.S. citizens, which is even greater than in the East San José region. Overall, Mountain View has a bit less racial and ethnic diversity compared to the other regions, with the largest ethnic groups being White (Non-Hispanic) making up 43.3% of the population, Asian (Non-Hispanic) making up 31.7% of the population, and White (Hispanic) making up 8.6% of the population. The Hispanic population makes up 18.1% of the population overall. In 2020, 4.6% of residents were uninsured, 8.8% had Medicaid, and 7.5% had Medicare. Similar to South County/Gilroy, the rate of poverty in Mountain View is 6.5%, but it is important to keep in mind the wealth disparities that exist and are only getting wider in Silicon Valley. Whites, Hispanics, and Asians, in that order, are the most common racial or ethnic groups living in poverty in this region. Furthermore, while the median household income in this area is relatively high at $144,116, focus group participants exhibited much lower income levels.[11] Among focus group participants in North County/Mountain View, 11.1% reported no income and 57.4% reported income below $50,000, with 35.2% reporting below $19,999 and 22.2% reporting between $20,000- $49,999. Only 7.5% reported an income greater than $50,000, and 24.1% provided no answer.

Overall, focus group participants across all regions were living in poverty. In Santa Clara County, 25% of households live below the real cost measure of $128,176 for a family of four with two adults and two children (preschool and school aged). Latino and Black residents have a disproportionate number of households living below the real cost measure, as 50% of Latino and 41% of Black households live below the real cost measure compared to 19% of White and 18% of Asian American/Pacific Islander households. It is clear that much of the population in the County struggles to meet basic needs, and focus group participants represented some of the most vulnerable and disadvantaged groups.[12]

Local Emergency Planning

Emergency plans at all levels of government were activated under the declaration of COVID-19 as a public health emergency to provide essential services and keep communities safe. An emergency plan is a document that defines a jurisdiction's scope of preparedness and emergency management actions to be taken in the event of an emergency.[13] These plans describe how resources will be used to protect

[11] Data USA, Mountain View, CA (n.d.). Retrieved May 1, 2023, from https://datausa.io/profile/geo/mountain-view-ca?covid-measure-covid-cases=covidMeasure3#health

[12] United Ways of California, Santa Clara County: The Real Cost Measure in California 2023 (2023). Retrieved June 13, 2023, from https://unitedwaysca.org/wp-content/uploads/2023/05/santa_clara_county.pdf

[13] California Governor's Office of Emergency Services, State of California Planning Best Practices for County Emergency Plans (2021). Retrieved May 8, 2023, from https://www.caloes.ca.gov/wp-content/uploads/Preparedness/Documents/Planning-Best-Practices-for-County-Emergency-Plans-draft.pdf

people, property, and the environment from potential hazards and threats, and they are maintained at different levels of government - state, local, tribal, and territorial.[14]

Counties and municipal agencies are designated as the local emergency management agencies, which can have various names (e.g., office of emergency management, public safety office, emergency operations center). Local governments are the first line of defense in the event of a disaster or emergency, with declarations being made by the local Chief Elected Official (CEO) such as a mayor, city manager, or commissioner. If the CEO determines that local resources will be exhausted in response to the emergency or disaster, they may request state assistance. Likewise, if the Governor of the state determines that the state's resources and capabilities will be exhausted, they may request federal assistance. After review of the Governor's request, the President may decide to issue a major disaster declaration and provide federal resources.[15] This bottom-up approach to emergency response ensures resources are used appropriately to recover from an emergency.

When an emergency plan is activated, government partners, first response agencies, non-profits, and the private sector will collaborate to take necessary actions to protect the community. In the initial response, which occurs during the emergency, immediate aid is provided to save lives and minimize damage. Then the recovery phase begins to restore public order and safety. Short-term recovery activities ensure the community returns to minimum levels of operation, such as restoration of essential services (e.g. medical care, water and power, shelter, etc.) or making repairs to public structures. Long-term recovery, which can take years, involves activities that restore previous conditions in the community as much as possible, as well as mitigation measures to better protect people and property from a similar event in the future.[12] Having a comprehensive emergency plan that outlines roles, responsibilities, and clear procedures for crisis response is critical for an effective recovery.

California counties are required to submit their emergency plans to the CAL OES, which ensures plans include best practices, steps to protect vulnerable populations during disasters, and procedures for alerting, evacuating, and sheltering community members during an emergency. Between 2016 and 2022, there were several updates made to county emergency plan legislation that introduced new requirements for the content and planning process, submission, and review of local emergency plans. Of

[14] FEMA, A Citizen's Guide to Disaster Assistance (2003). Retrieved June 6, 2023, from https://training.fema.gov/emiweb/downloads/is7complete.pdf
[15] FEMA, Emergency Management in the United States (n.d.). Retrieved June 6, 2023, from https://training.fema.gov/emiweb/downloads/is111_unit%204.pdf

note are Assembly Bill 2311 and Assembly Bill 477, implemented in 2016 and 2019, respectively. Assembly Bill 2311 required all California counties to integrate details regarding access and functional needs into their emergency plan upon the next update of their plan. Assembly Bill 477 required all California counties to include access and functional need population representatives in their plan upon the next update. Specifically, internal and external stakeholders had to be included in each phase of the emergency planning process in emergency communications, evacuations, and sheltering.[16]

The Federal Emergency Management Agency (FEMA) recommends that the following steps be taken during the planning process: 1) form a collaborative planning team, 2) understand the situation, 3) determine goals and objectives, 4) develop the plan, 5) prepare and review the plan, and 6) implement and maintain the plan. It is also best practice to engage the whole community in planning efforts. This whole community engagement can occur in various ways. Examples of activities include leveraging the expertise of community leaders who understand the needs and capabilities of the communities they represent, including individuals with access and functional needs (e.g., individuals with limited English proficiency, disabilities, and/or chronic conditions), engaging private and public sector partners who provide critical services to the public, and involving different stakeholder groups such as community emergency response teams (CERTs) and local emergency planning committees (LEPCs).[17] This report offers recommendations for how to incorporate the community's ideas and representatives into local emergency response planning using FEMA's whole community approach as a model.

APPROACH

The greatest experts in understanding a community's needs and capabilities are the people who are living in it. Community residents will have to live with the results of the local government's response to an emergency; therefore, they deserve to not only offer input but to guide the plan for actions that will be taken when a disaster occurs. Using a community-based approach, CHP conducted several information-gathering activities to engage residents in identifying priorities and solutions for emergency recovery and response planning. CHP engaged more than 500 community members in focus groups, which provided a space for community members to contribute ideas and comments that culminated in the recommendations and recovery vision described in this report. Additionally, CHP conducted interviews with a small subset of these participants in order to gain deeper insight into the various lived experiences of diverse community members, empower the individuals who shared their stories, and to use those positive narratives to inspire change.

Principles of equity, social justice, cultural humility, and mutual learning are embedded in this project. To advance equity and social justice, it is critical that emergency response planning efforts consider the entire population and its needs, taking special consideration to groups that have been historically underrepresented and marginalized. To ensure proper outreach was conducted to the community's various diverse groups, CHP developed partnerships with more than 20 community organizations that

[16] California Governor's Office of Emergency Services, State of California Planning Best Practices for County Emergency Plans (2021). Retrieved May 8, 2023, from https://www.caloes.ca.gov/wp-content/uploads/Preparedness/Documents/Planning-Best-Practices-for-County-Emergency-Plans-draft.pdf

[17] FEMA, Developing and Maintaining Emergency Operations Plans Comprehensive Preparedness Guide (CPG) 101, (2021). Retrieved May 8, 2023, from https://www.fema.gov/sites/default/files/documents/fema_cpg-101-v3-developing-maintaining-eops.pdf

serve and already have trusted relationships with these populations. These community partners assisted with recruitment efforts, which resulted in the successful engagement in focus groups and interviews of numerous socially vulnerable populations including people of color, low-income residents, unhoused persons, individuals with limited English proficiency, older adults, and undocumented folks. This allowed for conversations to focus on the development of solutions for equitable services that will meet everyone's needs in an emergency.

Different cultural groups were engaged in the project with cultural humility, and focus groups and interviews allowed individuals to tell their own stories without fear of judgment. Rather than making assumptions about the barriers and challenges experienced by these groups, community conversations appreciated individuals' expertise on the sociocultural context of their own experiences. A peer-to-peer approach was used to learn from the population of focus in a culturally appropriate manner, with facilitators being people who reflected the community in terms of language, race/ethnicity, and cultural background. Community members were listened to with empathy, and facilitators were completely transparent about the process and intent of the project. Thus, the project resulted in mutual learning and the creation of an inclusive plan for positive change.

Overall, using a community-based approach helped to build trust, strengthen collaboration, and empower local action. By providing a space that allowed equal opportunity for community members to share their voices and lead the identification of priorities, a community-owned plan for emergency recovery and response planning was developed. These efforts are consistent with CHP's overall organizational work to elevate the voices of its local community and develop and advance solutions for issues surrounding population health and overall wellbeing.

OVERVIEW OF INFORMATION-GATHERING ACTIVITIES

To engage the Santa Clara County communities hit hardest by COVID-19 in developing solutions for recovery response and recommendations to strengthen the local emergency response infrastructure, CHP conducted COVID-19 Community Resiliency and Recovery focus groups. These focus group discussions were split into three sessions that focused on different key aspects of the pandemic: 1) challenges, 2) coping and resiliency, and 3) recovery. The session on challenges invited participants to reflect and share their thoughts on how the pandemic affected them and their families, what they found to be most challenging during the pandemic, and which challenges they were still addressing. The session on coping and resiliency asked participants to share information about the services they received during the pandemic and how they learned about the services, what they experienced that was difficult in the beginning of the pandemic but got easier with time, and what they experienced that was relatively easy in the beginning but became more difficult with time. Finally, the session on recovery asked participants to share their ideas regarding what should be prioritized if there was another emergency, how the community could be better prepared for a future emergency, and how they became stronger during the pandemic.

A total of 47 focus groups were conducted from August 2022 to January 2023. Of the 47 focus groups, 27 (57.4%) were conducted in Spanish, 14 (29.8%) were conducted in Vietnamese, and six (12.8%) were conducted in English. The majority of focus groups took place in the East San José region, as 37 (78.7%) were conducted in East San José, five (10.6%) were conducted in South County/Gilroy, and five (10.6%) were conducted in North County/Mountain View. There were 513 total community members who

participated across all focus groups, with 250 (48.7%) being Spanish-speaking, 209 (40.7%) being Vietnamese-speaking, and 54 (10.5%) being English-speaking.

Table A: Number of Focus Groups

	East San José	South County/ Gilroy	North County/ Mountain View	Total
Spanish	18	4	5	27
Vietnamese	14	0	0	14
English	5	1	0	6
Total	37	5	5	47

The vast majority (96.1%) of focus group participants also completed a survey that captured demographic information and included questions about participants' experience with COVID-19. A total of 493 focus group participants completed the survey, of which 397 (80.5%) were from focus groups conducted in East San José, 42 (8.5%) were from focus groups in South County/Gilroy, and 54 (11%) were from focus groups in North County/Mountain View. Additionally, 225 (45.6%) were from Spanish-language focus groups, 219 (44.4%) were from Vietnamese-language focus groups, and 49 (9.9%) were from English-language focus groups.

Table B: Number of Community Member Surveys

	East San José	South County/ Gilroy	North County/ Mountain View	Total
Spanish	144	27	54	225
Vietnamese	219	0	0	219
English	34	15	0	49
Total	397	42	54	493

CHP followed up with individuals who participated in focus groups or who were connected to the partner organizations that hosted a focus group to conduct 23 interviews with 22 participants (two people were interviewed two separate times, and one interview involved two people). The purpose of these interviews was to obtain powerful stories of resilience to inspire positive change in other community members. Twelve interviews were conducted in Spanish, six were conducted in Vietnamese (with some English), and five were conducted in English. The majority of interviewees were women, with two participants who were male. Ten interviewees were over the age of 50, four were in their 20s, four were between 30 and 50 years of age, and the rest were of unknown age.

METHODS

Focus groups were conducted at CHP and partner organizations located in East San José, South County/Gilroy, and North County/Mountain View. CHP's Community Engagement Director sent a project overview document and letter via email to various CBOs to request their assistance in recruiting community members to participate in focus groups. The recruitment letter provided information about the purpose of the project, the logistics of the focus groups, and the questions that would be asked in focus groups. Follow-up to these organizations was conducted via email, phone, and meetings to

provide more information about the request. Additionally, a presentation was delivered to agencies in South County/Gilroy to request their partnership in the project. Twenty-one organizations agreed to assist with recruitment, use of their facilities to conduct the focus groups, and sometimes focus group facilitation. Partner organizations included community-organizing agencies, schools, neighborhood associations, advocacy organizations, social service agencies, and more. CHP provided these organizations with English, Spanish, and Vietnamese language recruitment flyers to distribute to their members and clients.

To prepare for the focus groups, CHP staff developed a facilitator guide and reviewed note-taking guidelines. Two of the 47 focus groups were conducted virtually via Zoom while the remaining ones were conducted in-person. During the in-person focus groups, CHP offered refreshments, hand sanitizer, emergency preparedness materials, safety net resources, and health coverage informational flyers to community members. All participants were also given a $30 gift card. Before beginning the focus group discussion, participants signed a consent form detailing the purpose of the focus groups, process, benefits and risks of participation, and confidentiality information.[18] Participants were then asked to complete the survey. Of the 513 community members who participated in the focus groups, 493 (96%) also completed the survey. Only a small percentage of participants did not complete the survey, usually because they were unable to read or write, or because they arrived late. These surveys were available in all three languages and were completed on paper during in-person focus groups or via email during Zoom focus groups. Once participants completed the survey, the focus group discussions began. The discussions were split into three sessions surrounding different topics, each lasting approximately 30 to 40 minutes. Focus group size ranged from four to 21 participants, with an average of 11 participants per focus group. Each group had at least one facilitator and one note-taker. Some focus groups were recorded if all participants consented.

One-on-one interviews took place after all focus groups were completed. Individuals had to indicate through self-selection that they consented to follow-up by CHP staff. If a focus group facilitator remembered a particularly impactful story from a focus group participant and the participant consented to follow-up, outreach was conducted to those individuals first. Remaining outreach was conducted by reviewing the list of individuals who had opted in to receive follow-up and attempting to select a diverse group. Interviews were conducted in person, over the phone, or virtually via Zoom. Interviews lasted approximately one hour, and participants received a $50 gift card for their time before the interview began. A facilitator and note-taker were present during each interview, and the sessions were recorded when permitted by the interviewee. Rev.com, a free transcription service, was also used in some sessions. The interviews were semi-structured and followed a basic interview structure, with slight differences in methodology based on the staff who conducted the interview. Most interviewees filled out a media release form consenting to the use of their story, and all provided at least verbal consent.

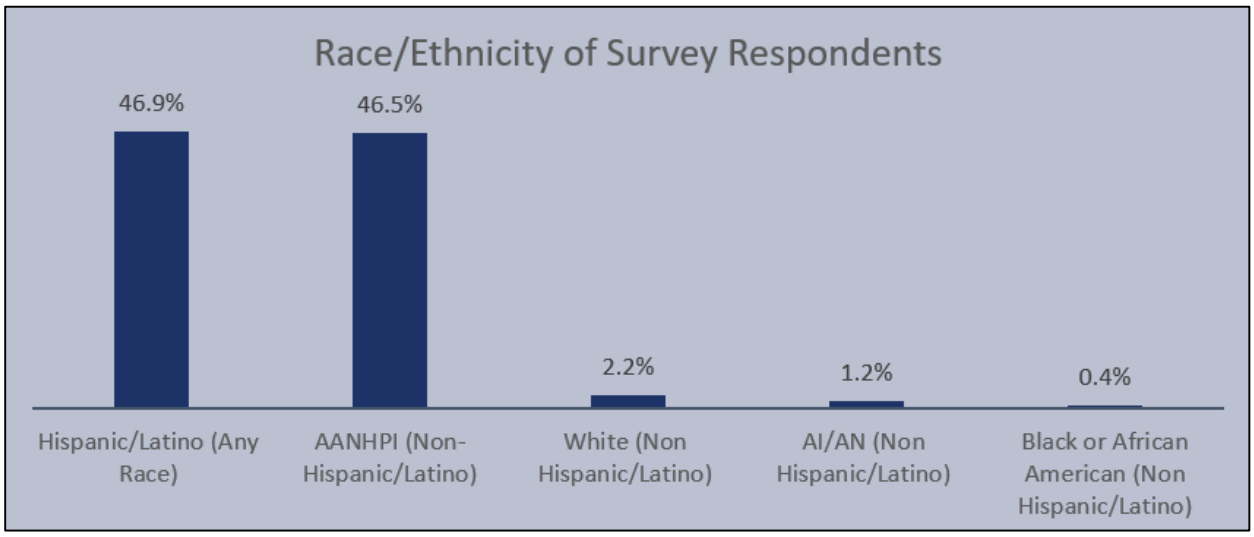
[18] A small handful of people refused to participate after learning about the purpose of the focus group because they were COVID skeptics or deniers. People may become distrustful of medical or government institutions when they feel their interests and needs are being dismissed, and the history of mistreatment of marginalized communities likely fuels these sentiments.

FINDINGS

Most participants were racial/ethnic minorities, of working age, living in poverty, and Medi-Cal beneficiaries. Survey responses demonstrated that participants were socially disadvantaged and exhibited key indicators of vulnerability prior to the COVID-19 pandemic, and it is clear that the pandemic aggravated these conditions. About one-fifth (21.1%) of participants said that the pandemic had a major negative impact on their household's ability to meet financial obligations, and almost the same number (22.0%) said it had a moderately negative impact. Of those who responded to the question about whether they needed additional support or resources during the pandemic, 55% indicated that they did. Furthermore, during the focus group discussions, numerous participants said that the pandemic had not made them stronger or more resilient but rather more vulnerable.

Participant Demographics	*n*	%
Age		
0- 17	3	0.6
18- 59	271	55.0
60+	205	41.6
Unknown	14	2.8
Income		
$0	73	14.8
< $20,000	157	31.8
$20,000 - $49,999	87	17.6
$50,000 - $89,999	44	8.9
> $90,000	11	2.2
Unknown	121	24.5
Insurance		
None	62	12.6
PCAP	4	0.8
Emergency Medi-Cal only	9	1.8
Medi-Cal, Medicare, Covered CA, or combination	305	61.9
Employer-sponsored or other	88	17.8
Unknown	25	5.1
N = 493		

Overall, the racial/ethnic breakdown of focus group participants who completed a survey was: 231 (46.9%) Hispanic or Latino (any race); 229 (46.5%) Asian, Native Hawaiian, or Other Pacific Islander (non-Hispanic/Latino); 11 (2.2%) White (non-Hispanic/Latino); six (1.2%) American Indian or Alaska Native (non-Hispanic/Latino); and two (<1%) Black or African American (non-Hispanic/Latino).



Less than 1% of survey respondents were youth aged 17 or younger, 55.0% were adults ages 18 to 59, 41.6% were adults aged 60 or older, and a small percentage (2.8%) unknown/refused to answer. Most were low-income, as 14.8% reported no income, 31.8% reported income under $20,000, 17.6% reported income $20,000 to $49,999, 8.9% reported income $50,000 to $89,999, and only 2.2% reported income

of $90,000 or greater. Almost a quarter (24.5%) provided no response or preferred not to answer. Respondents also reported their insurance status, with most insured by Medicaid. More than one in ten (12.6%) had no insurance, less than 1% had PCAP[19], 1.8% had emergency Medi-Cal only, 61.9% had Medicaid/ Medicare/ Covered CA/ combination of any, and 17.8% had insurance from their employer, family's employer, or other. Only 5.1% offered no response.

Findings are organized by focus group session topic – challenges, coping and resiliency, and recovery. Differences between regions or between languages emerged in some areas and are highlighted in the findings. Furthermore, there were times in which survey responses proved to be inconsistent with the information that was captured in focus groups. Significant areas of alignment or discrepancies are called out within each section of findings as well.

Challenges

Overall, the COVID-19 pandemic was negatively impactful for all focus group participants in at least some ways. Very few people said that the pandemic had affected them in a positive way (e.g., bringing family closer together, working in an industry where business was good during the pandemic, etc.). The majority of participants experienced fear and stress, illness from COVID at some point, a harder time obtaining essentials or running errands, and frustration with the inability to see friends and family or enjoy normal activities. In more than a quarter of focus groups, at least one participant had lost a loved one to COVID. Many lost employment while others were forced to continue working even though they felt unsafe, either because they were essential workers or because they could not afford to stop working. It became much harder for folks to continue their parental or familial duties. Children had to stay home and parents had a difficult time accessing childcare or managing their children's remote learning, and many older adults no longer had caretakers.

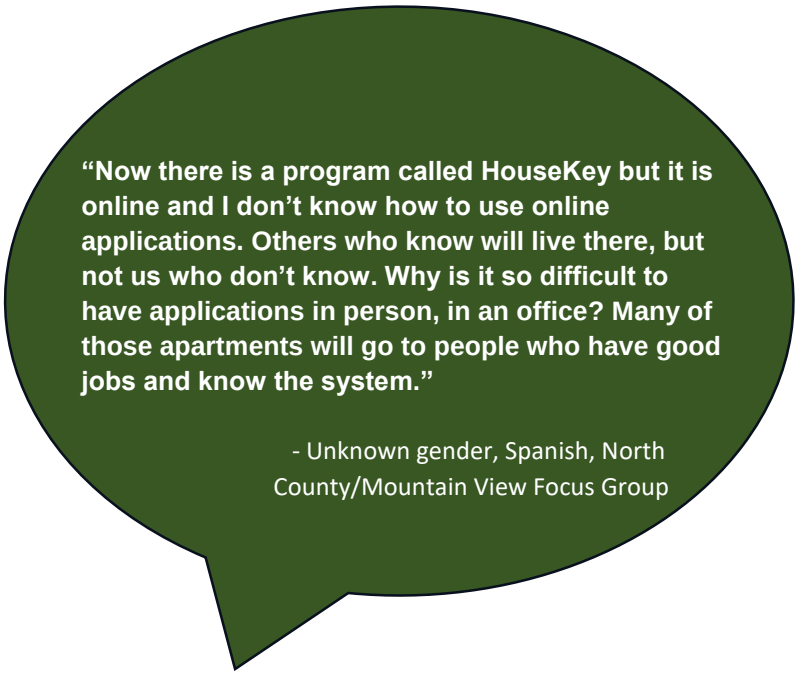
Financial Challenges

One of the greatest challenges was economic hardship. Across all focus groups, this was mentioned at least half of the time as something that affected individuals or their families, something that was one of the most difficult things about the pandemic, and something that they continued to experience. Employment loss, a reduction in hours, or forced retirement in particular were mentioned in three quarters of all focus groups, but they were much more likely to be mentioned in the Spanish-language focus groups. Among Spanish-language focus groups, this issue came up more than 95% of the time. This is likely due to the types of employment held by folks in the Spanish-language focus groups, as many worked in industries that were highly affected by the pandemic (e.g., restaurants, car repair, cleaning services, construction, etc.). Participants discussed many financial issues, but difficulty paying rent was a particular pain point, and again, it was most likely to be mentioned by Spanish-language focus groups. According to one Spanish-speaking mother of young children, **"When COVID started my husband was left without a job. I was the only one working, and because I was pregnant, I was only working four hours five days a week. My husband had to borrow money to pay rent, and I started working two jobs to support the family" (Female, Spanish, Individual Interview).** Stories like this one were common throughout the focus groups.

[19] The County of Santa Clara Primary Care Access Program (PCAP) is a low-cost coverage program for County adult residents who do not have access to other health insurance.

Inability to Obtain Aid

Despite the significant economic hardship faced by community members, assistance was hard to come by. An inability to obtain assistance was often mentioned by participants, and it was more likely to be mentioned in Spanish-language focus groups, South County/Gilroy focus groups, and North County/ Mountain View focus groups. For some, it was a matter of being unaware of the services and resources available or not having a clear understanding of eligibility requirements. Some who were struggling financially failed to apply for aid even when they knew about it because the information was confusing, or they found it hard to believe that aid would be granted. **Participants also discussed excessively long wait lists or application processing times, complex and timely applications, and requirements that were hard to meet.** Most applications had to be completed online or over the phone, which made the process difficult for older adults, individuals with limited English proficiency or illiteracy, and families with low broadband subscription. **Many had a difficult time obtaining help filling out applications, as it was hard to get a hold of government offices or get in-person assistance.**



A lot of people who really needed aid were unable to submit applications due to not being able to fulfill requirements. **Some applications required proof of income, a SSN, California ID, or other materials that people could not provide if they were not working or were undocumented. Undocumented individuals were excluded from federal stimulus payments and unemployment benefits, and they often had difficulty obtaining state aid that they were eligible for because of insufficient funds. Some mixed status families were also denied aid, and others did not ask for assistance at all because they were embarrassed to ask or were fearful of the public charge rule.** Others were denied aid because they were unable to provide required supporting documentation with their applications, either because they experienced challenges in submitting those documents or because they did not have them. Many people were unfamiliar with the use of online applications and simply did not know how to upload documents. In other cases, such as with rental applications that required rental agreements to be submitted, people did not have the correct documents. Many low-income families in these areas live in crowded homes and are hiding the number of people that are living under one roof. Without a lawful rental agreement, they were not able to get aid, and several people reported that their landlords were uncooperative or attempted to intimidate residents when they were approached for help. There was a lot of worry around paying rent, but tenants were unaware of their rights, and evictions were not uncommon even though there was a moratorium.

Residents of South County/Gilroy and North County/Mountain View **felt excluded from a lot of aid as well**. Assistance was more available in other areas that have a larger low-income population, like San José. Those outside of San José who described themselves as "the low-income families living among the high-income families" were frustrated that their neighborhoods were not receiving more aid. There were also comments that income restrictions were unfairly low. **Very few people live below the income threshold in those areas but still struggle financially because the cost of living is so high.** There was a lot of frustration among focus group participants who said that funds were not distributed to those most in need. It sometimes seemed that funds were awarded to some and not others arbitrarily, and several people felt they were discriminated against because of their race/ethnicity or immigration status. It should be noted, however, that there were some participants who did not share these sentiments. Several who participated in the Vietnamese-language focus groups actually felt that government aid was outstanding and expressed gratitude for the funds that were disbursed.

Because San José had more aid available, some South County/Gilroy and North County/Mountain View participants tried to access resources there; however, transportation was an issue. Public transportation services were halted in the beginning of the pandemic, which prevented many from traveling outside of their neighborhoods to seek out assistance. When buses were running, they were operating at minimal capacity to prevent crowding, and people were sometimes forced to wait for hours to take the next available bus.

Mental Health Issues

> **"Everything changed, it was something new and something that made me feel really scared, depressed. I was always in a state of alertness."**
>
> - Female, Spanish, Individual Interview

Mental health issues were also highly prevalent. Roughly three quarters of focus groups discussed mental health challenges such as stress, anxiety, depression, and other extreme emotional responses caused by isolation. Mental health was cited as one of the most challenging things about the pandemic in about half of all interviews, and a significant portion of participants also shared that mental health issues were something that they continue to face. These challenges were consistently experienced across all focus group types. Surprisingly, survey responses did not align with what was said in focus groups. Mental health issues were the most cited challenge in focus groups, with many describing very severe issues. However, when responding to the survey question that asked how their mental health had changed since the pandemic, the majority of respondents indicated there was no change or even improvement. In fact, 6.9% responded they experienced major improvement of mental health while only 4.1% responded they experienced major worsening of mental health.

About a quarter of focus groups mentioned mental health issues in children specifically as one of the most difficult challenges they dealt with during the pandemic, and there were many distraught parents who **felt frustrated not knowing how to help their children who were struggling with their mental health.** Many children's grades and educational experience suffered from the various symptoms of mental distress that they were experiencing. Parents noticed changes in their children such as greater anxiety, depression, overeating and weight gain due to stress, misbehavior, aggression and anger, suicidal ideation, and much more. Many youth expressed extreme fear of their parents dying from COVID-19, with some not wanting to go to school in fear of acquiring and spreading the virus to their

parents. One mom in a Gilroy focus group shared a story about her child's extreme anxiety when he saw his mom leave their home to do laundry, as he was afraid she would get COVID-19 and possibly die. Another parent in Gilroy shared, **"[My son] would always, as soon as he touched something, go wash his hands right away. He even hurt his skin from washing his hands so much" (Female, Spanish, South County/Gilroy focus group).**

While some barriers to accessing mental health services may have decreased because of the pandemic, others have increased. Mental health issues were highly prevalent during the pandemic, leading to better recognition and awareness. Because of this, certain barriers related to perceptions about mental health issues or services (e.g., difficulty identifying a child's need for mental health services, believing a mental health issue is not severe enough to warrant medical attention, stigma related to needing help) may have decreased. For example, a first generation Filipino student shared during her interview that when she began to see a therapist during COVID, her mother, who previously felt she did not need a therapist, became more open to the idea of therapy and even sought out therapy for herself. In another interview, a professor noticed that her students were talking about mental health much more than they had been pre-pandemic, which also led to a reduction in stigma among their parents, although the need to increase access to services still remained:

"The kind of openness that students… have now about their mental health needs. Or even them just trying to name that they have… mental health conditions or curiosities is much more pronounced… our campus is trying to pump in money to support this, but it's still at a snail's pace compared to the needs of our students."

- Female, English, Individual Interview

Structural barriers that already existed prior to the pandemic (e.g., provider shortages, long wait times, inability to pay for services, etc.) were exacerbated by the increased demand for services and disruptions to health care delivery caused by COVID-19. These issues were commonly experienced by focus group participants and interviewees, sometimes even leading to untimely deaths. Several parents talked about the difficulty they had in getting help for their children who were suffering from depression and anxiety. One mother said she was able to get help for her middle school age child but not for her high school age child. Some participants shared stories of youth who had died by suicide after being unable to access the care they needed, such as a student from East San José who talked about her sister's death:

"My mom reached out to the school and the district to help [my sister]. She felt unheard, and there weren't any resources... We didn't think that she would take her own life, so when that happened we were really shocked. We knew she struggled with her mental health, but there was only so much we could do. We were very devastated."

- Female, English, Individual Interview

Access to Care

Access to health care was a challenge for various reasons. Issues that existed prior to the pandemic like long wait times, lack of knowledge of where to access primary care, high cost, and lack of insurance were aggravated after COVID-19, and a new fear of contracting COVID-19 prevented many from accessing timely and necessary health care. Numerous participants stated that they avoided care because they were afraid they would be admitted to the hospital and possibly become more ill or die without being able to have visitors. Some also reported paying for personal protective equipment and COVID-19 tests because they were unaware they could obtain them for free, and uninsured folks especially were more likely to avoid seeking COVID treatment because they did not think they would be able to afford it. In August of 2020, the Department of Health Care Services implemented the COVID-19 Uninsured Group Program to provide free COVID-19 testing and treatment services (including vaccines, hospitalization, and all medically necessary care) to all uninsured persons, but many were unaware of the program and did not take advantage of these available services.[20] Furthermore, a good deal of people suffered from pre-existing chronic conditions that were aggravated due to the stress of the pandemic, and it became more difficult than ever to schedule timely appointments for other health issues because the system was overwhelmed by the COVID-19 response.

"And one change that I would like to see would be more staff like doctors and nurses in hospitals so that they are prepared in case of another pandemic. I think there were not enough doctors during the pandemic. The only bad experience I had was not being able to schedule appointments because of my diabetes."

- Male, Spanish, Individual Interview

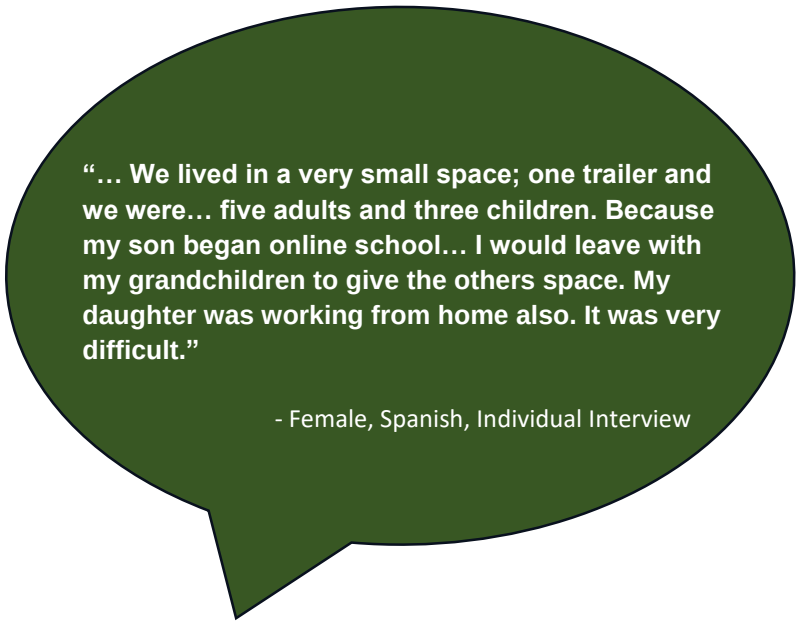
Although telemedicine proved to be a convenient and safe method for maintaining access to health care for many people during the pandemic, studies have shown that the uptake of telemedicine has not been consistent across different groups. Virtual visit rates have been lower among older people, high poverty communities, and Medicare or Medicaid populations.[21] This is consistent with findings from the focus groups, as a significant number participants had an aversion to telemedicine and experienced challenges with virtual and phone appointments. Older adults were especially frustrated with telehealth visits, as they felt they could not communicate as easily with their doctors over phone or video and would prefer that medical exams be completed in person. Some participants stated that they had more trouble hearing and understanding when appointments were not in person, and it was mentioned during a Vietnamese-language focus group that translation services were very inadequate for virtual appointments. Participants also commented about the need to connect to unfamiliar virtual platforms and operate digital devices that they normally did not use. Some were able to receive technology assistance from their children, but others continue to struggle and avoid telehealth visits.

[20] DHCS, COVID-19 Uninsured Group Program (2023). Retrieved June 8, 2023, from https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/COVID-19-Presumptive-Eligibility-Program.aspx

[21] Choi, Namkee G. et al. Telehealth Use Among Older Adults During COVID-19: Associations With Sociodemographic and Health Characteristics, Technology Device Ownership, and Technology Learning (2022). Retrieved June 8, 2023, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8847316/

Children's Education & Online Learning

Another commonly cited challenge was difficulties with **online learning and concerns about children's education.** Families who previously did not have computers, smartphones, or internet access were at a major disadvantage. To help address the digital divide, many low-income students received laptops from school and free home internet. However, these students continued to experience barriers, as many struggled to navigate unfamiliar online learning environments and were unable to receive help from frustrated parents who had low computer literacy. Internet connectivity was also unreliable for many families, and more than eight in ten children in the state who do not have high-speed internet at home are racial/ethnic minorities.[22] Unreliable wifi for teachers was also an issue, and classes were sometimes canceled. Children often became disengaged and fell behind, and many parents stated that their grades suffered drastically. Among Spanish-language focus groups, a common challenge was lack of an adequate work or study space, as many families live in small spaces with multiple children. Kids were sometimes embarrassed of their home environment and would turn off their cameras while they were in class, which got them in trouble with their teachers. Among Vietnamese-language focus groups, parents expressed more concern about how the online school experience was affecting their children's social skills and healthy development.



The learning disruptions from the pandemic resulted in historic declines in student learning and academic achievement across the nation, and the state of California was no exception. Test scores released by the California Department of Education at the end of 2022 revealed significant declines in math and English language arts/literacy scores. While all grade levels and students showed decline from pre-pandemic times, the effects on low-income students, English learners, and Black students and other students of color are the most concerning. These students already had lower test scores than other groups before the pandemic due to existing structural inequities, and they were also more likely to experience economic hardship during the pandemic, COVID illness and death in the family, inadequate access to technology, and parents who could not offer as much assistance with school because of low

[22] The Children's Partnership, Digital Equity: A Key to Children's Health & Racial Justice: A Call to Action & Policy Agenda 2023-2024 (2023). Retrieved June 12, 2023, from https://childrenspartnership.org/wp-content/uploads/2023/05/TCP-Digital-Equity-Brief_FINAL.pdf

English proficiency and low levels of formal education.[23] In addition to the learning disruptions caused by school closures and the very quick, tumultuous transition to remote learning, focus group participants talked about children's mental health challenges, high disengagement and absenteeism, and increases in bullying that also contributed to learning challenges.

In the case of one parent in an English-speaking focus group, her son's learning challenges led to very serious mental health issues. She stated, **"My son when he went back he was stressing out and the teacher said she found out he had suicidal thoughts and I didn't know. He thought he was dumb and he was feeling bad. He was very emotional and sad he didn't do good. He knows he was behind" (Female, English, East San José Focus Group).**

Technology Challenges

Technology was a pain point that was cited for different reasons, including telemedicine challenges and inexperience with digital devices that made online applications and remote learning difficult. New technology requires time to learn and is often intimidating, and many were left behind with the very rapid adoption of technologies in various areas. Expectations from health care, educational, and aid-offering institutions around use of computers and other digital devices changed quickly, but they did not align with the community's norms. There was very little time to adjust to the changes, and many focus group participants expressed a desire for additional technological support when interacting with various systems. While the use of technology became easier for most people as time went on, some participants did express that it never became easier even when more and more things needed to be completed online.

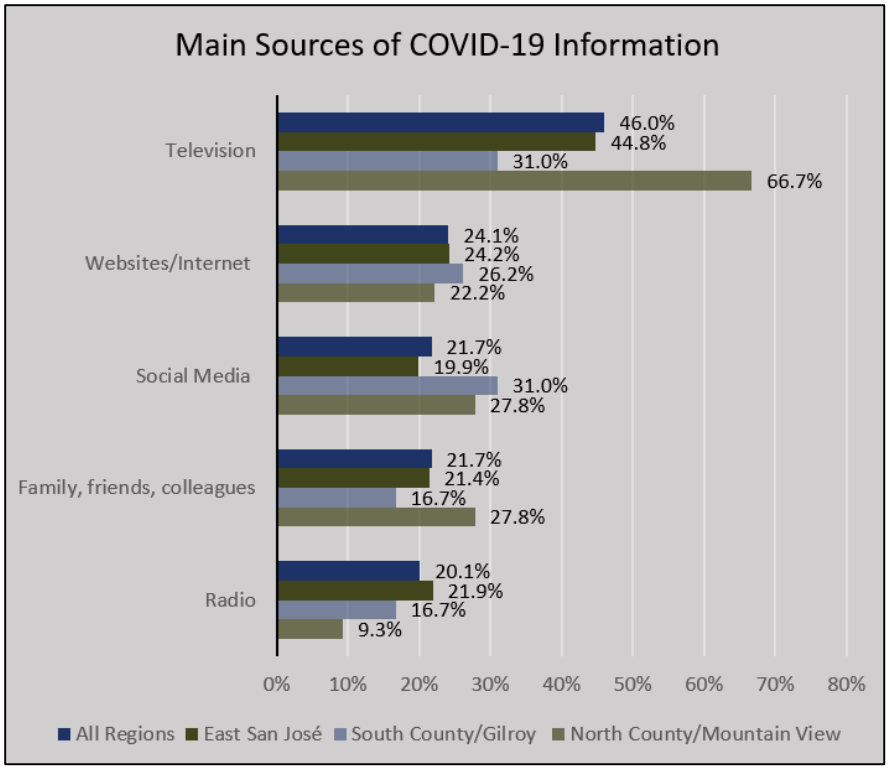
> **"It was difficult to find assistance; we didn't know how to connect to Zoom, and everything turned digital. The ones who were able to use the technology received the assistance first; the families with the greatest need were helped last. Technology was a challenge because it helped the ones who had access and knowledge but not the ones who didn't."**
>
> \- Female, Spanish, Mountain View Focus Group

[23] Hough, Heather J. & Chavez, Belen, California Test Scores Show the Devastating Impact of the Pandemic on Student Learning (2022). Retrieved June 8, 2023, from https://edpolicyinca.org/newsroom/california-test-scores-show-devastating-impact-pandemic-student-learning

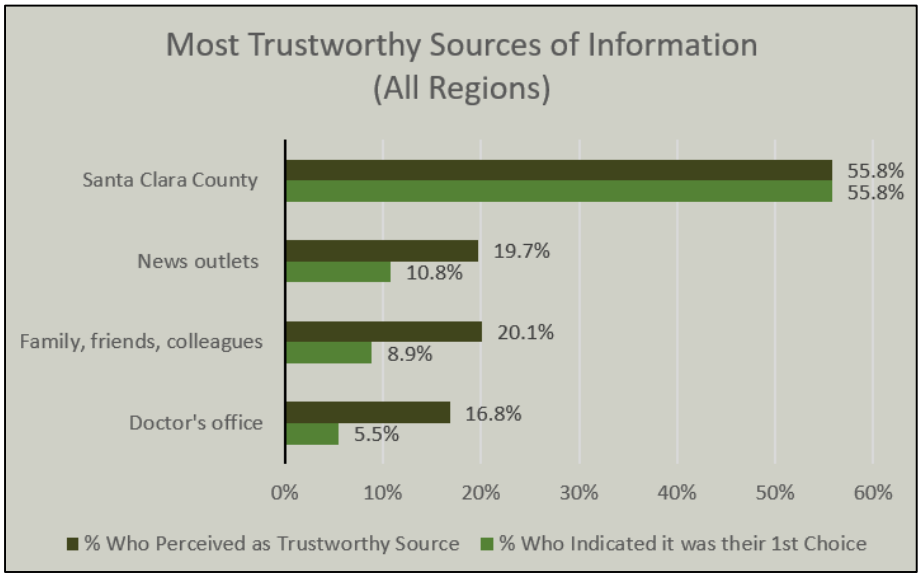
Misinformation

Another major challenge was the **misinformation and confusion surrounding the virus that was rampant during the earlier stages of the pandemic.** More than a quarter of focus groups indicated that this was one of the most difficult things about the pandemic. There was a lot of conflicting information, and people did not know where to turn to for accurate information. Furthermore, many felt that the government did not provide sufficient guidance or create an appropriate sense of urgency. This contributed to high rates of vaccine hesitancy and a lot of tension between those who were following recommendations and guidelines and those who were not. Across all focus groups, there was a mix of opinions regarding vaccines, and many people still felt uncertain about whether they had made the right choice by obtaining or refusing the vaccine. A range of symptoms and side effects were reported that people believed were due to the vaccine, such as cancer, weight gain, weight loss, chronic pain and aches, thyroid issues, forgetfulness, an inability to walk, and more. Numerous participants asked the focus group facilitators for advice on the matter and expressed confusion about the level of protection that vaccines or boosters offered. Some people even refused to participate in focus group discussions because of their high degree of COVID skepticism.

Survey responses revealed that community members were not always obtaining COVID-19 information from sources that they perceived to be the most trustworthy. Participants usually listed multiple sources when asked which outlets were their main sources of information, with the most commonly reported sources being television (46.0%), websites/internet (24.1%), social media (21.7%), family/ friends/ colleagues (21.7%), and radio (20.1%). This was true across all participants, although there were some variations between regions. Health professionals, employers, and community agencies, schools, or other organizations were also listed as main sources of information, although not as frequently. Only 12.2% of participants named health professionals, 7.1% of participants named employers, and 1.0% of participants named community agencies, schools, or other organizations as main sources of information.



These responses around the main sources of information provided insight into current practices, but a second survey question about the perceived trustworthiness of different sources revealed additional information about preferences. For example, television, websites, social media, and radio – which are all distribution channels for news media – represented most of the main sources of information. However, news outlets were perceived as trustworthy by only 19.7% of respondents, and only 10.8% of respondents indicated that news outlets were their number one top choice of trustworthy information. Approximately one in five (21.7%) respondents used family, friends, and colleagues as a main source of information, and about the same percentage (20.1%) perceived them to be trustworthy, but only 8.9% of people indicated this was their top choice for getting information. Doctor's offices were also perceived to be trustworthy sources of information by 16.8% of respondents, with 5.5% indicating that this was their first choice. The most trustworthy source of information was the County, as more than half (55.8%) of respondents said Santa Clara County information was one of their sources of trustworthy information, with all of them indicating that it was in fact their first choice for information. These responses seem to indicate that current information-seeking practices may not always reflect community members' preferences.



The most commonly accessed sources of information may not necessarily be the preferred methods, and many community members would likely prefer to obtain information via channels that they do not currently use as often.

Coping and Resiliency

A range of coping strategies, levels of optimism, and behavioral responses to COVID-19 were shared by focus group participants during the sessions around coping and resiliency. The most significant finding was that those who were part of a network or connected to a community group were overall better able to cope with the hardships of the pandemic. Within this session, focus group participants were also asked to name some things that got easier over time as well as things that became more challenging over time. The most common things that got easier over time were adhering to recommendations and guidelines (e.g., wearing masks, using hand sanitizer, social distancing), online learning, and using new technology. While the use of technology was commonly cited as something that became easier as time went on, there still was a sizable portion of participants who indicated that it never became easier. Overall financial struggles or paying for goods that had become more expensive were most often cited as things that became more difficult with time. There were mixed feelings about isolation/quarantine and going out without fear of contracting COVID, as these two things were frequent responses to both questions.

Services

Focus group participants were asked to share information about the services they obtained during the pandemic to cope with the various challenges, and by far the most common service obtained was food assistance. This included food pick-up and drop-off services from food banks and other CBOs, churches, schools, and the county, as well as monetary assistance for food items such as pandemic EBT for parents of young children and CalFresh. In more than 80% of focus groups, at least one person described receiving food assistance, and often it was multiple people. Food assistance was also one of the easiest services to obtain. Many people shared positive experiences with the process, as organizations typically did not ask for too much information to grant food assistance. A few people commented that some of the food was expired or that it was not culturally relevant for them, but in general people expressed satisfaction with the food assistance they received.

Stimulus checks and rental assistance were also common services that people obtained. At least one person mentioned receiving these in about half of all focus groups. If people did not receive a stimulus check it was typically because they did not file taxes or had not been California residents in the previous year. Some also mentioned receiving the Golden State stimulus check for undocumented persons. Although a significant portion of participants received some type of rental aid, these applications were a major pain point. Uncooperative landlords, complicated applications, long processing times, and technology issues that made it difficult to access online applications were some of the many stated challenges. Moreover, people were not usually granted all the aid they requested. Some were only offered one month's worth of rent when they had applied for more, even after applying multiple times.

Additional services and resources that participants received included free COVID tests, boxes of PPE and other essentials (e.g., hand sanitizer, cleaning products, diapers, etc.), gas cards, EBT, free or discounted utilities, and cash aid. In the Vietnamese-language focus groups, a few people also mentioned receiving aid for their small businesses. Unfortunately, many also reported receiving no aid, either because they were unaware or misinformed of the aid that was available, ineligible, or otherwise denied assistance. People learned about these services through various means, including from a community health worker/promotora, a clinic or hospital, their child's school, the county, the media (e.g., TV, news, radio, social media), a CBO, and word of mouth.

Coping within Families

Examples of coping strategies shared by participants included maintaining a routine in spite of the major changes happening in the world (e.g., getting dressed and ready for school or work even though people were not leaving their homes), offering assistance to others (e.g., cooking meals for neighbors, assisting with child care), leaning on loved ones for support, turning to religion/faith, and trying new activities or hobbies at home. One mother shared that she would go to the dollar store every week to pick up various snacks in order to set up an at-home "store" for her daughters. Other participants said that their families were making a more conscious effort to do things as a family, such as eating meals together. During interviews, the ability to access nature through hiking or parks was also mentioned as a way families coped.

Fostering Community

The COVID-19 pandemic was at the same time an isolating and unifying experience. Lockdown measures separated friends and family and removed people from their typical social support systems. However, all populations and communities felt at least some impact in almost all aspects of their lives, and this universal experience brought people together in many ways. Those who actively sought out connections with the community were better equipped to handle the pandemic's many challenges. First, being a part of a community network allowed individuals to learn about and obtain information and resources more quickly. Second, by building closer connections to people within their same population or community, individuals were able to overcome the language and culture barriers that were typically present.

When one promotora was asked why she decided to get involved in this type of work, she said **"because I like to help, because by helping others I am helping myself, because I also needed that help at one point, that helping hand" (Female, Spanish, Individual Interview).** Other community members who were not promotores stated that they would widely share information about resources whenever they learned that an organization was providing aid because they wanted everyone who qualified for assistance to receive it.

It is important to note that there was also a group of people on the other side of the spectrum who felt the pandemic made people fearful and distrustful of each other. They felt that communities were weakened and that the pandemic had not made them stronger but rather more vulnerable.

Recovery

During the session on recovery, focus groups were asked to share their ideas for what should be prioritized in future emergencies and what could be done to help ensure their communities were better prepared.

Trusted, Accessible, and Accurate Information

When asked what should be prioritized in the event of another emergency, focus groups participants emphasized the importance of having equal access to accurate and timely information. People were overwhelmed with the conflicting information they saw from various sources and had **difficulty knowing who to trust.** This resulted in increased fear and vaccine hesitancy, as well as misinformation about the requirements to access available resources. For some people, the greater issue was that **information was not visible enough**, resulting in a lack of knowledge altogether of those services, or not accessible, such as when applications for services needed to be completed online but one did not have access to the internet or the ability to read and write.

The discussions revealed various ideas to make information more reliable and accessible to better prepare the community for future emergencies**. Participants voiced a desire for trusted local authorities to provide information more swiftly and frequently, and for information to be made available in various languages. Although survey responses did not reflect this, many participants shared during focus group discussions that they had learned about resources via community health workers/promotoras and CBOs. Outreach techniques such as flyering, tabling, and door-knocking were well received by community members, as they appreciated the peer-to-peer approach and personal, in-person assistance. Participants felt these activities should be expanded to make information highly visible in various settings (e.g., clinics and hospitals, service centers, schools, libraries, and more), as they were perceived to be more trustworthy than other common sources of information. Many focus group participants also suggested communicating this information via multiple media channels (i.e., print, broadcasting, digital) to expand reach. However, given that community members do not commonly perceive news outlets to be the most trustworthy sources (as revealed by survey responses), the more community-based, grassroots approaches should be emphasized to reach socially disadvantaged populations.**

> **"There's a lot of social services that the community didn't know about. I would like more representation for more Vietnamese services that people can rely on. There's an educational gap and people aren't aware of what resources are out there in the community. They can get help they just don't know how."**
>
> - Male, Vietnamese, Individual Interview

Community-Building

Community-building, knowledge sharing, and mutual support were seen as important activities for helping individuals and communities to become stronger and become better prepared for future emergencies. **Focus group participants spoke highly of the neighborhood groups and community groups they were a part of and encouraged each other to get to know these groups in their neighborhoods to keep themselves informed.** By being part of these groups, community members could learn from other people with aligned interests and offer support to one another. Community health workers and promotoras were the biggest advocates of community-building, as they already belonged to a community group that they found to be highly valuable. These individuals had also witnessed first-hand the effectiveness of their outreach work in bringing resources and services to the people who needed it most. One promotora said, **"They connect with us because we are from the community in which we are working, we are people from the community. And they come and they trust us and they ask us for help" (Female, Spanish, Individual Interview).** A couple promotoras shared in their interviews that prior to the pandemic they were volunteers who served their communities without pay. They believed so strongly in the work that they obtained jobs to continue this work on the front lines during COVID, despite the risk and fear it brought them.

Community-based educational workshops and trainings on emergency preparedness and response for a variety of disasters were also highly desired and broadly discussed across all focus group types. Several focus group participants even offered feedback on the day's event, as CHP staff had offered all focus group participants information and materials about preparing for emergencies. Folks appreciated the

"… it brought us closer to the community… I began to raise awareness and help to be a volunteer from the beginning, even with fears, not knowing the expectations of how big this situation was going to be, huh? But the beautiful thing was that we were united, that there were families united and the community became more united."

- Female, Spanish, Individual Interview

information they had received and stated a need for additional opportunities for communities to receive education and resources, including handouts and emergency kits.

Support for Community-Based Frontline Workers

Many community health workers and promotoras participated in focus groups and interviews, and a need for additional support for individuals doing this work was revealed from the stories of challenges they shared. Although community health workers and promotoras valued their work and felt proud of the aid they provided to the community, they often faced fear, stress, and trauma on the job. By going door to door during the height of the pandemic, they faced threats to their own health and safety as well as indirectly to that of their families. Some community health workers/promotoras also revealed that they experienced feelings of anxiety and depression from being on the frontlines and knowing that many people were suffering and dying, as well as knowing that many people were not taking mandates and regulations seriously in spite of the severity of the situation.

Moreover, many received negative responses from the community members they were trying to help. One promotora had the following to say about her experience conducting outreach work in Gilroy:

"I would put on my uniform with gloves, masks, and knock on doors to deliver information. Ease their fears a little. We would go from house to house. I received all the training possible. We had to be empathetic to convince people. I received aggression from the community, they ran me out of their houses, they released their dogs on me, one person spit on me. It made me want to quit."

- Female, Spanish, Individual Interview

Community-based frontline workers need to maintain their own health in order to maintain the health of the populations they are serving. Community health workers and promotoras have deep knowledge of the target population's issues because oftentimes they themselves are directly impacted by those same challenges. Organizations that employ community health workers have a responsibility to implement practices that help support the wellbeing needs of these staff so that they may maintain the capacity to serve the community. Self-care training and mental health support that helps community health workers understand compassion fatigue and vicarious trauma can ensure they are able to manage work-related stress and prevent burnout. Another promotora working in Gilroy shared that there was a significant emotional toll placed on her and her colleagues during their outreach work. She stated, **"It was sad because we had to listen to a lot of stories from the community. They would tell us how they were feeling after losing a family member and sometimes we would cry with them. We had our own experiences and were listening to those of others. We had a lot of empathy" (Female, Spanish, Individual Interview).**

Safety-Net Resources

Access to essential safety-net resources like food, housing/shelter, and health care (including mental health services) were also priorities. **Food assistance and rental relief were some of the most common types of aid received, and while food assistance was relatively easy to obtain, people experienced extreme difficulty in receiving rental relief.** They wished for information about rental applications to be more visible, applications to not be so lengthy and confusing, and much quicker turnaround times. Long processing times of rental applications caused many challenges, as people became fearful of eviction when landlords continued to pressure for payment. In some cases, families were forced to obtain personal loans to pay for rent, but once the rent assistance programs saw that payments had been made, families would be disqualified for aid. Overall, there was great frustration among focus group participants who felt excluded from COVID-19 assistance that they felt they should have qualified for, and making application requirements less restrictive was a priority.

The strain on the health care system during the height of the pandemic was a major challenge, which is why so many people indicated that improved access to health care services should be a priority in case of future emergencies. Of the focus group participants who completed a survey, 35.7% indicated a worsening of their physical health since the pandemic, and 10.8% described their current mental health as bad or very bad. About half the focus groups stated that health care should be prioritized in the event of another emergency, and many also stated that access to such services would help the community to be better prepared. Participants also mentioned disparities in access to medical care, with some saying that race/ethnicity and insurance status affected whether people accessed care early when they needed it. Better access to mental health resources, especially for children, was also a priority.

Finally, a significant portion of focus groups believed additional programs and resources are needed to protect the most vulnerable groups, including undocumented folks, seniors, and unhoused individuals.

RECOMMENDATIONS

Solutions for COVID-19 Recovery Efforts and Preparing for Future Emergencies

1. ***Ensure equitable COVID-19 relief application processes by only enforcing requirements that guarantee a fair process and by removing application barriers.***

Although many focus group participants did receive some type of COVID relief or aid, it was generally not sufficient for the level of financial hardship they experienced. Continued financial struggles were common despite the aid that was received, with many people saying that they had lost all savings and/or were now in debt. It took a great deal of effort to obtain accurate information about the assistance that was available, and many people had to apply for assistance several times to multiple programs. There were many obstacles and restrictions that stood in the way of people receiving funds that they should have otherwise been eligible for. For example, a promotora in one of the Spanish-language focus groups commented that an email was required on rental assistance applications, and although people would indicate on the application that they wanted to be contacted by phone in case of follow-up, agencies would instead contact applicants by email to request additional information. Older adults who struggle to use technology and those without broadband access would miss those emails, and by the time they received help from the promotora, they would realize that the deadline to complete the follow-up had passed and their application had been denied.

Such cases of denial are quite common. According to 2022 data from the California Department of Housing and Community Development (HCD), nearly one third of applicants who applied for the statewide Emergency Rental Assistance Program (ERAP) were denied aid. Almost all (93%) of the denied applications were within the income threshold to be eligible for the program. The vast majority (83%) of denials were issued because applicants failed to respond after HCD staff's outreach attempts and/or because the applicant provided "inconsistent or unverifiable" information. However, many applicants are unresponsive because they are missing emails due to access challenges as stated by the promotora, and others are unresponsive because they do not speak English and are unable to respond to HCD notices that are only sent in English. Also, denied applications receive no explanation as to what information is deemed "inconsistent" and no indication of whether the inconsistent information was submitted by tenants or landlords. After applicants are denied, they also are not offered an opportunity to see the information that was used to deny their application.[24]

Problematic requirements and denial processes such as these must be eliminated to ensure assistance programs are implemented equitably. To ensure relief funds are more available to the people who would benefit the most from them, application processes should be simplified as much as possible. Information about the availability of aid needs to be communicated widely and clearly. This information needs to be communicated in various languages, and the applications themselves should also be available in different languages. When applications are lengthy and confusing, only available in English, and only available online, those with more time and resources or who may be more technology savvy receive aid sooner. Greater efforts must be made to ensure that people with limited English proficiency or illiteracy, people with limited access to technology or low digital literacy, and people with disabilities receive accommodations and assistance as needed.

Aid agencies can avoid creating disproportionate challenges for marginalized and vulnerable groups in several ways. For example, given the widespread adoption of online applications and multiple institution-specific application portals, it is important to make sure those applications and online portals are as streamlined and easy to use as possible. Accessibility is not only about language and cultural considerations, but also about access to technology. Not all community members will be able to use technology in the same capacity or have consistently reliable broadband, so institutions should make efforts to bridge the divide between the community's current capabilities and changing norms. Aid agencies need to be flexible and teach digital literacy skills or offer additional support to high need populations. If in-person support is not feasible, on-demand support over the phone can help to ensure a more fair application process.

Conducting direct, targeted outreach to provide assistance to highly vulnerable populations can be immensely impactful and should be done as much as possible to advance equity. In an English-language East San José focus group, there was a pregnant, unhoused woman in her late twenties with a substance use disorder who had been unhoused since the age of 11. During the pandemic, an outreach worker who was targeting homeless encampments reached out to her and connected her to various services. The woman was provided with housing in a hotel, addiction treatment services, and employment

[24] Treuhaft, Sarah et al. State of Denial: Nearly a Third of Applicants to California's Emergency Rent Relief Program Have Been Denied Assistance (2022). Retrieved May 10, 2023, from https://nationalequityatlas.org/CARentalAssistance

assistance. She is now in recovery, living in an apartment with her son, and in a much better position than she was prior to the pandemic.

2. Ensure crisis communication is timely and targeted, and take steps to combat misinformation.

While many among the general population supported and complied with the mitigation behaviors that were recommended by health organizations (e.g., frequent hand-washing, social distancing, obtaining vaccines and boosters, etc.), a significant portion of the population did not. A large contributing factor to this was the fact that messaging was inconsistent and misinformation about the pandemic was pervasive, especially in the early stages of the pandemic. Varied guidelines and mandates from different governments caused confusion, as community members did not know what to think of the stark contrast between what was being enforced in the U.S. and what was being enforced abroad. Local mandates often differed even among neighboring counties in the state. Focus groups revealed frustration with the government's lack of urgency in the initial stages of the pandemic, with many calling out a need for stronger and more aligned messaging. Some focus group participants felt that the Trump administration undermined COVID response efforts, contributing to a decline in the public's trust in the government.

Trust requires transparency, and local government has a responsibility to communicate accurate, clear, and timely information to the community. Without visibility of sustained and coordinated efforts, many may fail to take expert advice seriously. Urgent information should not be concealed. It should be made known immediately to allow residents to take steps to protect themselves. Accurate information needs to be communicated regularly through various channels and in all the community's most prevalent languages, with an emphasis on community-based, on the ground communication and outreach. Nowadays, a lot of information is available in Spanish, but the whole community's language diversity needs to be reflected in messaging. Among Vietnamese-language focus groups, participants repeatedly emphasized the importance of having more information available in their language. Local government can also ensure crisis communication is more targeted by working early with the community-based, health centers, faith-based, and human services organizations that already have trusted relationships with hard-to-reach populations. These organizations can help ensure the local government's messaging is delivered to all intended audiences.

Misinformation and disinformation about the pandemic have caused panic and confusion that still remains today. Individuals with low digital literacy may have a harder time discerning and avoiding fake news. To combat this issue, local governments can work to promote professional journalism and point the community towards trusted sources of information. Local news organizations should call attention to disinformation and debunk common myths by clearly explaining why they are false and what the motivation behind them may be. Other organizations that are also delivering information such as educational institutions and CBOs can help people to increase their news literacy by teaching them to analyze their news sources and attention-grabbing headlines.

3. Improve access to health care by increasing health coverage enrollment assistance activities.

Difficulty in obtaining medical and mental health care services was a persistent challenge for focus group participants, and increased access to such services was a stated priority in the case of a future emergency. Also, very few focus group participants talked about obtaining health care or insurance services during the pandemic. At the beginning of the pandemic, federal relief legislation was enacted to

mitigate adverse impacts on health care access due to widespread loss of employment and income. The federal continuous coverage requirement postponed disenrollments from Medi-Cal during the public health emergency declaration. People could maintain their eligibility, get their Medi-Cal premiums waived due to financial hardship, and qualify for a program with better coverage. Also, many people who were uninsured prior to the pandemic became eligible for free health coverage through Medicaid or the exchange.[25] However, only a few focus group participants mentioned assistance like receiving aid with health coverage enrollment or becoming eligible for full Medi-Cal coverage when they previously only had emergency coverage.

Navigating the health care system can be difficult for even the most informed patients. Health insurance concepts and coverage options are not well understood by most, and there are many misconceptions around programs that can offer low-cost health coverage. Medicaid expansion helps people gain access to comprehensive primary care services, but it needs to be coupled with navigation and enrollment assistance to maximize the number of people who benefit from it. The Trump Administration had reduced funding for Affordable Care Act (ACA) outreach, marketing, and navigation assistance activities, and many who were newly eligible for health coverage remained uninsured because they did not know how to enroll. By contrast, after the Biden Administration re-invested in ACA marketplace outreach and enrollment assistance, navigators were able to help more uninsured people to gain coverage, particularly people of color and other populations who often experience barriers to marketplace enrollment.[26]

With the recent end to the federal COVID-19 emergency declaration and the expansion of full-scope Medi-Cal coverage for adults between the ages of 26- 49 without a satisfactory immigration status that will begin January 1, 2024, health coverage enrollment efforts and navigation assistance continue to be vital. These activities must be ramped up given the implications for coverage, costs, and access for vulnerable groups.

4. Increase community-based workshops and trainings to help improve residents' access to emergency planning and response information.

When responding to questions about recovery, many focus groups discussed actions that they should be taking themselves to be better prepared for future emergencies rather than framing suggestions as strategies for local government to strengthen the community. Participants said things such as "*we* need to stock up on food," "*we* need to save money," and "*we* need to educate *ourselves*." The community is aware that it is not only the local and federal government's responsibility to protect them in an emergency. Residents want to create a culture of preparedness and take steps to develop their own emergency plans. Expanding education and increasing the availability of information around emergency planning and response is a great way to help communities to help themselves. Community-based workshops and trainings that are appropriate for the community in regards to language, culture, and literacy levels can help to ensure that more individuals and families develop their own emergency plans, and immigrants understand their rights in the time of a disaster. These workshops and trainings should

[25] Lukens, Gideon et al. COVID Relief Provisions Stabilized Health Coverage, Improved Access and Affordability (2022). Retrieved May 10, 2023, from https://www.cbpp.org/research/health/covid-relief-provisions-stabilized-health-coverage-improved-access-and

[26] McDermott, Daniel et al. How Has the Pandemic Affected Health Coverage in the U.S.? (2020). Retrieved May 10, 2023, from https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/

be highly visible to the community, and they should be delivered through various modalities so as to meet the needs and preferences of different groups.

5. ***Prepare the community for future disasters through community-building activities.***

Many focus group participants emphasized the need to have a strong community network to relay information and resources effectively and to build close community or neighborhood level connections. Community-based outreach staff especially indicated that they felt very grateful to have each other, but they realized that not everyone in the community belonged to a group that could offer the same type of community and support. Furthermore, many participants emphasized the importance of getting to know their neighbors and having access to information and resources that met their language and cultural needs. Residents have a desire to connect with and receive information from individuals who are reflective of their communities in their experiences. Residents already have established relationships with their local CBOs, as they turn to them for a variety of health and social needs. They trust that the information and services they access from these organizations will be accurate and culturally and linguistically relevant. Therefore, the role of CBOs in this process should be to facilitate the creation of these community networks and groups.

During an emergency, many residents prefer to turn to CBOs for assistance rather than government programs. In some cases, it is because it is often much easier to apply for assistance from CBO programs, which have fewer requirements and restrictions. Many participants expressed gratitude towards the CBOs that advertised and offered aid widely but felt frustrated by government aid programs that made them feel like they had to jump through hoops to simply submit an application. Furthermore, residents trust their local CBOs and feel more comfortable requesting information from them. There was much focus group discussion around the need for assistance targeted towards undocumented individuals because of the confusion around what services undocumented folks and mixed status families could access. Many were afraid or ashamed to even request more information; however, folks who had already accessed services from the CBO felt more comfortable seeking information from them. CBOs can therefore offer emergency preparedness and response training that is more targeted towards the populations they serve. For example, CBOs who serve large immigrant populations should share information about the disaster rights of immigrants or partner with an organization who can provide relevant services and information. This can reduce barriers and relieve community members' apprehensions about seeking out resources.

6. ***Prioritize long-term recovery efforts and activities.***

During an emergency or disaster, the immediate response is focused on preventing the loss of lives and minimizing damage. Then, recovery efforts begin in an attempt to return to normalcy after the emergency or disaster. Short-term recovery ensures essential services are restored so that the community can operate at a minimum level at least, and long-term recovery restores the community to pre-disaster conditions while also taking steps to better protect the community from future emergencies. Long-term recovery efforts should not be neglected, even if they take years to complete.

The federal Public Health Emergency declaration for COVID-19 ended on May 11, 2023 while California and the County of Santa Clara ended their state and county level emergency declarations on February 28, 2023. Nevertheless, COVID-19 recovery efforts are continuing, although not at the same level. Enhancing access to safety net resources (e.g., health care, housing, food, etc.) should be prioritized

right now, as communities are not yet back to pre-pandemic conditions, and the end of the emergency declarations means that people may not be able to access COVID-19 resources as easily. It was clear from focus group discussions and interviews that the vast majority of community members have not yet fully recovered from the pandemic. Participants often stated that they continued to struggle financially. Many had lost savings that had taken them years to acquire. Safety net resources are part of long-term recovery, and they must be utilized to help community members transition out of the emergency declaration period. Providing safety net resources to vulnerable and marginalized populations now can also help ensure that those populations are better equipped to cope with future disasters.

Incorporating Community Representatives into Local Emergency Response Planning

Strive to use a whole community approach by building and maintaining partnerships with community leaders, leveraging the expertise of CBOs, and increasing visibility into emergency response planning activities and opportunities for community members to get involved.

Local government emergency management personnel can build trust with the community by soliciting meaningful participation from community leaders. Non-profit leaders, local council members, community organizers, volunteers, and other community leaders hold valuable expertise on the gaps that exist between needs and solutions related to emergency response efforts. As esteemed members of the community, they can also garner support from the public and unite residents to participate in local emergency management and personal preparedness activities. Santa Clara County emergency management staff would therefore benefit from increasing opportunities for participation in emergency preparedness and response activities for community leaders. This may look like regional planning commissions, coalitions, or other similar partnerships. Local government and its community leader partners should prioritize timely information-sharing with the public and be transparent about ongoing planning efforts. This can help to inspire trust between the community and local government, as residents already view community leaders as trustworthy sources of information.

CBOs are also highly knowledgeable about the issues facing the community and are trusted sources as well. Using a whole community approach involves leveraging and further supporting the existing institutions that act as effective community networks. CBOs are assets to the community, as they already have established approaches for community outreach and engagement that are proven to work. As previously discussed, partnerships with CBOs should be established so they may assist in delivering important emergency preparedness and response messaging. In fact, CBOs should be engaged by local government even before the community outreach phase to co-design the health communication content. Early and collaborative planning efforts to develop health communication materials can help maximize the effectiveness of those tools by ensuring they are culturally appropriate and meet the community's literacy level.

Finally, emergency response planning activities and opportunities for community members to get involved should be highly visible to empower local action by residents. Many community members want to get involved but simply do not know how. If information about volunteer opportunities is posted online, there should be clear information about steps community members can take to get involved and contact information should they have questions. Given that many community members do not have easy access to information that is posted online, local emergency response agencies should also form partnerships with CBOs to help publicize opportunities for involvement. Local government and CBOs can work together to host in-person and virtual informational sessions and community conversations to

outreach to folks who may want to become more involved in local emergency response planning activities. Participation in such events should also be made easy. Widespread communication about these events should be prioritized to ensure all stakeholders are notified about the opportunity to participate in the conversation. Various communication channels should be used, and advertisements should be translated into the various languages that are most commonly spoken in the community. The events themselves should also be accessible to all. Things to consider for in-person events include choosing a location that is near public transportation, hiring interpreters for the event, having childcare services available during the event, etc. Of course, focus groups, surveys, and similar information-gathering projects are also excellent ways to gain community input.

CONCLUSION

Engaging community members as partners in emergency planning is necessary to develop effective collective actions and goals, as these individuals are the most knowledgeable about their own community's needs and gaps. This COVID-19 Community Resiliency & Recovery Efforts Report used inputs from community member focus groups, surveys, and interviews to provide community-driven solutions for COVID-19 recovery efforts and preparing for future emergencies, as well as recommendations for how to incorporate the community's ideas and representatives into local emergency response planning. To ensure diverse input and properly elevate the voices of the whole community, CHP used a community-based approach when conducting information-gathering activities. To advance equity and social justice, CHP took care to gain the perspectives of groups that have been historically underrepresented and marginalized by leveraging partnerships with local CBOs that have trusted relationships with these populations. Different cultural groups were engaged in the project with cultural humility, and the project emphasized mutual learning. A peer-to-peer approach was used to gain the trust of participants and to learn from them without making assumptions about their barriers and challenges.

Thanks to these activities, this report proposes recommendations to ensure equitable COVID-19 relief application processes, ensure timely and targeted crisis communication is communicated, improve access to health care, increase community-based workshops and trainings to help improve residents' emergency planning and response, improve community-building activities, and prioritize long-term recovery efforts. Additionally, to incorporate community-centric ideas into local emergency response planning, it is critical to use a whole community approach. This can be done by building and maintaining partnerships with community leaders, leveraging the expertise of CBOs, and increasing visibility into emergency response planning activities and opportunities for community members to get involved while taking actions to minimize barriers to participation in such activities. This project allowed equal opportunity for community members to lead the identification of priorities and develop a community-owned plan for emergency recovery and response planning. Thus, this report should be used to improve current and future disaster recovery efforts as well as strengthen future collaboration with the community.