NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS'
ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN)
MEMBER ADVISORY COMMITTEE

THURSDAY, FEBRUARY 22, 2018
3:00 P.M.

CALOPTIMA
505 CITY PARKWAY WEST, SUITE 109-N
ORANGE, CALIFORNIA 92868

AGENDA

This agenda contains a brief, general description of each item to be considered. The Committee may take any action on all items listed. Except as otherwise provided by law, no action shall be taken on any item not appearing in the following agenda.

Information related to this agenda may be obtained by contacting the CalOptima Clerk of the Board at 714.246.8806 or by visiting our website at www.caloptima.org. In compliance with the Americans with Disabilities Act, those requiring special accommodations for this meeting should notify the Clerk of the Board's office at 714.246.8806. Notification at least 72 hours prior to the meeting will allow time to make reasonable arrangements for accessibility to this meeting.

I. CALL TO ORDER
Pledge of Allegiance

II. ESTABLISH QUORUM

III. APPROVE MINUTES
A. Approve Minutes of the December 14, 2017 Regular Meeting of the OneCare Connect Member Advisory Committee (OCC MAC)

IV. PUBLIC COMMENT
At this time, members of the public may address the Committee on general topics. Public Comment on posted item(s) will follow staff presentation of the item(s) to the Committee. If you wish to speak on an item contained in the agenda, please complete a Public Comment Request Form(s) identifying the item(s) and submit the form to the assistant to the OneCare Connect MAC. When addressing the Committee, it is requested that you state your name for the record. Please address the Committee as a whole through the Chair. Comments to individual Committee members or staff are not permitted. Speakers will be limited to three (3) minutes.

V. CEO AND MANAGEMENT REPORTS
A. Chief Executive Officer (CEO) Update
B. Chief Medical Officer Update

C. Federal and State Legislative Update

VI. INFORMATION ITEMS

A. OneCare Connect MAC Member Updates
B. OCC MAC Member Presentation on SeniorServ
C. OCC MAC Member Presentation on Ombudsman Update

VII. COMMITTEE MEMBER COMMENTS

VIII. ADJOURNMENT

MINUTES

REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' ONECARE CONNECT CALMEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE

December 14, 2017

A Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on December 14, 2017, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Vice Chair Patty Mouton called the meeting to order at 3:08 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Patty Mouton, Vice Chair; Ted Chigaros, Christine Chow, Josefina Diaz, Sandy Finestone, Richard Santana, Kristin Trom; Jyothi Atluri (non-voting)

Members Absent: Gio Corzo, Chair; John Dupies; Sara Lee; Adam Crits (non-voting); Amber Nowak (non-voting); Erin Ulibarri (non-voting)

Others Present: Ladan Khamseh, Chief Operating Officer; Dr. Richard Helmer, Chief Medical Officer; Dr. Richard Bock, Deputy Chief Medical Officer; Sesha Mudunuri, Executive Director, Operations; Phil Tsunoda, Executive Director, Public Affairs; Candice Gomez, Executive Director, Program Implementation; Tracy Hitzeman, Executive Director, Clinical Operations; Belinda Abeyta, Director, Customer Service; Albert Cardenas, Director, Customer Service; Becki Melli, Customer Service; Eva Garcia, Customer Service

MINUTES

Approve the Minutes of the November 16, 2017 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Member Sandy Finestone, seconded and carried, the OCC MAC approved the minutes as submitted.***

PUBLIC COMMENT

There were no requests for public comment.

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Medical Officer (CMO) Update

Dr. Bock, Deputy Chief Medical Officer, reported that CalOptima is waiting for final guidance from the state on Palliative Care, effective January 1, 2018. Dr. Bock also reported that CalOptima has implemented additional restrictions on the prescribing patterns of opioids, including limiting the quantity that dentists may prescribe, and limiting the strength and total morphine equivalent dosage that can be prescribed at a time. CalOptima continues to outreach to physicians and other prescribers regarding appropriate prescribing. In addition, CalOptima is coordinating with the Orange County Health Care Agency to ensure members have access to medication assisted treatment.

Federal and State Legislative and Budget Update

Phil Tsunoda, Executive Director, Public Affairs, reported that Congress passed a continuing resolution (CR) to fund the operations of the federal government through December 22, 2017, including the Medicaid and Medicare programs, avoiding a shutdown of the federal government. Any new CRs or more permanent federal spending bills will require a 60-vote majority in the Senate. Staff will keep the Committee informed of the progress.

INFORMATION ITEMS

OCC MAC Member Updates

Vice Chair Mouton announced that Alzheimer's Orange County and the Orange County Advanced Care Planning Partners debuted a new film called 'Extremis' on end of life care decisions. This documentary of life and death in the Intensive Care Unit (ICU) can be viewed on Netflix.

Member Ted Chigaros reported that several CalOptima staff members visited the Lakewood Skilled Nursing and Health Care facility (SNF), a locked facility for people with dual diagnosis, such as a mental health issue and another medical issue. There are currently 7-10 long-term CalOptima members in the facility. The facility has expressed interest in expanding their relationship with CalOptima.

Vice Chair Mouton reported that a joint meeting with the Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC) is proposed for March 8, 2018, and the invitation has been extended to OCC MAC. Upon agreement of OCC MAC members to participate in the joint meeting, the OCC MAC committee agreed to have OCC MAC Chair Gio Corzo and Vice Chair Mouton serve on an ad hoc subcommittee with MAC and PAC representatives to determine the agenda.

Vice Chair Mouton reported that OCC MAC's progress towards meeting its FY 2017-18 Goals and Objectives is on target, noting that OCC MAC has completed most of its goals. However,

Vice Chair Mouton reminded OCC MAC members about the importance of attending meetings because if the committee does not reach quorum, the meeting and any goals attained do not count. CalOptima staff encouraged OCC MAC members to attend Awareness & Education Seminars, CalOptima Informational Series workshops, and Community Alliance Forums to increase committee members' awareness of issues.

Palliative Care Overview

Tracy Hitzeman, Executive Director, Clinical Operations, presented an overview of palliative care. Senate Bill 1004 requires the Department of Health Care Services (DHCS) to establish standards and provide technical assistance to ensure delivery of palliative care services by Managed Care Plans. DHCS standards are specific to Medi-Cal and will be implemented no later than January 1, 2018. Ms. Hitzeman explained that palliative care is defined as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. In addition, palliative care addresses physical, intellectual, emotional, social and spiritual needs and facilitates patient autonomy, access to information and choice. Health networks will be responsible for all SB 1004 palliative care services for their assigned members. CalOptima has provided DHCS with draft reporting guidance and is awaiting approval on its plans.

OneCare Connect (OCC) Enrollment Process Overview

Maria Wahab, Manager, Member Outreach and Education, reported that OCC is regulated by DHCS and the Centers for Medicare & Medicaid Services (CMS). OCC services include comprehensive health, prescriptions, dental, care coordination, transportation, fitness and vision. OCC has an ongoing marketing and advertising campaign and includes print advertising, radio advertising, and monthly member direct mailers to dual eligible households. In addition, CalOptima's outreach campaign consists of partnerships with delegated OCC networks, Harbage Consulting, community events, provider outreach and education, as well as making outbound calls to prospective members. OCC enrollment methods include telephone enrollment or in-person enrollment at CalOptima, the member's home, senior center/residence or a shelter. Members may choose their doctor and health network, and may change their doctor and/or health network every month.

ADJOURNMENT

Patty Mouton announced that the next OCC MAC meeting is scheduled for Thursday, February 22, 2018.

Hearing no further business, the meeting adjourned at 4:08 p.m.

/s/ Eva Garcia
Eva Garcia
Program Assistant

Approved: February 22, 2018

MEMORANDUM

DATE:	February 1, 2018
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee

Behavioral Health Transition
Effective January 1, CalOptima assumed responsibility for administering Medi-Cal behavioral health benefits for members. CalOptima's successful efforts to contract with hundreds of providers offering mental health and Applied Behavior Analysis services ensured that the vast majority of members were able to continue seeing their existing providers. Fewer than 300 members requested continuity of care arrangements. Under a continuity of care arrangement, a member may continue to see the same provider for up to a year if the provider agrees to accept the standard rate through a member-specific Letter of Agreement. Further, CalOptima has hired nearly all the necessary clinical and customer service staff needed to administer the behavioral health benefits and looks forward to the opportunity to better coordinate physical and mental health, which can improve outcomes for members.

Children's Health Insurance Program (CHIP)
On January 22, Congress reauthorized six years of funding for CHIP. This is good news for approximately 112,000 of our Medi-Cal members who are eligible because of CHIP, which provides coverage for children age 0–19 whose parents earn up to 266 percent of the federal poverty level. Prior to this decision, as part of the Affordable Care Act (ACA), California was required to maintain CHIP eligibility levels and enrollment through 2019 in what's known as a maintenance of effort provision. Therefore, the lapse in federal funding would not have caused our members to lose eligibility, but it could have caused budget concerns at the state level.

Continuing Resolution (CR)
The important reauthorization of CHIP was part of a larger CR that funds the federal government through February 8. The CR specifies that, in the short term, funding for Medicare and CHIP will continue without disruption. Regarding Medicaid, states already have sufficient funding through the second quarter. In the event of another government shutdown, the U.S. Department of Health & Human Services has a contingency plan that covers all three public health programs.

State Budget Proposal
On January 10, Gov. Brown released his proposed FY 2018–19 state budget, which starts on July 1, 2018. Given California's positive fiscal outlook, the budget includes a $6.2 billion surplus that the governor plans to put into reserves. Spending for Medi-Cal in FY 2018–19 will be relatively stable, with a total budget of $101.5 billion, which correlates to a flat statewide enrollment

projection of 13.5 million beneficiaries. When releasing his budget proposal, Gov. Brown acknowledged that it does not account for the potential impact of federal actions on health care, such as the recent passage of the tax bill or future efforts affecting ACA. Hearings on the budget proposal will take place during the next few months, followed by the release of the May Revision, which will consider any federal changes to health care programs and an updated financial picture based on April tax returns and 2019 federal tax law.

Medi-Cal Rates

Alongside the state budgeting process, the Department of Health Care Services (DHCS) follows a routine rate-setting process for Medi-Cal. For FY 2018–19, we expect draft rates for both our Classic and Expansion populations by May. Historically, the state has been paying managed care plans more for Expansion members that gained coverage through the ACA even though their health needs and utilization of services are similar to the Classic population. More recently, the state has been gradually adjusting those rates downward, and CalOptima has been passing on the reduction to providers. We anticipate this will be the case for FY 2018–19, and we have been notifying health networks accordingly. Specific guidance is not yet available. However, Medi-Cal health plan financial leaders across the state expect the Expansion rate to be similar to the Classic rate for adult Temporary Assistance for Needy Families (TANF) members. To prepare for the next fiscal year, we have informed health networks that they may want to develop their budgets with this assumption in mind.

Proposition 56 Revenue

While a reduction to Expansion rates is expected for the upcoming fiscal year, Medi-Cal providers can anticipate retroactive supplemental payments for certain services rendered in this fiscal year. Due to the Proposition 56 tobacco tax approved by voters in 2016, California is collecting $2 more in taxes on each pack of cigarettes. Recently, DHCS provided CalOptima with an estimate of add-on capitation, which we will pay to providers based on specific procedure codes used by primary care physicians and psychiatrists. Tobacco tax dollars are also boosting benefits and reimbursement in Denti-Cal. Starting in 2018, the program restored services for adults that were previously eliminated and raised rates for dentists by 40 percent.

Medical Loss Ratio (MLR) Audit

In January, DHCS released final instructions and data templates for the MLR audit of Medi-Cal Expansion. Importantly, the regulator clarified that all capitation payments made by a contractor to delegated entities for Expansion members are attributable to services and considered allowed medical expenses. This is consistent with how CalOptima records medical expenses. The MLR corridor amounts were also announced: MLR less than 85 percent, contractor shall return the difference; MLR greater than 95 percent, DHCS shall make additional payments to the contractor; and MLR between 85 percent and 95 percent, no MLR adjustment will be made to/from the contractor. The data is to be reported for two periods: 18 months (January 1, 2014, through June 30, 2015) and 12 months (July 1, 2015, through June 30, 2016). Our response is due March 9. CalOptima has reserved an appropriate level in anticipation of potential recoupment from the state.

California Children's Services (CCS)/Whole-Child Model (WCM)
CalOptima has begun the yearlong process of transitioning the CCS program from a Medi-Cal carve-out administered by the Orange County Health Care Agency to the fully integrated WCM, overseen by CalOptima. This affects more than 13,000 Orange County children, all of whom have significant medical conditions. Transparency in this effort is a priority, and CalOptima has already held meetings with health network leaders and the general stakeholder community. In fact, our January meeting featuring Jacey Cooper, DHCS assistant deputy director, drew more than 100 attendees. Further, six family-focused forums are planned for this month to engage parents with children in the CCS program. In the spring, CalOptima staff will ask your Board to consider actions necessary to effectuate this change, including CalOptima's proposed approach of using our existing delivery system to provide CCS services. To guide our efforts, we are launching a WCM Family Advisory Committee, and individuals can apply until February 28 using the forms here. Overall, CalOptima is committed to a smooth transition that provides children with CCS conditions continued access to familiar providers essential to their care.

Health Homes Program
The Centers for Medicare & Medicaid Services recently approved California's proposal to create health homes to improve care for Medi-Cal beneficiaries with chronic health conditions. DHCS' Health Homes Program will begin the first phase of implementation in July 2018, and Orange County is expected to participate beginning January 1, 2019. The Orange County Health Care Agency is leading this effort, and CalOptima will be a participating entity.

EXECUTIVE SUMMARY
MEMBER HEALTH NEEDS ASSESSMENT

CalOptima
A Public Agency
Better. Together.

In summer and fall 2017, more than 6,000 CalOptima members, service providers and community representatives participated in one of the most extensive and inclusive member health needs assessments (MHNA) undertaken by CalOptima in its 20-plus year history. The MHNA provides data critical to ensuring that CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima participates in numerous efforts to assess the health of Orange County's residents and create community-driven plans for improving the health of the Medi-Cal population. Some examples are detailed below.

- The 2013 Orange County Health Profile, produced by the Orange County Health Care Agency, highlighted key health indicators as well as other social, economic and environmental indicators that impact health conditions in groups of people based on economics, race, ethnicity, gender, age and geography.
- The 2016 Orange County Community Indicators Report tracked and analyzed Orange County's health and prosperity on a myriad of issues.
- The 2017 Conditions of Children in Orange County Report offered a comprehensive and detailed summary of how children in Orange County fair in the areas of health, economic well-being, educational achievement, and safe homes and communities.
- CalOptima's Group Needs Assessment, conducted every five years with annual updates in between, identifies members' needs, available health education, cultural and linguistic programs, and gaps in services.

When combined, these assessments provide a broad picture of important health information in Orange County. However, they do not focus specifically on Medi-Cal beneficiaries or on ethnic and linguistic minorities within this population, whose health needs are at the core of CalOptima's mission. For this reason, CalOptima undertook this comprehensive MHNA, summarized on the following pages.

By the Numbers

5,815
Surveys

31
Focus Groups

24
Stakeholder Interviews

21
Provider Surveys

10
Languages

Birth–101
Years of Age

CalOptima's comprehensive MHNA is an innovative collaboration that builds upon existing data-gathering efforts and takes them a step further. The study was designed to be a more comprehensive assessment, using engaging methods that resulted in a much more personal experience for our members and the community. The MHNA captures the unique and specific needs of Medi-Cal beneficiaries from an array of perspectives, including providers, community leaders and, most importantly, the members themselves. As a result, this in-depth study offers actionable recommendations for consideration by the CalOptima Board of Directors and executive leadership.

The MHNA was designed to help CalOptima identify:

1. Unique needs and challenges of specific ethnic communities, including economic, social and environmental stressors, to improve health outcomes

2. Challenges to health care access and how to collaborate with community-based organizations and providers to address these barriers

3. Member awareness of CalOptima services and resources, and effective strategies to increase awareness as well as disseminate information within target populations

4. Ways to leverage outreach efforts by partnering with community-based organizations on strategic programs

Our Partners

To guide the direction of the study, CalOptima established an MHNA Advisory Committee made up of community-based representatives. The committee then engaged CalOptima staff and Harder+Company Community Research (Harder+Company), in partnership with the Social Science Research Center (SSRC) at California State University, Fullerton. A summary of their qualifications to participate in this extensive effort is below.

Harder+Company was founded in 1986 and works with philanthropic, nonprofit and public-sector clients nationwide to reveal new insights about the nature and impact of clients' work. Harder+Company has a deep commitment to lifting the voices of marginalized and underserved communities — and working across sectors to promote lasting change. In addition, Harder+Company offers extensive experience working with health organizations to plan, evaluate and improve services for vulnerable populations, along with deep experience assisting hospitals, health departments and other health agencies on a variety of efforts, including conducting needs assessments, engaging and gathering meaningful input from community members, and using data for program development and implementation.

SSRC was established in 1987 to provide research services to community organizations and research support to university faculty. The center's primary goal is to assist nonprofit and tax-supported agencies and organizations to answer research questions that will lead to improved service delivery and public policy. The SSRC conducts surveys, evaluation research and other applied research activities to meet its clients' information needs. The center conducts multilingual telephone surveys from its 24-station computer-assisted telephone interviewing lab, as well as web-based, mailed and face-to-face surveys. In the past 10 years, SSRC has successfully completed 200 telephone survey projects using a variety of sample designs in diverse areas of focus, such as health care, public safety, education, workforce development and pregnancy prevention.

harder + co | community research

CALIFORNIA STATE UNIVERSITY FULLERTON

Due to strong partnerships with the community, the 2017 MHNA engaged members who may be hard to reach. We are proud that our efforts included:

- Young adults on the autism spectrum
- People with disabilities
- Homeless families and children
- High school students
- Working parents
- New and expectant mothers
- LGBTQ teens
- Farsi-speaking members of faith-based groups
- PACE participants
- Chinese-speaking parents of children with disabilities

More Comprehensive

To represent CalOptima's nearly 800,000 members, an in-depth analysis was performed to uncover their unique needs and challenges. An oversampling was thoughtfully incorporated in the calculation of responses needed to achieve a true statistical representation of the Orange County Medi-Cal population. For the mailed survey, more than 42,000 members were selected within a specific sampling frame that included language, age range and region.

With the oversampling, the aim was to collect 4,000 responses with targets for each subgroup. The final data collection results were far beyond the goal in every subgroup. More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

The assessment gathered responses from all geographic areas of Orange County, across all age groups and 10 languages. Additionally, the assessment reached new groups of members whose voices have rarely been sought out or heard before, such as young adults with autism, people with disabilities and homeless families with children.

Ultimately, the assessment concentrated on the underlying social determinants of health that have been recognized as factors that impact the health of individuals. The MHNA probed a broader view of members' lives beyond immediate health care needs to explore issues related to:

- ☑ Hunger
- ☑ Child care
- ☑ Economic stress
- ☑ Housing status
- ☑ Employment status
- ☑ Physical activity
- ☑ Community engagement
- ☑ Family relationships
- ☑ Mental health
- ☑ Personal safety
- ☑ Domestic violence
- ☑ Alcohol and drug use

More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

More Engaging

The MHNA used a mixed-methods approach to engage members who generally have been underrepresented in previous assessments as well as community stakeholders who work directly with the Medi-Cal population. The data collection effort was extensive, incorporating both qualitative and quantitative methods and going beyond previous processes in Orange County. The mixed-methods approach consisted of the following:

Member Survey

5,815 members completed an in-depth 50-question survey that was available in each of CalOptima's seven threshold languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic. As described further below, three additional languages that are less common in Orange County were also incorporated to ensure the assessment was comprehensive. Most surveys were completed and returned via mail (86 percent), with 9 percent completed via telephone and 5 percent online. Telephone calls were made to reach members who were homeless or more transient and may not have a permanent address. An online survey was offered for members' convenience.

Provider Survey

An online survey of 20 questions was sent to a broad sample of providers in CalOptima's network to seek insight on the challenges that members face. Providers identified what they perceive as the top problems for Medi-Cal members as well as barriers for these members in accessing health care. There were 21 network or physician medical groups that completed the provider survey.

Focus Groups

31 focus groups were conducted with members in partnership with community-based organizations across Orange County. Focus groups allowed for face-to-face conversations with members in comfortable and familiar environments, which helped to foster organic, open-ended discussions where members felt safe to share their thoughts. The discussions were conducted in CalOptima's seven threshold languages, as well as Cambodian, Marshallese and American Sign Language. Focus group conversations covered numerous key topics, including quality of life, community assets, barriers to accessing care, violence, behavioral health, chronic disease, and health practices, such as healthy eating and active living.

Key Stakeholder Interviews

24 leaders from community-based organizations participated in the interviews. Those chosen for the study have direct interactions with Medi-Cal members or serve as advocates for Orange County's vulnerable population. Interviews focused on key health issues facing Medi-Cal members, the provision of culturally competent services, and the social determinants of health, such as economic and environmental factors.

In the spirit of collaboration, individuals and groups in the community came together in a remarkable way to demonstrate their dedication to CalOptima members. Countless hours were spent planning, engaging and meeting with members. For example, in addition to serving as stakeholder interviewees, many of CalOptima's community partners reached out to members to encourage them to respond to the surveys, and they also hosted and recruited members to focus group meetings. Community organizations were invaluable in helping members feel comfortable with the process and in providing another view into members' lives. The engagement of community partners and member advocates was instrumental in the success of the MHNA.

More Personal

The MHNA aimed to give CalOptima members a more personal experience by hosting focus group conversations in familiar locations at convenient times, often evenings and weekends. These settings were intentionally selected based on members' comfort levels. Focus groups were also held at specific times to ensure that members could have their voices heard without having to miss work, school or other obligations. Focus groups were conducted in 10 languages enabling members to respond in their preferred spoken language.

Focus groups were held at:

- Apartment complexes
- Churches
- Community centers
- Schools
- Homeless shelters
- Recuperative care facilities
- PACE center
- Community clinics
- Restaurant meeting rooms

Methods

With a strong focus on engaging a representative sample of CalOptima members, Harder+Company and SSRC developed the sample frame to capture a breadth of perspectives as well as focus on the specific needs of key populations. Although the purpose of the MHNA was to assess the needs of Medi-Cal members in Orange County overall, Harder+Company and SSRC sought to gain a better understanding of the needs of CalOptima's non-English speakers by purposefully oversampling all seven subgroups. The oversampling of members designated as speaking one of the seven threshold languages ensured that CalOptima and community stakeholders can be 95 percent confident that the true population parameters for any particular subgroup will fall between +/- 5 percent of the observed sample estimate.

At more than 5,800 members, the survey response far exceeded the target number of respondents in the sampling frame. The robust response was due to a comprehensive data collection plan that included communication with members and partners in advance of sending the survey, reminder phone calls and multilingual computer-assisted telephone interviewing for members preferring to respond by phone.

Survey data was entered, monitored and quality checked by SSRC before being exported for analysis by Harder+Company. All variables were screened to determine the amount of missing data, and basic frequencies were initially computed for each question by language, region and age. To adjust for the oversampling built into the sampling frame, comprehensive statistical analysis was then completed applying weights calculated by SSRC. Additional analysis included collapsing of questions, construction of scale scores and cross-tabulations.

Exhibit 1: Distribution of Completed Surveys and CalOptima Population by Language, Region and Age

Language	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
English	658	11.3%	55.5%
Spanish	715	12.3%	28.6%
Vietnamese	981	16.9%	10.3%
Korean	940	16.2%	1.4%
Farsi	743	12.8%	1.1%
Arabic	648	11.1%	0.6%
Chinese	731	12.6%	0.5%
Other	399	6.9%	2.0%

Region	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
Central	2,315	39.8%	51.5%
North	1,947	33.5%	32.4%
South	1,538	26.4%	15.1%
Out of County	15	0.3%	1.0%

Age	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
0–18 years old	1,665	28.6%	41.8%
19–64 years old	2,453	42.2%	47.2%
65 or older	1,697	29.2%	10.9%

KEY FINDINGS

Given the scope and depth of the study, the MHNA revealed many key findings, which will all be included in the final, comprehensive report. This Executive Summary shares five **key findings**, including related **bright spots** and **opportunities**. Bright spots are CalOptima and community-based resources that already serve to support health behaviors and outcomes. CalOptima can nurture, leverage and build upon these assets. **Opportunities** are areas that CalOptima and its partners can strengthen to positively impact the health and well-being of members.

KEY FINDING: SOCIAL DETERMINANTS OF HEATLH

Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

Given that Medi-Cal eligibility is income-based, it is not surprising that many CalOptima members struggle with economic insecurity. In fact, 55.7 percent of members receive some form of public benefits (Exhibit 2). Further, in the past six months, more than one-quarter of members indicated they needed help with food (32.4 percent), housing (24 percent), money to buy things they need (43.1 percent) and transportation (28.8 percent) (Exhibit 3). Economic stress and financial insecurity cause members and their families to make tradeoffs, such as living in more dense and overcrowded housing with limited space for play and exercise, buying cheaper but less healthy food, or not going to the doctor despite wanting to.

Exhibit 2: Percent of members who receive public benefits (n=5,117)

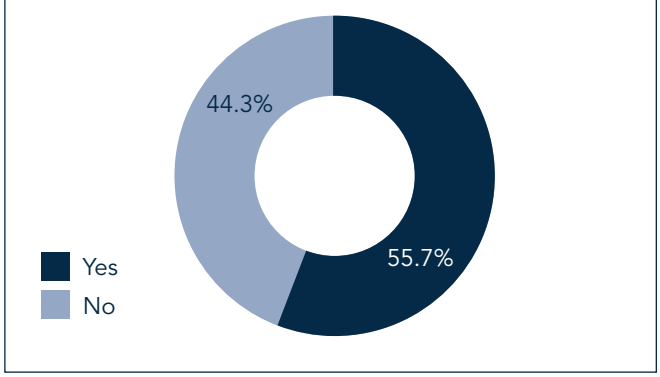
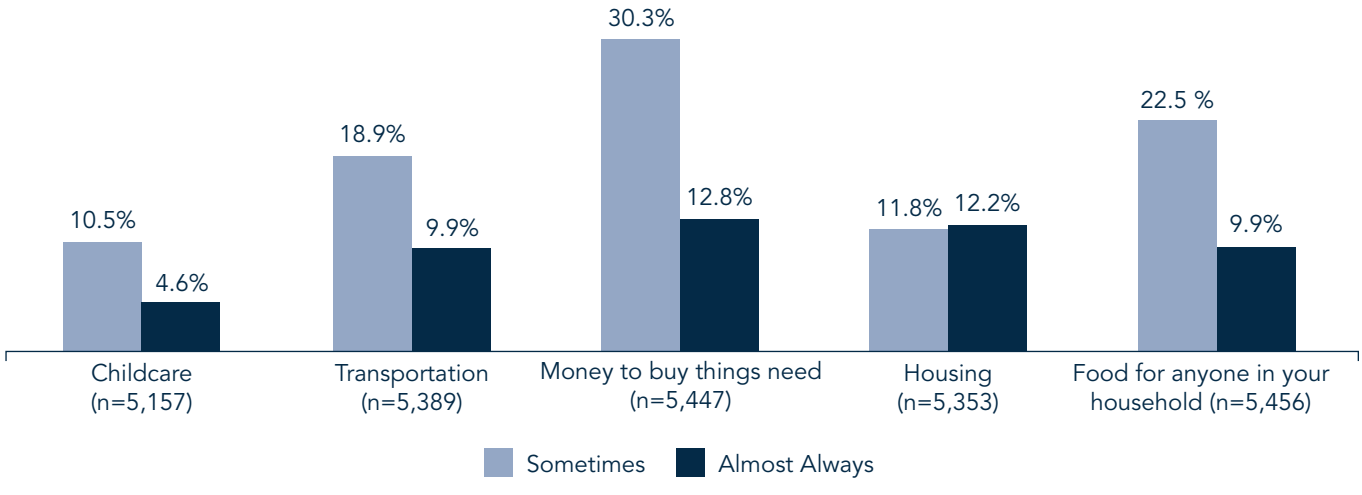
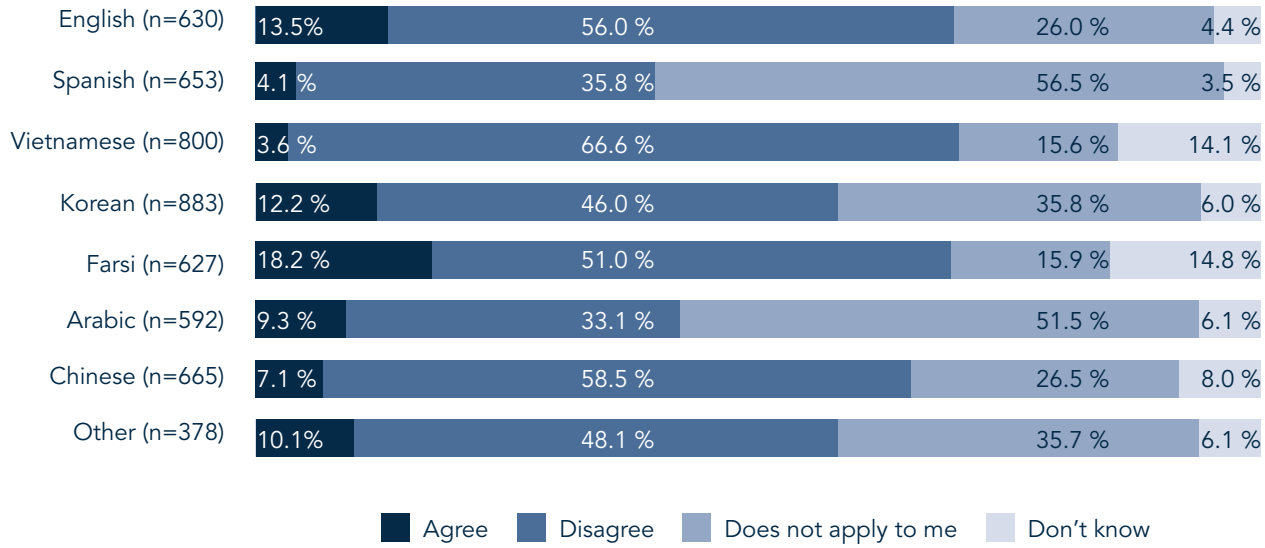


Exhibit 3: Percent of members who needed help with basic needs in the past six months



Social isolation negatively impacts the overall health and well-being of some CalOptima member populations. Social isolation is characterized by a lack of social supports and relationships. It occurs for many reasons, including language barriers, immigration status, age, ability and sexual orientation. In focus groups, members described how feelings of being disconnected from the community can lead to depression, lack of follow-up with health care or service providers, and negative health behaviors. In the survey, 10 percent of all respondents indicated that they felt lonely or isolated. Yet there were higher rates among certain populations, with loneliness and isolation affecting more speakers of English (13.5 percent), Korean (12.2 percent) and Farsi (18.2 percent) (Exhibit 4).

Exhibit 4: Percent of those who reported feeling lonely or isolated by language



Environmental factors also contribute to social isolation and other negative health behaviors, such as lack of physical activity. Focus group participants discussed feeling unsafe in their neighborhoods, which caused them to stay inside or to avoid nearby parks and/or other common spaces.

In addition, lack of affordable housing was a major concern to MHNA respondents, and it resulted in living in overcrowded households, neighborhoods with high crime rates, areas with poor indoor and outdoor air quality, and in the most extreme cases, homelessness.

Bright Spot: CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health a priority, not a lack of knowledge or concern.

Opportunity: CalOptima has already taken steps to strengthen the safety net for members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand this work would positively impact health outcomes in the long run. CalOptima can ensure that providers and community partners understand the social and economic issues that members face and how to adapt health care services accordingly.

KEY FINDING: MENTAL HEALTH

Lack of knowledge and fear of stigma are key barriers to using mental health services.

About 14 percent of members reported needing mental health services in the past year (Exhibit 5). However, local and national data suggest that the need for mental health services is likely underreported and underrecognized. Among those reporting a need, nearly 25 percent did not see a mental health specialist (Exhibit 6). Members did not seek mental health services for several reasons (Exhibit 7), including not knowing who to call or how to ask for help making an appointment (39.8 percent), not feeling comfortable talking about personal problems (37.5 percent) or concern that someone would find out they had a problem (26.1 percent). These factors, along with data gathered from key stakeholder interviews and focus groups, reflect a fear of stigma associated with seeking mental health services.

Exhibit 5: Percent of members who indicated they needed to see a mental health specialist (n=5,723)

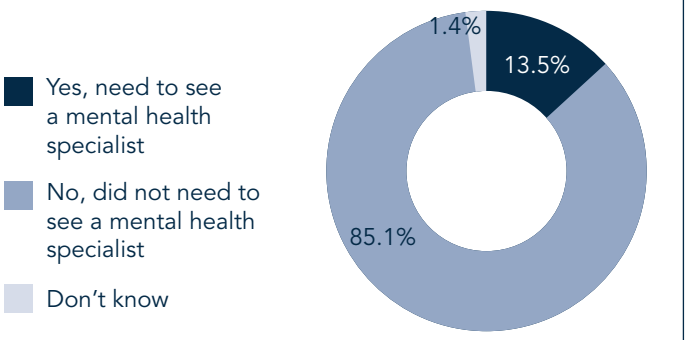
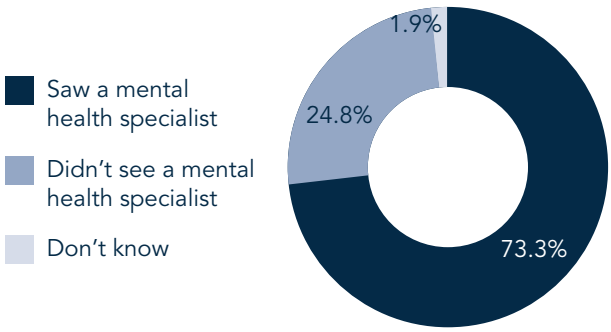
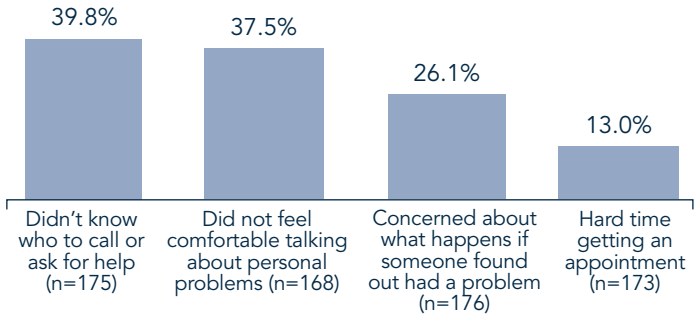


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



Fear of stigma is more prevalent among certain language groups. For example, Chinese-speaking members were more likely to indicate discomfort talking about personal problems and concern about what others might think if they found out about a mental illness than other language groups, followed by Korean-, Vietnamese- and English-speaking members. Conversations with community members and service providers offered cultural context for these findings as many stakeholders described prevalent feelings of shyness, avoidance and shame around discussing mental health issues, let alone seeking care.

Exhibit 7: Reasons why members (who needed to see a mental health specialist but) didn't get services



Bright Spot: CalOptima provides access to mental health services, which meets a clearly established need. Although members needing mental health services do not always connect with providers, many do not do so because of a lack of knowledge, an issue that can be addressed through strengthened connections with existing systems.

Opportunity: Although mental health services are covered by CalOptima, fear of stigma may prevent members from seeking services. This presents an opportunity for CalOptima to continue to provide culturally relevant education around mental health to improve understanding of available services and to address fear of stigma many people face. Community partners with deep knowledge of specific cultural communities are eager to offer support that would increase the use of mental health services.

KEY FINDING: PRIMARY CARE

Most members are connected to primary care, but barriers can make it challenging to receive timely care.

The majority of CalOptima members indicated that they are connected to at least one primary care doctor (82.6 percent), and most go to a doctor's office (69.2 percent) or clinic/health center (18.1 percent) when they need medical attention (Exhibits 8 and 9). However, navigating the health care system can be challenging, and significant barriers make it difficult for people to seek or follow through with care when needed.

Exhibit 8: Percent who report at least one person as their doctor (n=5,749)

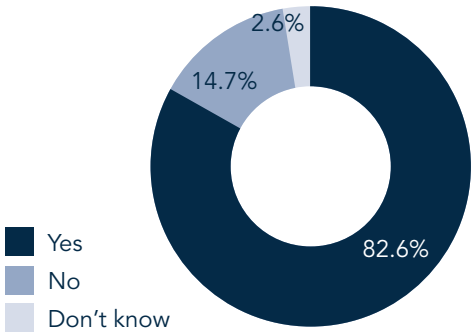
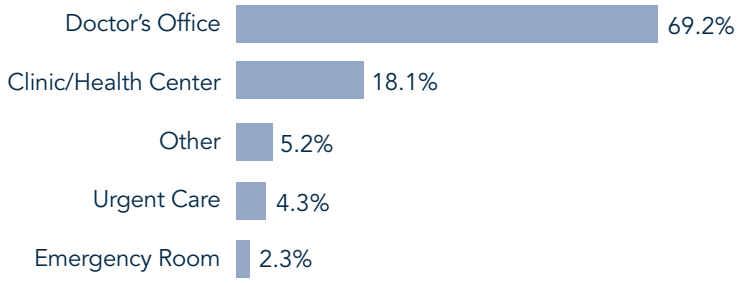


Exhibit 9: Where respondents go to see their doctor (n=5,743)

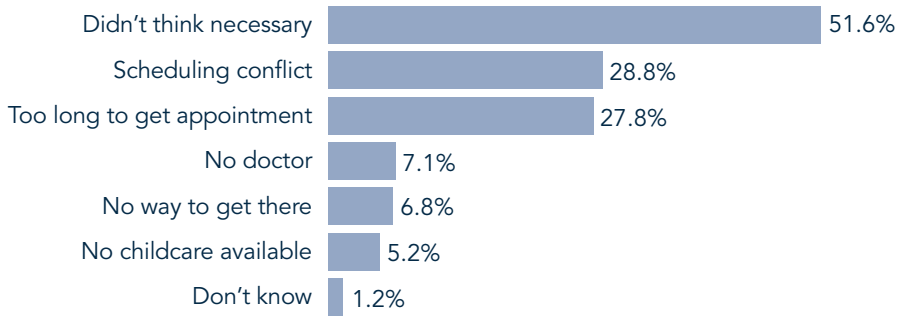


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited hours of operation and inefficiency of public transportation, can make it difficult for people to receive care when needed. When asked why they don't make an appointment to see a doctor, 27.8 percent of CalOptima members indicated that it takes too long to get an appointment while 51.6 percent of members did not think it was necessary to make an appointment (Exhibit 10).

Bright Spot: CalOptima members have access to more than 1,500 primary care providers and 6,200 specialists, as well as 14 different health networks. And staff members are dedicated to continually engaging and educating these providers and networks to ensure they are ready to deliver the care needed by members.

Opportunity: The challenge of maintaining a robust provider network never goes away, and CalOptima must carefully monitor members' access to care. The provider community may be ready to embrace innovations that enhance access, such as extended hours, weekend operations or telemedicine visits, to expand the options for members.

Exhibit 10: Reasons why members don't make an appointment to see doctor (n=4,598)[1]



KEY FINDING: PROVIDER ACCESS

Members are culturally diverse and want providers who both speak their language and understand their culture.

CalOptima members hail from around the globe, reflecting the rich diversity of Orange County's population. In total, 40.3 percent of respondents were born outside of the U.S. and 23.6 percent indicated that they don't speak English well (Exhibits 11 and 12). Among non-English speakers, more than 50 percent were born outside of the United States and many are still acculturating to life in the U.S. This presents challenges when finding a well-paying and fulfilling job, safe and affordable housing, and healthy and familiar food. It also affects the ways members interact with the health care system. In fact, those born outside of the U.S. were significantly less likely to have a doctor and more likely to report feeling lonely or isolated.

Exhibit 11: How well members speak English (n=5,549)

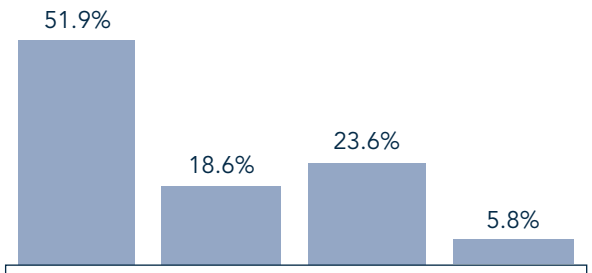
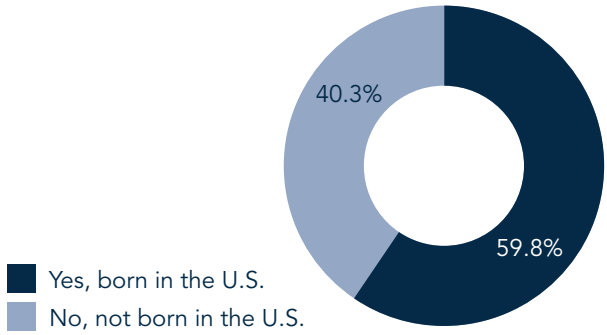


Exhibit 12: Percent of members who were born in the United States (n=5,599)



Further, they report having to adapt to new ways of receiving medical care. Some focus group participants shared that they did not understand why they must wait so long to see a doctor, as it is not this way in their country of origin. Others shared that cultural beliefs and practices made them uncomfortable and often unwilling to see a physician of the opposite gender. In addition, members and key stakeholders indicated that it can be challenging to seek medical care from providers who do not speak members' preferred language, which leads to issues with communication and comfort level. Although many stakeholders highlighted the availability of translation or interpretation services, such services do not always meet members' needs, especially when limited by short appointment times and when sharing sensitive information.

Bright Spot: CalOptima provides services and resources to members in seven languages[2] and can connect members to translation and interpretation services in any language when needed. Members appreciate that CalOptima recognizes the importance of providing care in familiar languages, and they also highly value providers who are sensitive to the cultural norms and practices of their homeland.

Opportunity: CalOptima has an opportunity to build its existing resources and deepen cultural competence of providers and services. CalOptima can engage partners in culturally focused community-based organizations to tailor and implement trainings for providers around specific populations. Trainings can build language and sensitivity skills and increase knowledge in areas such as ethnopharmacology (variations in medication responses in diverse ethnic populations). This can strengthen the workforce and improve member/provider interactions overall.

KEY FINDING: DENTAL CARE

Many members are not accessing dental care and are often unsure about what dental services are covered.

The gap in dental health care is striking and pronounced; 38.2 percent of members indicated they had not seen a dentist within the past 12 months (Exhibit 13). Among those individuals, 41 percent cited cost as the main reason they did not see a dentist (Exhibit 14). Members expressed confusion about dental care benefits available to them via Medi-Cal/Denti-Cal, and they said they would be more likely to seek out a dentist if they knew some of their visits were covered.

Bright Spot: Members in all CalOptima programs are eligible for routine dental care through Denti-Cal, and members in OneCare and OneCare Connect have access to supplemental dental care as well. Better yet, for 2018, California restored additional Denti-Cal benefits, expanding the covered services even further. The challenge is ensuring that members know about these benefits and then actually obtain the services.

Opportunity: To boost the number of members receiving dental care, CalOptima will have to first raise awareness about the availability of services and correct misperceptions that dental care comes at a cost. Further, to remove barriers to care and expand access, the community may embrace the use of alternative providers, such as mobile dental clinics, or the option of co-located dental and medical services.

Exhibit 13: When members last saw a dentist (n=5,685)

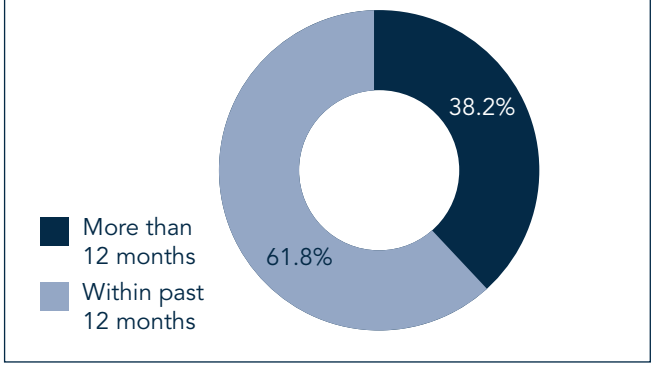
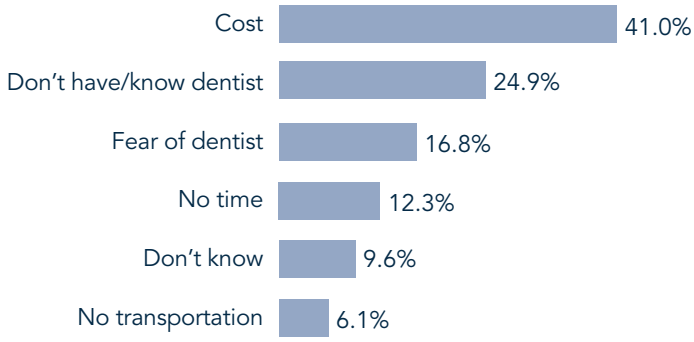


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3][4]



Endnotes

[1] Members could choose multiple answers; thus, the total does not equal 100 percent.

[2] CalOptima provides bilingual staff, interpreter services, health education and enrollment materials in seven languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.

[3] Members could choose multiple answers; thus, the total does not equal 100 percent.

[4] Only reported those who have not seen a dentist within the past 12 months.

Member Health Needs Assessment

OneCare Connect Member Advisory Committee
February 22, 2018

Claudia S. Hernandez
Manager, Strategic Development

Member Health Needs Assessment

A better study offering deeper insight, leading to a healthier future.

A Public Agency

CalOptima

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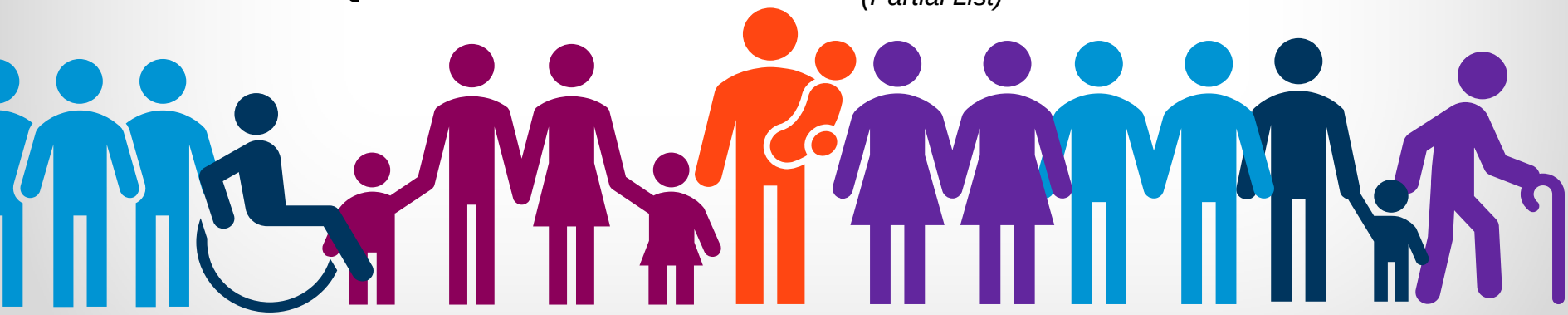
A Better Study

- ➔ More Comprehensive
- ➔ More Engaging
- ➔ More Personal

More Comprehensive

- Reached new groups of members whose voices have rarely been heard before
  - Young adults with autism
  - People with disabilities
  - Homeless families with children
  - High school students
  - Working parents
  - New and expectant mothers
  - LGBTQ teens
  - Homeless people in recuperative care
  - Farsi-speaking members of a faith-based group
  - PACE participants
  - Chinese-speaking parents of children with disabilities

(Partial List)



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More Comprehensive (Cont.)

- Gathered responses from all geographic areas of Orange County

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More Comprehensive (Cont.)

- Probed a broader view of members' lives beyond immediate health care needs
  - Hunger
  - Child care
  - Economic stress
  - Housing status
  - Employment status
  - Physical activity
  - Community engagement
  - Family relationships
  - Mental health
  - Personal safety
  - Domestic violence
  - Alcohol and drug consumption

(Partial List)

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More Comprehensive (Cont.)

- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In the past 12 months, did you have the need to see a mental health specialist?
  - How open are you with your doctor about your sexual orientation?
  - How sensitive are your health care providers in understanding your disability?

(Partial List)

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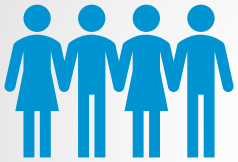
More Engaging: Members



Focus Groups

- 31 face-to-face meetings in the community
- 353 members

Telephone Conversations

- 534 live interviews in members' languages

Mailed Surveys

- Nearly 6,000 surveys returned

Electronic Responses

- More than 250 replied conveniently online

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More Engaging: Member Advocates

- Abrazar Inc.
- Access CA Services
- Alzheimer's OC
- Boys & Girls Club
- The Cambodian Family
- CHOC
- Dayle McIntosh
- La Habra Family Resource Center
- Latino Health Access
- Korean Community Services
- Mercy House
- MOMS Orange County
- OMID
- SeniorServ
- South County Outreach
- State Council on Developmental Disabilities
- Vietnamese Community of OC Inc.

(*Partial List)*

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More Personal

- Met in familiar, comfortable locations at convenient times for our members
  - Apartment complexes
  - Churches
  - Community centers
  - Schools
  - Homeless shelters
  - Recuperative care facilities
  - PACE center
  - Community clinics
  - Restaurant meeting rooms

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More Personal (Cont.)

- We spoke their language
  - English
  - Spanish
  - Vietnamese
  - Korean
  - Farsi
  - Chinese
  - Arabic
  - Cambodian
  - Marshallese
  - American Sign Language

The Voice of the Member

Offering Deeper Insight

- → Barriers to Care
- → Lack of Awareness About Benefits and Resources
- → Negative Social and Environmental Impacts

Notable Barriers to Care

- Study revealed that members encounter structural and personal barriers to care
  - Structural
    - It can be challenging to get an appointment to see a doctor
    - It takes too long to get an appointment
    - Doctors do not always speak members' languages
    - Interpreter services are not always readily available
    - Doctors lack understanding of members' cultures
  - Personal
    - Members don't think it is necessary to see the doctor
    - Members have personal beliefs that limit treatment
    - Members are concerned about their immigration status
    - Members are concerned someone would find out they sought mental health care

Barriers to Care (Cont.)

Examples

52%

Don’t think it is necessary to see the doctor for a checkup

28%

Takes too long to get an appointment

26%

Concerned someone would find out about mental health needs

41%

Didn’t think it is necessary to see a specialist, even when referred

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Notable Lack of Awareness

- Survey revealed a lack of understanding about available benefits and services
  - 25 percent of members who needed to see a mental health specialist did not pursue treatment
  - 38 percent of members had not seen a dentist in more than a year

- Focus group participants commented frequently about having difficulty regarding certain resources
  - Interpreter services
  - Social services needs
  - Transportation

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Lack of Awareness (Cont.)

Examples

40%

Didn’t know who to ask for help with mental health needs

41%

Didn’t see a dentist because of cost (i.e., didn’t know dental care was covered)

25%

Don’t have or know of a dentist

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Negative Social and Environmental Impacts

- Survey revealed significant social and environmental difficulties
  - Lack of well paying jobs and employment opportunities
  - Lack of affordable housing
  - Social isolation due to cultural differences, language barriers or fear of violence
  - Economic insecurity and financial stress
  - Lack of walkable neighborhoods and the high cost of gym programs

Negative Impacts (Cont.)

Examples

32%

Needed help getting food in the past six months

56%

Accessing other public assistance

43%

Needed help to buy basic necessities

29%

Needed help getting transportation

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Negative Impacts (Cont.)

Stakeholder Perspective

> There's a significant issue with improper nutrition. They may not have enough money or the ability to go to the grocery store to buy the right foods. They get what they can, and that's what they eat.
>
> *—Interviewee*

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Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

Funding

$14.4 Million

Total Available IGT 5 Funds

- **Member Health Needs Assessment results drive funding allocations**

- **Eight Requests for Proposal (RFPs) to expand access to mental health, dental and other care, and outreach/education services**

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Eight RFPs

Description	Funding Amount
Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	$5 million
Expand Mental Health and Socialization Services for Older Adults	$500,000
Expand Access to Mental Health/ Developmental Services for Children 0–5 Years	$1 million
Nutrition Education and Fitness Programs for Children and Their Families	$1 million
Medi-Cal Benefits Education and Outreach	$500,000
Expanded Access to Primary Care and Programs Addressing Social Determinants of Health	$4 million
Expand Adult Dental Services and Provide Outreach to Promote Awareness of Services	$1.4 million
Expand Access to Children's Dental Services and Provide Outreach to Promote Awareness of Services	$1 million
Total	**$14.4 million**

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Moving Forward

- Eight Grant Applications/RFPs
  - Expand access to mental health, dental and other care services
  - Expand access to childhood obesity services regarding nutrition and fitness
  - Support outreach and education regarding social services and covered benefits
- RFPs to be released in March 2018
- Recommended grantees to be presented at June Board meeting

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

SENIORSERV®

Nourishing Home, Health & Heart

Gio Corzo, VP Home & Care Services
SeniorServ
gcorzo@seniorserv
714-823-3285

SENIORSERV®

Nourishing Home, Health & Heart

- Our mission is to nourish the wellness, purpose, and dignity of seniors and their families in our community.
- 50th Anniversary
- $12+ million in revenue
- Multi-services
- 600+ volunteers

SENIORSERV®

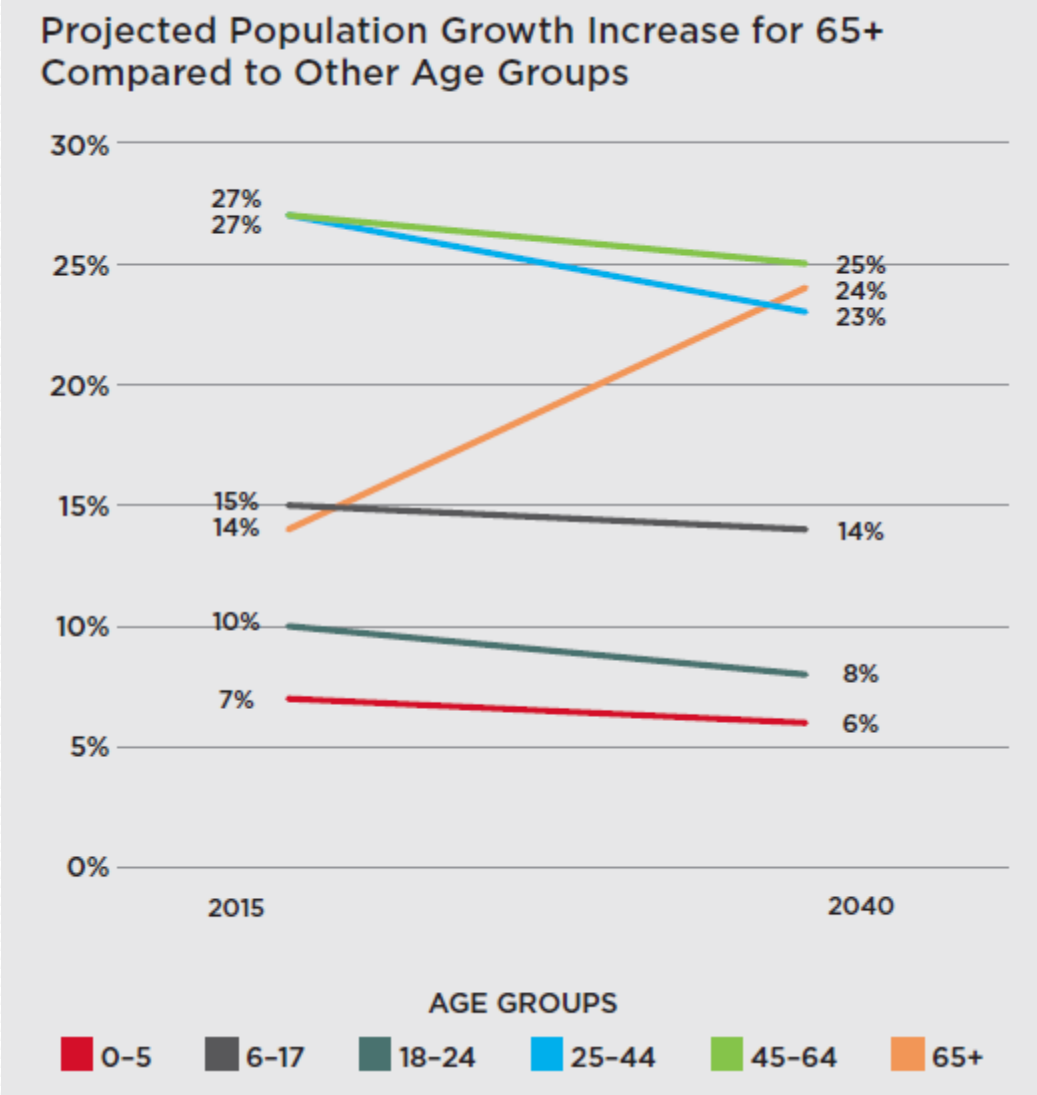
Nourishing Home, Health & Heart

- **1,000,000 meals annually**
- **2,500 seniors a day (on average)**
  - Senior Center Lunch Programs - social connections
  - Meals on Wheels delivered to home by friendly drivers
  - Case Management
  - More than Just a Meal!
- Friendly Visitors
- Adult Day Care /Adult Day Health Care/ CBAS
- Care Management Services
- Social Enterprise : Commercial foods

Senior Population in OC – Rapidly Increasing

Only age demographic growing in OC

Doubling to 24% by 2040 compared to 12% in 2010



Source: OC Older Adult Profile, 2016

24% of OC Seniors are **Food Insecure or Malnourished**

- **Limited or uncertain** access to adequate food

- **Contributing factors**
  - Low Income
  - Adverse Social Conditions
  - Reduced Mobility
  - Health

Why Poor Nutrition Matters

- **50% of all diseases** impacting older Americans are directly connected to **lack of appropriate nutrient intake** [1]

- **Food insecure older adults are:** [3]
  - **60%** more likely to suffer **congestive heart failure or a heart attack**
  - **50%** more likely to have **diabetes**
  - **Three times** as likely to **suffer depression**

1. Ziliak, Gunersen and Haiste. *The Causes Consequences and Future of Senior Hunger in America.* University of Kentucky Center for Poverty Research and Iowa State University (2008)
2. Older Americans Act Nutrition Programs. Lloyd & Wellman. Journal of Nutrition in Gerontology and Geriatrics 34:2, 90-109, 2015. www.tandfonline.com/loi/wjne21

What's the **Impact** of **SeniorServ's Programs**?

- **Meals on Wheels**
  - Reduced anxiety, loneliness and isolation
  - Sustained increase in wellness
  - Reduction in hospitalizations
  - Reduced length of stay

- **Senior Center Lunch Program**
  - Improved quality of life
  - Physical health improved
  - Significantly more friends
  - More connected to their community and city

Continued **Impact** of **SeniorServ's Programs**?

- **Adult Day Health Care/ CBAS**
  - Monitoring Health Conditions
  - Improvement in nutritional intake
  - Lessens the impact of acute health issues
  - Reduces Admissions, Readmissions and Unnecessary ER visits
- **Care Transitions**
  - Restore or maintain maximum ability for self-care and independence
  - Ensure safe transition from hospital/SNF to home
  - Provide and deliver resources to member for continuum of care

Thank you!

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Health Consumer Action Center (HCAC)
of the
Legal Aid Society of Orange County

OMBUDSMAN UPDATE

Sara Lee, Supervising Attorney
OSP Toll Free: 1-855-501-3077
Legal Aid Society of Orange County
Hotline: 1-800-834-5001
Korean Hotline : 714-489-2796

Most of the OCC members referred by CalOptima involves Medi-Cal eligibility issue.

▪Most of the termination or proposed termination is linked to annual renewal process.

▪The OSP assists dual eligible consumers with Share of Cost (SOC)affordability issues and whether they were placed in the correct Medi-Cal Aid Code which will not be a barrier for OCC enrollment or prevent disenrollment.

▪ For example, OSP assisted members avoid SOC by placing them in the Working Disabled Medi-Cal Program and maintain OCC coverage.

- OSP continues to educate members about the benefits of OCC such as the role of the PCC and care coordination.

- Need clarification and requests helpful consumer sheet on what benefits are supplemental dental benefits since full restoration of Denti-Cal

•LASOC helps bridge services for members who were terminated from OCC.

•OSP advises consumers about LINET when they are disenrolled from OCC. (Limited Income Newly Eligible Transition Program – Humana https://www.humana.com)

• Inappropriate Balance Billing is an issue affecting dual eligibles, especially for consumers with Fee For Service Medicare and Medi-Cal/CalOptima.

CalOptima Seeks Volunteers for *New Advisory Committee*

CalOptima seeks advocates and volunteers on its new Whole-Child Model Family Advisory Committee (WCM FAC). The state's Whole-Child Model (WCM) is incorporating California Children's Services (CCS) for Medi-Cal-eligible children and youth, into CalOptima's Medi-Cal managed care plan.

Candidates with knowledge of or experience with CCS are encouraged to apply. The deadline is Wednesday, February 28, 2018.

Apply today!

Applications are available at caloptima.org home page under Quick Links. To learn more, call **1-714-246-8635**.

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PRI-036-728 E (01/18)