NOTICE OF A
REGULAR MEETING OF THE
WHOLE-CHILD MODEL
FAMILY ADVISORY COMMITTEE

TUESDAY, JUNE 18, 2024
9:30 A.M.

CalOptima Health
505 City Parkway West, Room 107-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. To speak on an item during the public comment portion of the agenda, please register using the Webinar link below. Once the meeting begins the Question-and-Answer section of the Webinar will be open for those who wish to make a public comment and registered individuals will be unmuted when their name is called. You must be registered to make a public comment.

In compliance with the Americans with Disabilities Act, those requiring accommodations for this meeting should notify the Clerk of the Board's Office at (714) 246-8806, at least 72 hours prior to the meeting.

The Regular Whole-Child Model Family Advisory Committee's meeting agenda and supporting materials are available for review at CalOptima Health, 505 City Parkway West, Orange, CA 92868, 8 a.m. – 5:00 p.m., Monday-Friday, and online at www.caloptima.org.

Register to Participate via Zoom at:
https://us06web.zoom.us/webinar/register/WN_Yx9mR5OuSFOLsWPHSF6V9Q and Join the Meeting.

Webinar ID: 821 3095 0571

Passcode: 701004 -- Webinar instructions are provided below.

1. **CALL TO ORDER**
   Pledge of Allegiance

2. **ESTABLISH QUORUM**

3. **APPROVE MINUTES**
   Approve Minutes of the March 19, 2024 Regular Meeting of the Whole-Child Model Family Advisory Committee

4. **PUBLIC COMMENT**
   At this time, members of the public may address the Whole-Child Model Family Advisory committee on matters not appearing on the agenda, but within the subject matter jurisdiction of the Committee. Speakers will be limited to three (3) minutes.

5. **REPORTS**
   A. Approve Whole-Child Model Quarterly Schedule for FY 2024-2025

6. **INFORMATIONAL ITEMS**
   A. Quality Improvement Update
   B. OneCare Program
   C. Committee Member Updates

7. **MANAGEMENT REPORTS**
   A. Chief Executive Officer
   B. Chief Operating Officer
   C. Chief Medical Officer

8. **COMMITTEE MEMBER COMMENTS**

9. **ADJOURNMENT**

TO JOIN THE MEETING

Please register for the Regular Meeting of the Whole-Child Model Family Advisory Committee on June 18, 2024 at 9:30 a.m. (PDT)

To **Register** in advance for this webinar:

https://us06web.zoom.us/webinar/register/WN_Yx9mR5OuSFOLsWPHSF6V9Q and join from a PC, Mac, iPad, iPhone or Android device

On day of meeting, please click this URL to join: Please click this URL to join.
https://us06web.zoom.us/s/82130950571?pwd=9EI4flLDHPTzEZWAGz7FLr24i5bqmR

Passcode: **701004**

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Or join by phone:

Dial(for higher quality, dial a number based on your current location):
US: +1 669 444 9171 or +1 720 707 2699 or +1 253 205 0468 or +1 253 215 8782 or +1 346 248 7799 or +1 719 359 4580 or +1 305 224 1968 or +1 309 205 3325 or +1 312 626 6799 or +1 360 209 5623 or +1 386 347 5053 or +1 507 473 4847 or +1 564 217 2000 or +1 646 558 8656 or +1 646 931 3860 or +1 689 278 1000 or +1 301 715 8592

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Passcode: 701004

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MINUTES

REGULAR MEETING OF THE
CALOPTIMA HEALTH
WHOLE CHILD MODEL
FAMILY ADVISORY COMMITTEE

March 19, 2024

A Regular Meeting of the Whole-Child Model Family Advisory Committee (WCM FAC) was held on March 19, 2024 at CalOptima Health, 505 City Parkway West, Orange, California via in-person and teleconference (Zoom).

CALL TO ORDER
Chair Kristen Rogers called the meeting to order at 9:34 a.m. and led the Pledge of Allegiance.

ROLL CALL

Members Present: Kristen Rogers, Chair; Cally Johnson (Remote); Monica Maier (Remote.); Sofia Martinez (Remote) (10:03 a.m.); Jessica Putterman; Lori Sato (Remote)

Members Absent: Jennifer Heavener; Erika Jewell; Janis Price

Others Present: Yunkyung Kim, Chief Operating Officer; Sharon Dwiers, Clerk of the Board; Cheryl Simmons, Staff to the Advisory Committees;

MINUTES

Approve the Minutes of the December 19, 2023 Regular Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

Action: ***On motion of Member Sato, seconded and carried, the WCM FAC Committee approved the minutes of the December 19, 2023, meeting. (Motion carried 5-0-0; Members Heavener, Jewell and Price absent)***

PUBLIC COMMENTS
There were no public comments.

INFORMATION ITEMS

California Children's Services Update
Doris Billings, Interim Division Manager/Chief Therapist, California Children's Service (CCS), Orange County Health Care Agency provided an update on the Orange County CCS program and noted that Orange County had implemented an inter-county transfer process per the Department of Health Care Services (DHCS) All Plan Letter (APL). She noted that DHCS had created a checklist tool to use between the sending and receiving counties to better facilitate communication between the counties and to ensure continued services for children with special needs who are switching

between counties. Ms. Billings also provided an update on the Medical Therapy Units (MTU) as they continue to provide services, including occupational therapy and physical therapy and answered questions from members of the committees.

CalAIM Update

Mia Arias, Director, CalAIM provided a CalAIM update to the committee and discussed the 42 community-based organizations contracted to provide Enhanced Care Management services to members. Ms. Arias discussed how CalAIM is improving services by collaborating with all providers, coordinating care and engaging the community to ensure members' voices drive the evolution of services. She also discussed respite services to children with special needs through contracted providers and noted that any caregiver can refer themselves or be referred through the regional center.

Committee Member Updates

Chair Kristen Rogers announced that Maura Byron who held a Community Based Organization seat on the committee had resigned her seat as she had been appointed to the CalOptima Health Board of Directors. Staff has initiated a recruitment for this seat. She also reminded the committee that recruitment for the committee was underway and if they wished to be reappointed they would need to submit a new application.

CEO AND MANAGEMENT REPORTS

Chief Operating Officer Report

Yunkyung Kim, Chief Operating Officer provided an update to the committee and noted that CalOptima Health has approximately 9,600 Whole-Child Model members with Children's Hospital Orange County (CHOC) and CalOptima Health being the largest health networks for these members. Ms. Kim also informed the committee that CalOptima Health had been ranked third among all Medicare managed care plans in California and she also discussed how input from advisory committee members had increased funding for the Workforce Development Grant to address provider shortages in Orange County.

ADJOURNMENT

Hearing no further business, Chair Kristen Rogers adjourned the meeting at 10:28 a.m.

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Cheryl Simmons
Staff to the Advisory Committees

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Whole-Child Model
Family Advisory Committee

FY 2024-25 Meeting Schedule

September

Tuesday, September 24, 2024 at 9:30 AM
Conference Room 109-N Via Zoom

November

Tuesday, November 19, 2024 at 9:30 AM
Conference Room 109-N and Via Zoom

February

February 18, 2025 at 9:30 AM
Conference Room 109-N and Via Zoom

May

Tuesday, May 20, 2025 at 9:30 AM
Conference Room 109-N and Via Zoom

Regular Meeting Location and Time
CalOptima Health
505 City Parkway West, 1st Floor
Orange, CA 92868
Conference Room 109-N or Via Zoom
9:30 AM – 11:30 AM
www.caloptima.org

All meetings are open to the public. Interested parties are encouraged to attend.

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Update on Quality Improvement Programs

Whole-Child Model Family Advisory Committee Meeting
June 18, 2024

Linda Lee, Executive Director, Quality Improvement

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Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Agenda

- Quality Initiatives

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Quality Initiatives

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Performance Improvement Projects (PIP) Medi-Cal

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Well-Child Visits in the First 15 Months of Life PIP

- DHCS-required topic to address health disparities for Black/African-American members
- MY2022 baseline rate: 34.64% (n=153 members)
  - Overall rate: 45.76% (n=12,369)
- Intervention: Call campaign started 5/1/24 (85 members)
  - Well-child visit education
  - Reminders to complete well-child visits
  - Appointment coordination for visits
  - Barrier survey with $25 gift card for participation

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Plan-Do-Study-Act (PDSA) Project

- **Well-Child Visits in the First 30 Months of Life, 15 to 30 Months PDSA** (2023)
  - Cycle 3: 7/31/23 - 11/30/23
  - Intervention: telephonic call campaign and birthday card mailer.
  - Findings: Members who had two successful telephonic outreaches (87.50%) had a comparable compliance rate to those who had three successful telephonic outreaches and a birthday card mailing (88.89%).
  - Recommendation: Aim for two successful telephonic outreaches, and if member is unreachable, then a birthday card mailing is recommended.

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Behavioral Health Non-Clinical PIP

- This PIP aims to increase the enrollment of CalOptima Health Medi-Cal only members into Care Management (CM), Complex Case Management (CCM), or Enhanced Care Management (ECM) for members diagnosed with Specialty Mental Health (SMH)/Substance Use Disorder (SUD) to achieve better health outcomes, reduce emergency department visits, reduce health care cost and linkage to services.
- Activities:
  - Baseline data collected and initial report created
  - First draft of PIP submitted to DHCS
  - Technical Assistance requested and utilized
  - PIP resubmitted, reviewed, and validated.

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2024 Behavioral Health Quality Interventions

- Text message campaigns
- Member health rewards
- Member outreach
- Member Newsletter
- Automation via CalOptima Health provider portal
- Provider Communication: Tip sheets, Best Practice Letters

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Blood Lead Screening

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Lead Screening in Children (LSC) MY2024 Prospective Rate by Health Network

February 2024 Prospective Rates by Health Network vs MY2023 Preliminary Rate

Health Network	Rate
MY2023	63.26%
Medicaid; n=11584	59.13%
HPN Regal; n=40	22.50%
Optum; n=1527	46.76%
AMVI; n=167	49.10%
Prospect; n=135	50.37%
UCMG; n=417	54.20%
Noble; n=190	59.47%
CCN; n=1402	59.49%
CHOC; n=6846	63.37%
Family Choice; n=231	63.64%
AltaMed; n=482	65.56%

MY2024 MPL (50th percentile): 62.79%

Hybrid measure
3 health networks have attained the 50th percentile; n= members in denominator
February 2024 rates are non-continuous data
MY2023 rate preliminary and based on continuous enrollment data

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Blood Lead Screening Initiatives

- 2024: Implemented Member Health Reward for Blood Lead Test at 12-Months and 24-Months of Age
  - March 2024- launched on CalOptima Health website
- One-way text campaign for blood lead screening to members that are untested for lead as defined by the lead screening in children (LSC) measure.
- Live-call campaign to close HEDIS gaps slated for June 2024.
- Two-way text campaign reminders to test for lead at 12- and 24-months of age projected for Q3 2024.

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Medicare and Medi-Cal in Orange County

Whole-Child Model Family Advisory Committee
June 18, 2024

Cheryl Meronk, Director of Medicare Program Development

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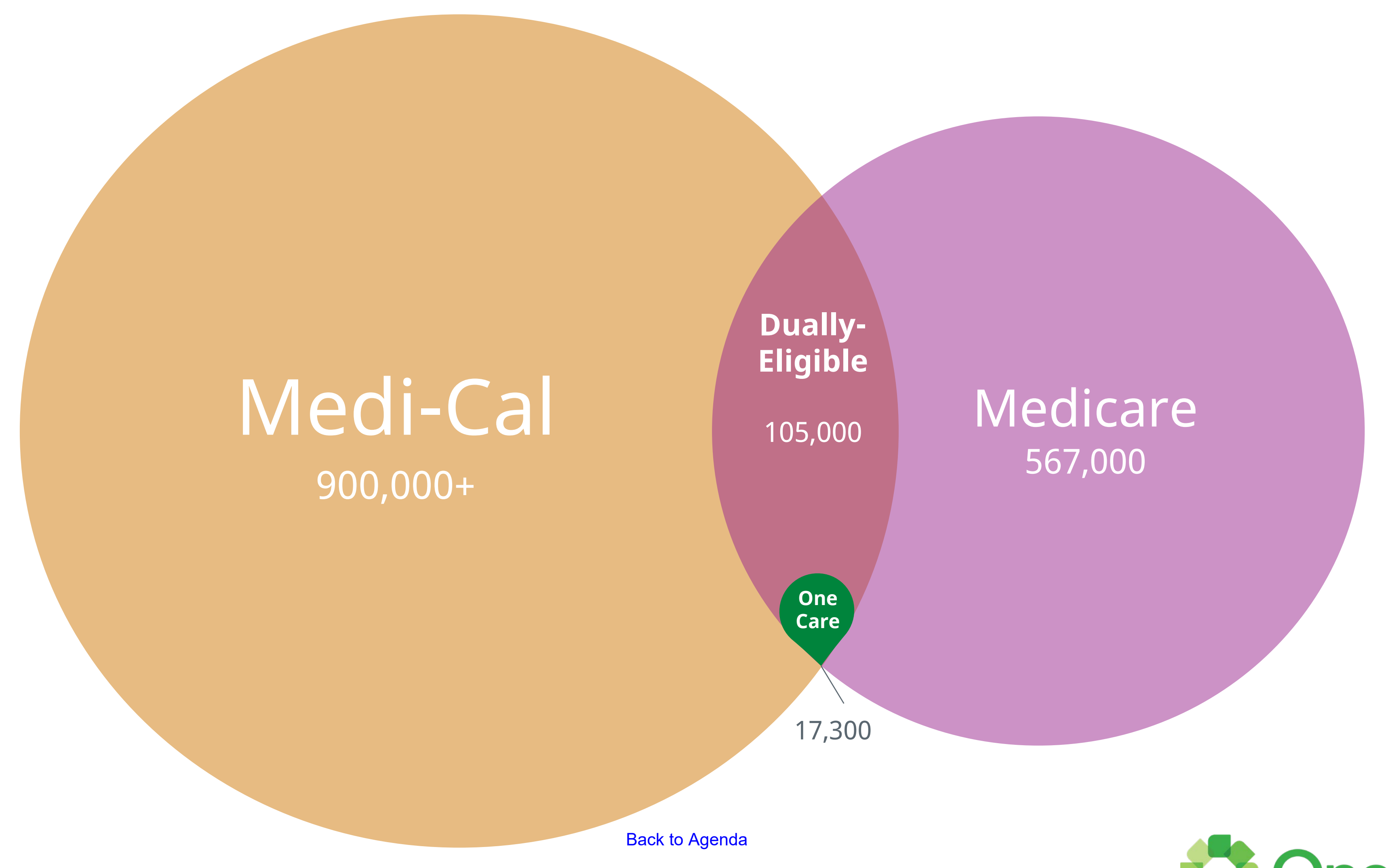
Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Orange County Population



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OneCare
CalOptima Health

OneCare for Dual-Eligible Beneficiaries

- CalOptima Health offers a Medi-Cal plan and a Medicare plan (OneCare).
  - Individuals can be eligible for both plans at the same time.
  - OneCare is specifically designed for individuals with both Medi-Cal and Medicare.
  - OneCare provides and coordinates both sets of benefits.
    - Sometimes, Medicare may not cover certain benefits; Medi-Cal often fills these gaps.

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OneCare Enrollment

- CalOptima Health Medi-Cal members who become eligible for Medicare can enroll into OneCare and continue to receive services from CalOptima Health.
  - This includes eligible members aging out of Whole Child Model.
  - All Health Networks participate as OneCare networks, except CHOC.
  - The majority of CCN providers participate in OneCare.

- OneCare is also known as an Exclusively Aligned Enrollment Dual Special Needs Plan (EAE D-SNP).
  - This refers to OneCare's ability to seamlessly provide and coordinate Medicare and Medi-Cal services under one organization.

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OneCare and OneCare Connect

- CalOptima Health offered a plan called OneCare Connect from 2015-2022.
  - This was a pilot program that provided a high level of integration.
- OneCare is similar to OneCare Connect including the availability of Personal Care Coordinators, Supplemental Benefits, and Medi-Cal Wrap Around benefits.
  - OneCare, as an EAE D-SNP, reflects the same coordination and integration that OneCare Connect offered.
- While Medicare is the primary coverage, Medi-Cal provides some services that Medicare does not cover.
  - These are referred to as “Medi-Cal Wrap-Around” services
  - Examples of these services include Durable Medical Equipment like incontinence supplies and CalAIM Community Supports services such as Housing Navigation, Home Modifications, Asthma Remediation, and Respite Care for Caregivers.

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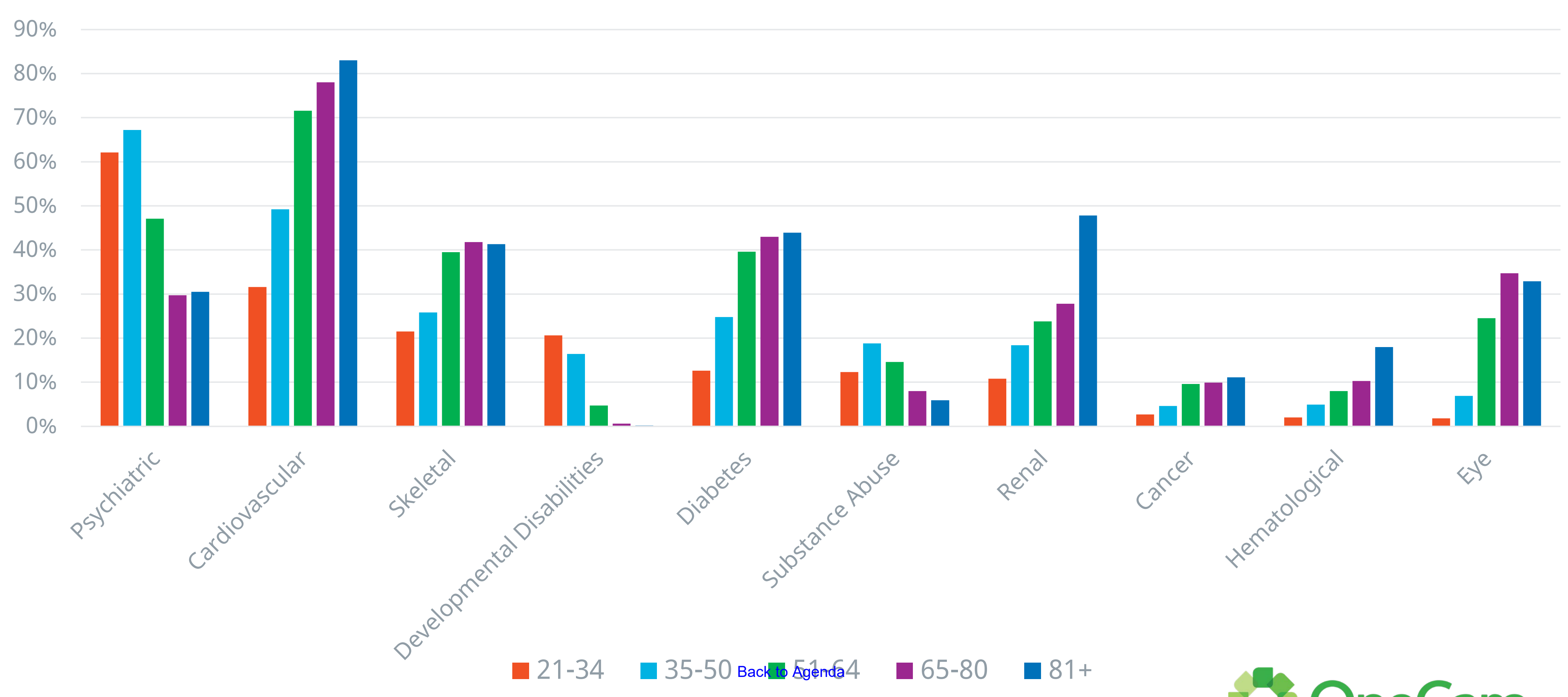
OneCare Population Overview

OneCare Condition Prevalence by Age Groups



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OneCare CalOptima Health

OneCare Care Coordination

Services	Original Medicare	OneCare
Case Management	None	• Coordinate through a network of providers to meet member's needs • Review of health needs and care plan to address needs, such as: • Community resources, LTSS, Waivers, Community Supports • Transitional Care Services • Case Manager or Personal Care Coordinator who will make sure you get the care and support you need

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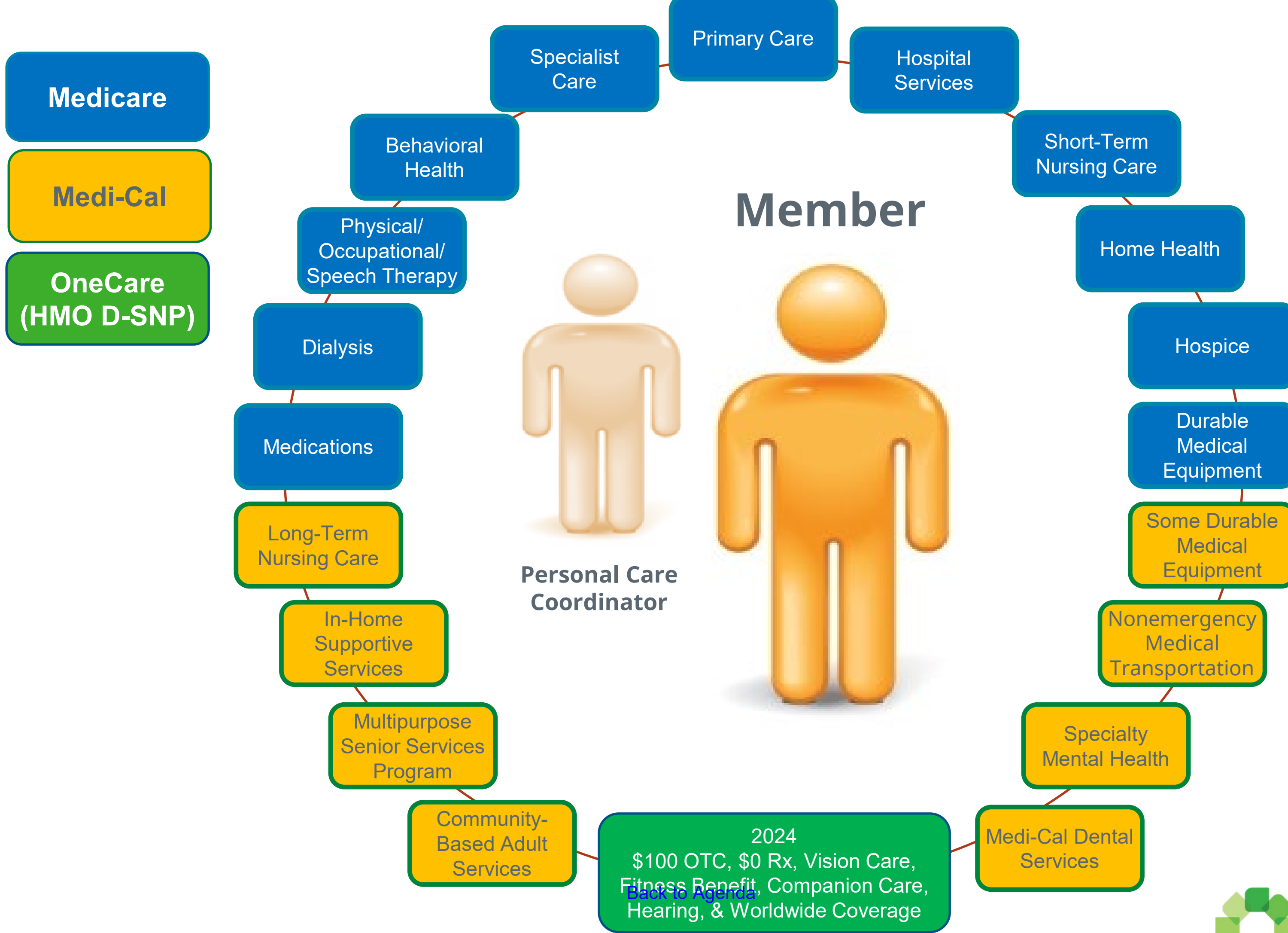
Integrated Benefits



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OneCare CalOptima Health

CalOptima Health Invests in OneCare

- New medical and executive leadership
- New OneCare campaign launching
- Competitive benefit package
- CMS Value-Based Insurance Design Model participation
  - Addresses Health-Related Social Needs like food and housing insecurity
  - Health Equity
  - Eliminates copays for all Part D drugs
  - Increased focus on Advance Care Planning

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2024 Benefit Highlights

Prescription Medicines

$0 copay for all prescription medication.

OTC Medicines

$100 per quarter (no rollover) to purchase from OTC catalog.

Vision Care

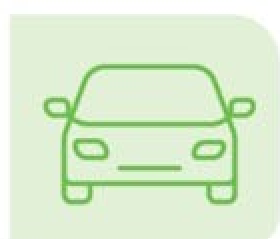
One annual eye exam, and glaucoma screening. $250 above Medi-Cal Limit for eyeglasses or contacts.

Hearing Services

$2,510 per fiscal year for hearing aids including molds, supplies and accessories.

Fitness Benefit

Gym membership, one home fitness kit, coaching, and on-demand fitness videos.



Transportation

Unlimited trips per year to an-approved medical services (i.e., doctor, pharmacy). Unlimited trips to/from gym.

Worldwide Emergency Care

$100,000 reimbursement per year for emergency and urgent care and transportation received outside the U.S.

Companion care

90 annual hours of help with instrumental activities of daily living.

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Annual Physical Exam

One physical exam per year.

Dental Services

Dental care services provided by Medi-Cal Dental.

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MEMORANDUM

DATE: May 31, 2024

TO: CalOptima Health Board of Directors

FROM: Michael Hunn, Chief Executive Officer

SUBJECT: CEO Report — June 6, 2024, Board of Directors Meeting

COPY: Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. Governor Announces May Revision to FY 2024–25 Proposed State Budget

On Friday, May 10, Gov. Gavin Newsom released the May Revision to the Fiscal Year (FY) 2024–25 Proposed State Budget, which includes total spending of $288.1 billion ($201 billion General Fund). The May Revision estimates the budget deficit has grown to $44.9 billion, up $7 billion from the January projection of $37.9 billion. Although the governor and Legislature passed "early action" budget measures in April to reduce the original shortfall by approximately $17.3 billion, this leaves a remaining deficit of $27.6 billion. The May Revision seeks to address this balance with additional spending cuts, including in health care programs. Reductions that may impact CalOptima Health include the following:

- Diverts Managed Care Organization (MCO) tax revenues to the General Fund to support existing core services, resulting in the following changes to previously proposed MCO tax allocations:
  - Eliminates targeted rate increases (TRIs) for Medi-Cal providers that were scheduled to be effective on January 1, 2025. TRIs previously implemented on January 1, 2024, will be maintained.
  - Eliminates annual funding for Graduate Medical Education and the Medi-Cal Workforce Pool.
- Due to triggers included in the 2022 Budget Act, these previously passed initiatives will not be funded or implemented at this time:
  - Continuous Medi-Cal coverage for children ages 0–4
  - Medi-Cal share of cost reform
- Reduces funding for Equity and Practice Transformation payments to Medi-Cal providers for quality, health equity and primary care infrastructure
- Reduces funding for several behavioral health initiatives, including the Children & Youth Behavioral Health Initiative, Behavioral Health Continuum Infrastructure Program and Behavioral Health Bridge Housing Program
- Reduces funding for certain substance use disorder initiatives, including the Naloxone Distribution Project and Medication Assisted Treatment Expansion Project
- Reduces funding for multiple housing and homelessness initiatives, including the Multifamily Housing Program and the Homeless Housing, Assistance and Prevention Grant Program
- Eliminates funding for various health care workforce initiatives related to community health workers, nursing, social work, residencies and more

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- Eliminates In-Home Supportive Services coverage for undocumented individuals of all ages
- Eliminates remaining funding for health enrollment navigators
- Eliminates Medi-Cal's adult acupuncture benefit
- Eliminates augmented funding for free clinics
- Eliminates ongoing funding to state and local public health

Despite these reductions, the May Revision preserves funding for CARE Court and the recent expansion of Medi-Cal coverage to undocumented adults. In addition, new funding is proposed for directed payments to children's hospitals to support access to critical services. Budget negotiations continue regarding funding for the health care worker minimum wage increases that are set to take effect this summer, pursuant to Senate Bill 525. In its initial assessment of the May Revision, the Legislative Analyst's Office concluded that the governor's proposals are largely prudent solutions to address the growing deficit but also provided additional suggestions for legislators to consider. On May 29, legislative leaders released a budget counterproposal to the May Revision, which would, of note, instead delay the future MCO TRIs from January 1, 2025 to January 1, 2026, rather than eliminate those TRIs altogether. Next, the governor and legislators will continue to negotiate a final budget, which is required to pass both houses of the State Legislature by June 15.

B. CalOptima Health Submits One-Year Update on State Audit

On May 2, 2024, CalOptima Health submitted to the California State Auditor (CSA) a one-year status update on the implementation of CSA's audit recommendations. This is the final of three updates due 60 days, six months and one year after the release of the audit report on May 2, 2023. The enclosed CSA status tracker includes our latest actions in response to the four outstanding recommendations that CSA had not yet deemed fully implemented. That document is also posted publicly on the CalOptima Health website. Specifically, on April 4, 2024, the Board approved modifications to the Non-Retaliation for Reporting Violations policy to add contractors as participants in CalOptima Health's annual, anonymous employee survey. On May 2, 2024, to address the balance of unallocated resources, the Board increased the Board-Designated Reserve Fund levels from 1.4–2.0 months to 2.5–3.0 months of consolidated capitation revenues and committed approximately $526 million over 30 months to provider rate increases (subject to formal appropriation as part of the Fiscal Year 2024–25 Operating Budget). Also on May 2, 2024, the Board approved amending the CalOptima Health Bylaws to prohibit all Board members from being employed by CalOptima Health for a period of one year after their Board terms end. With these latest actions, CalOptima Health has deemed all seven recommendations as fully implemented. While no additional updates are required at this time, CSA indicates that it will contact CalOptima Health in the fall of each year to discuss any outstanding recommendations that CSA has not yet deemed fully implemented.

C. Governor Newsom Holds Proposition 1 Press Conference

On May 14, Gov. Gavin Newsom held a press conference to provide an update on the implementation of Proposition 1, which was narrowly approved by voters during the March 5, 2024, primary election. Emphasizing that "decisions will be made in months, not years," the governor shared that state agencies will open applications for the first round of behavioral health treatment facility bonds this July, followed by applications for supportive housing bonds in late 2024. As part of the accountability measures required in Proposition 1, the governor's office has created a new website (mentalhealth.ca.gov), which will eventually include a comparative map of counties' progress on Proposition 1 requirements and related behavioral health and housing initiatives. Of note, the state is also closely monitoring counties' implementation of CARE Court.

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D. CalOptima Health Is a Certified Great Place to Work

Following an employee survey in April, CalOptima Health is proud to now be a Certified Great Place to Work! Great Place to Work Certification is a highly coveted achievement that requires consistent and intentional dedication to the overall employee experience. This year, 80% of employees said it's a great place to work — 23 percentage points higher than the average U.S. company. Great Place to Work Certification is the only recognition based entirely on what employees report about their workplace experience — specifically, how consistently they experience a high-trust workplace. Great Place to Work Certification is recognized worldwide by employees and employers alike and is the global benchmark for identifying and recognizing outstanding employee experience. Every year, more than 10,000 companies across 60 countries apply for certification as a Great Place to Work. We owe our continued success to our team of dedicated employees at CalOptima Health. We celebrate and thank them for all they do to earn this incredible recognition. Please view our certified company profile here: CalOptima Health: Great Place to Work.

E. Provider Workforce Development Initiative Grants Celebrated by Recipients

During the past month, three institutions that were awarded first-round funding for the Provider Workforce Development Initiative announced their grants during special presentations:

- On April 29, Chief Executive Officer Michael Hunn presented a ceremonial check for $1.2 million to Rancho Santiago Community College District's Board of Trustees. Santiago Canyon College will use the funding for expanded programs for behavior technicians and medical assistants, and a new tuition-free program for Licensed Vocational Nurses.
- On May 3, CalOptima Health Chief Operating Officer Yunkyung Kim visited Concordia University to present a $5 million check to the Board of Trustees. The funding will be used for Concordia University's Nursing Pipeline Program to increase and diversify enrollment in Concordia's Accelerated Bachelor of Science in Nursing and ultimately boost the number of nurses joining the workforce in Orange County.
- On May 15, CalOptima Health co-hosted a press conference at Cal State Fullerton with Vice Chairman of the Board of Supervisors and CalOptima Health Board Member Doug Chaffee in the nursing school's training simulation center. The press conference announced and celebrated CalOptima Health's $5 million Provider Workforce Development Initiative grant. The funding will allow Cal State Fullerton to increase the number of Associate Degree in Nursing (ADN) to Bachelor of Science in Nursing (BSN) students in the Jump Start, Concurrent Enrollment and regular BSN programs.

Upcoming Press Conference:

- On June 5, leaders from UC Irvine, CalOptima Health and the Orange County Board of Supervisors are hosting a press conference to announce CalOptima Health's $5 million grant to UCI to help launch the NURSE-OC program to expand the nursing workforce and boost access to quality care for Medi-Cal members. This program will offer externships to 60 prelicensure nursing students and residencies to six graduate students pursuing Family Nurse Practitioner and Psychiatric Mental Health Nurse Practitioner licensure. The five-year program will aim to recruit more than 50% of participants from underrepresented groups or low-income backgrounds to promote a workforce that represents CalOptima Health's members.

F. Garden Grove Sees Reduction in Homelessness; Program Honored With Award

Every two years, the County of Orange, in compliance with HUD guidelines, conducts a Point in Time count (PIT) to establish a baseline for understanding the scope of homelessness in our county. The results of the most recent PIT have been released, demonstrating a collective 28% increase in homelessness across the county from 2022 to 2024. While there are several variables that impact this

reality, we do know that increasing service provision and permanent affordable and supportive housing are proven strategies to address and ultimately reduce homelessness. The City of Garden Grove has shown us that this strategy works! By embracing a collaborative approach by inviting vital services into their community, including CalOptima Health's Street Medicine Program, the recent PIT count showed a 39% reduction in Garden Grove's population of people experiencing homelessness compared with the prior count in 2022. We are honored to be a part of the solution to ending homelessness in Garden Grove. As further recognition, on May 8, the Association of California Cities–Orange County honored the program with its Golden Hub of Innovation Award in the category of Collaborative Community Development & Innovation, recognizing the successful partnership of the City of Garden Grove, CalOptima Health and Healthcare in Action.

G. New Senior Housing Funded in Part by CalOptima Health

On May 20, I spoke at the grand opening of Santa Angelina, a senior housing development in Placentia built by National CORE, with an investment of $1.3 million from CalOptima Health. In the past few years, we have become a major player in affordable housing and permanent supportive housing for Orange County. In fact, our funding in 2023 alone has contributed toward 1,175 units. The 65 units at Santa Angelina's are among the newest to open to address housing for our vulnerable senior population.

H. CalOptima Health Gains Media Coverage

Reflecting the media's recognition of our ongoing innovation and program development, CalOptima Health recently received the following coverage:

- California Healthline published an article on Tuesday, May 14, about CalAIM featuring a quote from an interview with Kelly Bruno-Nelson, DSW, Executive Director of Medi-Cal/CalAIM. The article also appeared on NPR.
- As a result of CalOptima Health's press conference at Cal State Fullerton to announce the $5 million Provider Workforce Development Initiative grant to the nursing program, the following media covered the news:
  - **Daily Pilot/LA Times OC** published an article online and in the Sunday, May 19, print edition on Page A4.
  - Orange County Register mentioned the grant in a piece about the nursing school.
  - Univision ran a lengthy piece about the grant and nursing student experience.
  - KNX Radio aired an interview that ran multiple times.
  - KFI Radio also aired an interview that ran multiple times.
  - CSUF Newswire posted an article announcing the news.

Fast Facts
June 2024

Mission: To serve member health with excellence and dignity, respecting the value and needs of each person.

Membership Data* (as of April 30, 2024)

Total CalOptima Health Membership

928,430

Program	Members
Medi-Cal	910,806
OneCare (HMO D-SNP)	17,138
Program of All-Inclusive Care for the Elderly (PACE)	486

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for 10 months ended April 30, 2024)

	YTD Actual	YTD Budget	Difference
Revenues	$4,048,391,120	$3,394,943,442	$653,447,678
Medical Expenses	$3,699,385,794	$3,187,898,080	($511,487,714)
Administrative Expenses	$185,721,701	$213,035,296	$27,313,595
Operating Margin	$163,283,626	($5,989,934)	$169,273,560
Medical Loss Ratio (MLR)	91.4%	93.9 %	(2.5%)
Administrative Loss Ratio (ALR)	4.6%	6.3%	1.7%

Note: Totals may not add due to rounding

Reserve Summary (as of April 30, 2024)

	Amount (in millions)
Board Designated Reserves	$629.8*
Capital Assets (Net of depreciation)	$96.1
Resources Committed by the Board	$535.6
Resources Unallocated/Unassigned	$682.3*
Total Net Assets	$1,943.8

Total of Board-designated reserves and unallocated resources can support approximately 112 days of CalOptima Health's current operations.

Note: On May 2, 2024, the Board approved a commitment of $526.2 million from undesignated reserves to support Medi-Cal provider rate increases for a 30-month period. The unallocated resources balance will be reduced by this amount in the May 2024 month-end closing.

Total Annual Budgeted Revenue **$4 Billion**

NOTE: CalOptima Health receives its funding from state and federal revenues only.
CalOptima Health does <u>not</u> receive any of its funding from the County of Orange.

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CalOptima Health Fast Facts

June 2024

Personnel Summary (as of May 18, 2024, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,308.9	85.85	45.45%	54.55%	6.16%
Supervisor	79	5	60%	40%	5.95%
Manager	114	6	50%	50%	5%
Director	64.75	2	100%	---%	3%
Executive	19	3	---%	100%	13.64%
Total FTE Count	1,585.6	101.9	47.89%	52.11%	6.04%

FTE count based on position control reconciliation and includes both medical and administrative positions.

Provider Network Data (as of April 30, 2024)

	Number of Providers
Primary Care Providers	1,231
Specialists	9,712
Pharmacies	528
Acute and Rehab Hospitals	39
Community Health Centers	52
Long-Term Care Facilities	104

Treatment Authorizations (as of March 31, 2024)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	34.18 hours
Prior Authorization – Urgent	72 hours	19.78 hours
Prior Authorization – Routine	5 days	2.37 days

Average turnaround time for routine and urgent authorization requests for CalOptima Health Community Network.

Member Demographics (as of April 30, 2024)

Member Age

Member Age	
0 to 5	8%
6 to 18	23%
19 to 44	36%
45 to 64	20%
65 +	13%

Language Preference

Language Preference	
English	55%
Spanish	30%
Vietnamese	9%
Other	2%
Korean	2%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	39%
Expansion	38%
Optional Targeted Low-Income Children	7%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

US Measles/Pertussis Outbreak 2024

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members’ social determinants of health.

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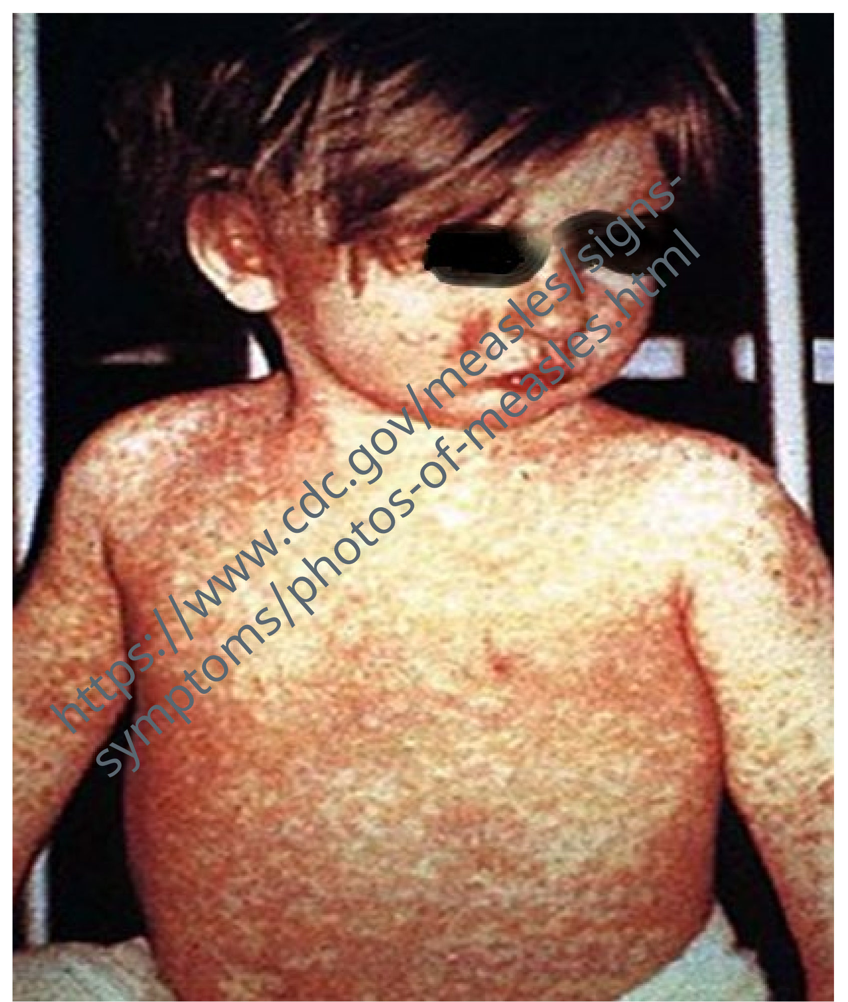

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https://www.cdc.gov/measles/signs-symptoms/photos-of-measles.html

In All of 2023
What was the total number of Measles cases in the US?

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58

[Back to Agenda]

58 → 132

First 4 months of 2024

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CalOptima Health

U.S. Hospitalizations in 2024

- **53%** of cases hospitalized (70 of 132 cases) for isolation or for management of measles complications.
- Under 5 years: **64%** (37 of 58)
- 5-19 years: **37%** (11 of 30)
- 20+ years: **50%** (22 of 44)

U.S. Measles Cases In 2024 So Far
132

Vaccination Status

Unvacc/unkno: **81%**
One MMR dose: **14%**
Two MMR doses: **5%**

Age

Under 5 years: **58 (44%)**
5-19 years: **30 (23%)**
20+ years: **44 (33%)**

https://www.cdc.gov/measles/cases-outbreaks.html#:~:text=Measles%20cases%20in%202024,Pennsylvania%2C%20Virginia%2C%20and%20Washington.

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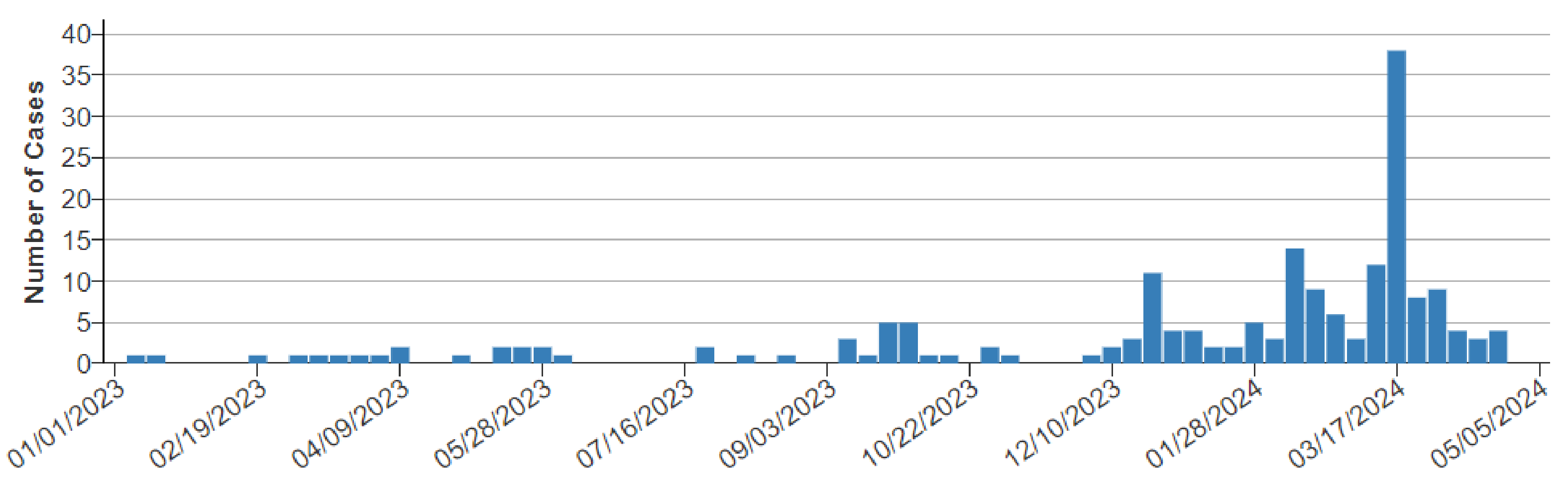
CDC as of May 9th 2024



https://www.cdc.gov/measles/cases-outbreaks.html#:~:text=Measles%20cases%20in%202024,Pennsylvania%2C%20Virginia%2C%20and%20Washington.

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Complications of measles

- Ear infections.
- Scarring of the cornea.
- Pneumonia.
- Encephalitis (inflammation of the brain) which occurs in about one in every 1,000 people with measles.

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Measles Worldwide

According to a report by the U.S. Centers for Disease Control and Prevention and the World Health Organization, the number of measles cases increased by 18% from 2021 to 2022, up to 9 million, while deaths spiked by 43%, to 136,000. Children accounted for most of the deaths. Nov 16, 2023

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Does Measles vaccine work?

Reported Measles Cases in the United States from 1962 – 2023*

1963
Vaccine licensed

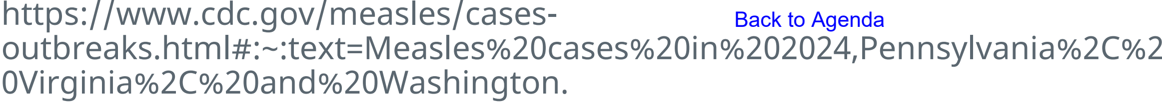
1989
2nd dose recommended

2000
Elimination declared†

Number of Cases
600,000
500,000
400,000
300,000
200,000
100,000
0

1960
1965
1970
1975
1980
1985
1990
1995
2000
2005
2010
2015
2020*

Year



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Measles Cases in the US

58 cases all of 2023

132 cases

First 4 months of 2024

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Pertussis Outbreak 2024

- Endemic bacteria in the US
- About 10,000 cases per year*
- Prior vaccine >200,000 cases/yr
- Much lower during the pandemic
- 2024 has 3X's number of 2023 cases

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Pertussis 2024 Outbreak

- < 1y/o highest mortality rate
- Pre-VAX about 9,000 deaths/year
- Prior rate 4.5 deaths/1,000
- Post-VAX 0.003 deaths/1,000
- Between 2010 - 2020 20 babies/ year die

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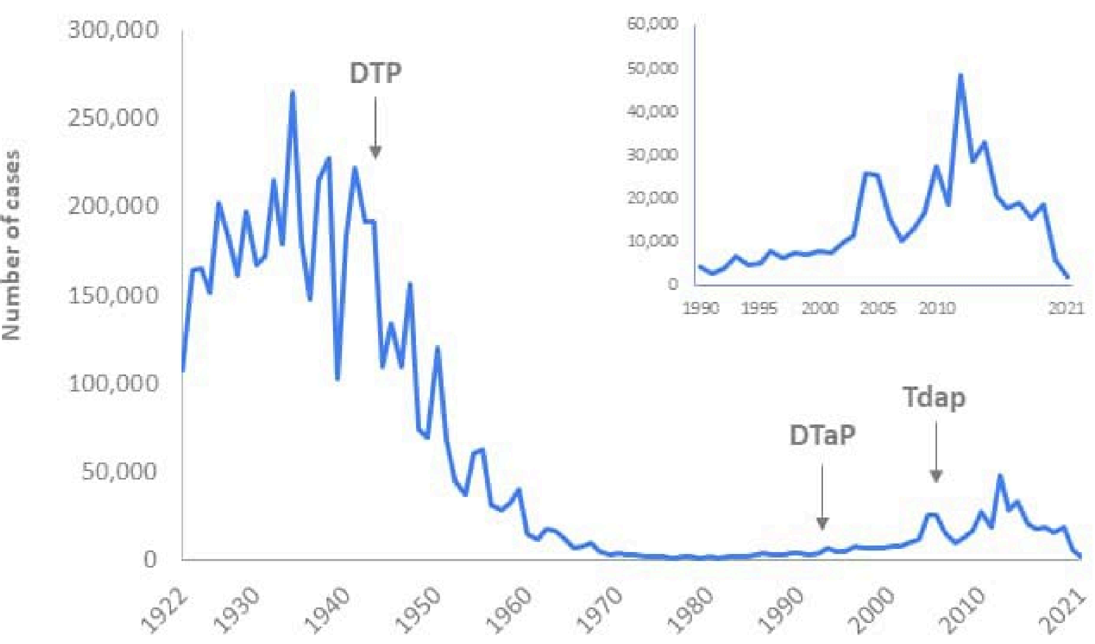
Cases prior to VAX



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An official website of the United States government Here's how you know

Morbidity and Mortality Weekly Report (*MMWR*)

Measles Outbreak Associated with a Migrant Shelter — Chicago, Illinois, February–May 2024

Weekly / May 16, 2024 / 73(19);424–429

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Summary

What is already known about this topic?

Measles, a highly contagious respiratory virus, was declared eliminated from the United States in 2000; however, with ongoing global transmission, infections in the United States still occur. Receipt of 1 and 2 doses of measles vaccine is 93% and 97% effective, respectively, in preventing measles.

What is added by this report?

Fifty-seven measles cases were associated with residence in or contact with persons in a migrant shelter in Chicago, Illinois. Most cases occurred in unvaccinated persons. A prompt and coordinated response with a high-coverage mass vaccination campaign reduced the size and duration of the outbreak.

What are the implications for public health practice?

Ensuring high measles vaccination coverage during an outbreak can control measles spread and prevent wider transmission.

Related Materials

Article PDF

Full Issue PDF

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View suggested citation

Abstract

Measles, a highly contagious respiratory virus with the potential to cause severe complications, hospitalization, and death, was declared eliminated from the United States in 2000; however, with ongoing global transmission, infections in the United States still occur. On March 7, 2024, the Chicago Department of Public Health (CDPH) confirmed a case of measles in a male aged 1 year residing in a temporary shelter for migrants in Chicago. Given the congregate nature of the setting, high transmissibility of measles, and low measles vaccination coverage among shelter residents, measles virus had the potential to spread rapidly among approximately 2,100 presumed exposed shelter residents. CDPH immediately instituted outbreak investigation and response activities in collaboration with state and local health departments, health care facilities, city agencies, and shelters. On March 8, CDPH implemented active case-finding and coordinated a mass vaccination campaign at the affected shelter (shelter A), including vaccinating 882 residents and verifying previous vaccination for 784 residents over 3 days. These activities resulted in 93% measles vaccination coverage (defined as receipt of ≥1 recorded measles vaccine dose) by March 11. By May 13, a total of 57 confirmed measles cases associated with residing in or having contact with persons from shelter A had been reported. Most cases (41; 72%) were among persons who did not have documentation of measles vaccination and were considered unvaccinated. In addition, 16 cases of measles occurred among persons who had received ≥1 measles vaccine dose ≥21 days before first known exposure. This outbreak underscores the need to ensure high vaccination coverage among communities residing in congregate settings.

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Investigation and Results

Measles is a highly contagious respiratory virus with the potential to cause severe complications, hospitalization, and death (*1*). Although measles was declared eliminated from the United States in 2000, global transmission is ongoing (*2*). Receipt of 1 and 2 doses of measles vaccine is 93% and 97% effective, respectively, in preventing measles (*1*).

Since August 2022, approximately 41,000 migrants have arrived in Chicago, Illinois from the U.S. southern border (*3*); most (88%) are from Venezuela, a country with a recent decline in routine childhood immunization coverage, including with measles vaccine (*4*). On February 22, 2024, approximately 12,000 persons were residing in 27 temporary migrant shelters operated by the city of Chicago. The largest shelter (shelter A) is a congregate setting with shared sleeping areas, dining area, and bathrooms. On February 22, 2024, approximately 2,100 persons resided in shelter A, with some rooms housing 500 or more persons.

Index Patient

A male shelter A resident aged 1 year developed a rash on February 26, 2024, and was hospitalized on February 27 with suspected measles. On March 4, when the Chicago Department of Public Health (CDPH) was first notified of the suspected case, confirmatory measles testing with real-time reverse transcription–polymerase chain reaction (RT-PCR) was requested by CDPH. The child had arrived in the United States >5 months earlier and had received 1 dose of measles, mumps, and rubella (MMR) vaccine 5 weeks before rash onset[†]; he had no recent travel or known exposure to measles. Upon confirmation of wild-type measles infection by measles vaccine assay (MeVA)[§] on March 7, CDPH alerted residents and staff members the same evening and arranged a vaccination event for the next morning. Given the highly congregate nature of shelter A, CDPH considered anyone who had been inside the shelter during February 22–27, the index patient's infectious period at shelter A, to be exposed.

Case Identification

A shelter A–associated case was defined as an RT-PCR–confirmed, wild-type measles infection in a person with a shelter A measles exposure, either by virtue of residing in, working at, or having a known epidemiologic link to persons from shelter A with a confirmed measles infection, during February 26–May 13. Laboratory confirmation included measles RT-PCR testing at the Illinois Department of Public Health Laboratory. To distinguish measles vaccine reaction from wild-type measles infection, laboratory confirmation required MeVA testing be performed by the Minnesota Department of Health Public Health Laboratory for persons who had received measles vaccine 5–21 days before rash onset. Among exposed persons who did not have a rash (but who had measles signs and symptoms, such as fever, cough, coryza, or conjunctivitis), RT-PCR collection date was used to determine the need for MeVA testing. For all cases, standard genotyping was attempted for available specimens. This activity was reviewed by CDC, deemed not research, and was conducted consistent with applicable federal law and CDC policy.[¶]

Additional Cases

During February 26–May 13, CDPH confirmed 57 shelter A–associated measles cases, including 52 among residents, three among staff members, and two among community members (Figure) (Table). The median age of persons with confirmed infections was 3 years (range = 0–52 years); most were originally from Venezuela (43; 84%) and arrived in the United States a median of 124 days (range = 56–202 days) before rash onset. Most persons (41; 72%) did not have documentation of measles vaccination and were considered unvaccinated. Among all cases, 16 (28%) occurred among persons who had documentation of ≥1 measles vaccine dose ≥21 days before first known exposure, and four (7%) occurred among persons who had documentation of ≥2 measles vaccine doses. The median age of previously vaccinated persons with confirmed measles infections was 9.5 years (range = 1–49 years); seven patients (44%) were aged <5 years. Two cases occurred among persons who resided at shelter A during February 22–March 7, but had resettled or transferred to less crowded shelters with private sleeping areas after March 7; no secondary cases occurred at those shelters. As of May 13, identical measles genotype D8 sequences were identified from 52 case specimens; the remaining five isolates could not be sequenced. Fifty-one persons (89%) were hospitalized for either or both isolation and measles complications; no deaths were reported. As of May 13, the date of last known exposure at shelter A was April 5.

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Public Health Response

After identification of the index case, CDPH instituted a mass campaign to provide vaccination and verify vaccination records, active case-finding, and shelter movement restrictions (Figure). To deliver culturally and linguistically accessible messaging about measles infection and the importance of vaccination and quarantine, CDPH collaborated with trusted community health workers and leaders. These persons, who included "promotores de salud," were effective liaisons for communicating messages from CDPH because they were fluent in Spanish and possessed insight and understanding of the community served.

Vaccination

CDPH implemented a rapid and comprehensive vaccination campaign at shelter A during March 8–10, within 1 day of confirmation of the index case (Figure). Staff members verified physical vaccination records and vaccination status in Illinois' immunization information system. All nonpregnant residents aged ≥6 months without documentation of previous measles vaccination and residents aged ≥1 year who had received a first dose ≥28 days earlier were offered MMR vaccination.** Shelter staff members and community partners were engaged to communicate the importance of vaccination and were recommended to provide evidence of measles immunity themselves.

During March 8–10, records documenting previous measles vaccination were verified for 784 (44%) of the 1,801 residents, and 882 (49%) eligible residents received MMR vaccine. By March 11, a total of 1,666 (93%) of 1,801 residents at shelter A had documentation of receipt of ≥1 dose of measles vaccine. As of May 13, CDPH had led approximately 130 mass vaccination events across 25 Chicago migrant shelters and administered approximately 9,500 MMR vaccine doses, prioritizing the shelters that had previously received residents from shelter A (all of whom were presumed to be exposed) and shelters with pregnant women and young children. This strategy included additional vaccination events at shelter A beginning on March 25, with a focused second-dose vaccination campaign during April 8–10 (Figure).

Active Case-Finding

CDPH began active case-finding at shelter A on March 8 (Figure). Medical and shelter staff members walked bed to bed to screen residents for measles signs and symptoms.[††] On the basis of the degree of clinical suspicion for measles,[§§] symptomatic residents were either tested and remained on site or were immediately transported to a hospital for testing and isolation. The median interval from rash onset to isolation was 1 day, ranging from 3 days before to 3 days after rash onset.

Movement Restriction

All shelter A residents without evidence of receipt of ≥1 dose of measles vaccine ≥21 days before first known exposure were advised to quarantine in shelter A until 21 days from first MMR vaccination or, if unvaccinated, 21 days from last known exposure at shelter A. School exclusion for children in quarantine began on March 8 (Figure). Quarantine remained voluntary rather than imposed by city officials or law enforcement to encourage continued cooperation between CDPH and shelter A residents. Twenty-two family units with members who were at highest risk for infection (i.e., infants aged ≤6 months, nonimmune pregnant women, and immunocompromised persons) were transferred during March 11–12 to a repurposed hotel for quarantine. Intake of new residents to shelter A was halted on March 8, and movement of shelter A residents to nonquarantine shelters only occurred for persons with documentation of receipt of ≥1 dose of measles vaccine. Because of the inability to isolate symptomatic persons within shelter A, residents with laboratory-confirmed measles or high clinical suspicion of measles were isolated in Chicago hospitals for the remainder of their infectious periods.

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Discussion

After identification of a large measles outbreak among migrants, primarily from Venezuela, who resided in a shelter, active case-finding and rapid mass vaccination of residents likely reduced transmission and outbreak size and duration (*5*). Engagement of community partners contributed to the success of these public health interventions.

Measles is a highly contagious respiratory virus (*1*), and this outbreak occurred in a densely populated congregate setting with high potential for transmission. Isolation space was needed although lacking for public health control measures, both at shelter A and in the larger community, placing a strain on Chicago hospitals. Persons isolated in hospitals occupied

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airborne infection isolation rooms during their infectious period or until measles was ruled out, underscoring the importance of having dedicated isolation space outside of hospitals for patients without medical need.

Measles is preventable with a highly effective vaccine (*1*); however, the national first-dose measles vaccination coverage among Venezuelan residents aged ≥12 months declined from 96% to 68% during 2017–2021 (*4*). Decreases in measles vaccination coverage, attributed to the disruption of routine immunization services during the COVID-19 pandemic, have been observed worldwide (*6*).

Measles postexposure prophylaxis (PEP) with MMR vaccine must be administered within 72 hours of exposure to be effective in preventing measles[¶¶] (*1*). Mass vaccination at shelter A occurred outside the window for PEP after the initial exposure but likely prevented measles cases resulting from later exposures, thereby limiting the size and duration of the outbreak (*5*). Residents' ineligibility for PEP because of the 6-day delay in notification to CDPH highlights the importance of prompt notification of suspected and confirmed measles cases to health departments.

The percentage of measles cases among persons with a history of previous vaccination was higher than that reported through recent national surveillance in the United States (*7*), likely owing to a high degree of exposure from the congregate living situation (*5*). Infections in vaccinated persons can occur because of primary vaccine failure, in which an immunologic response to vaccination does not occur, or secondary vaccine failure, in which infection occurs despite previous response to vaccination. Primary vaccine failure occurs in approximately 4% of recipients of 1 MMR dose and is rare among recipients of 2 MMR doses (*6*). Secondary vaccine failure generally occurs because of prolonged or close exposure to measles virus and has been observed in congregate settings (*8,9*). A full assessment of whether these infections are due to primary or secondary vaccine failure is ongoing.

Measles was declared eliminated from the United States in 2000; however, with ongoing global transmission, infections in the United States still occur (*2*). Although persons in the community affected by this outbreak had recently arrived in the United States, the index patient's arrival in Chicago months before illness onset suggests that the disease was acquired locally. To date, a direct epidemiologic link to another case has not been identified. The risk for transmission within and outside of shelters can be mitigated by maintaining high MMR vaccination coverage among both established and newly arrived residents.

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* These authors contributed equally to this report.

† Up to 5% of persons who receive MMR vaccine will develop a vaccine reaction with rash, which is clinically indistinguishable from a rash resulting from wild-type measles infection.

§ After measles vaccination, vaccine strain measles virus can be detected with conventional measles RT-PCR, and MeVA is used to differentiate between vaccine strain and wild-type measles virus. The MeVA test is a real-time RT-PCR assay that detects only measles vaccine strains.

¶ 45 C.F.R. part 46.102(l)(2), 21 C.F.R. part 56; 42 U.S.C. Sect. 241(d); 5 U.S.C. Sect. 552a; 44 U.S.C. Sect. 3501 et seq.

** https://www.cdc.gov/vaccines/vpd/mmr/hcp/recommendations.html

†† Symptoms concerning for measles included fever, rash, cough, coryza, or conjunctivitis.

§§ High clinical suspicion included persons with fever and rash or fever and either cough, coryza, or conjunctivitis.

¶¶ Measles incubation period ranges from 11 to 12 days, with rash onset typically occurring 14 days after exposure.
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References

1. McLean HQ, Fiebelkorn AP, Temte JL, Wallace GS; CDC. Prevention of measles, rubella, congenital rubella syndrome, and mumps, 2013: summary recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Recomm Rep 2013;62(No. RR-04):1–34. PMID:23760231
2. CDC. Measles (rubeola): measles elimination. Atlanta, GA: US Department of Health and Human Services, CDC; 2020. https://www.cdc.gov/measles/elimination.html
3. City of Chicago. New arrivals situational awareness dashboard. Chicago, IL; City of Chicago; 2024. Accessed April 1, 2024. https://www.chicago.gov/city/en/sites/texas-new-arrivals/home/Dashboard.html
4. World Health Organization. Venezuela (Bolivarian Republic of): WHO and UNICEF estimates of immunization coverage: 2022 revision. Geneva, Switzerland: World Health Organization; 2023. https://immunizationdata.who.int/dashboard/regions/region-of-the-americas/VEN
5. Masters N, Holmdahl I, Miller P, et al. Real-time use of a dynamic model to measure the impact of public health interventions on measles outbreak size and duration—Chicago, Illinois, 2024. MMWR Morb Mortal Wkly Rep 2024;73:430–34. https://www.cdc.gov/mmwr/volumes/73/wr/mm7319a2.htm?s_cid=mm7319a2_w
6. Minta AA, Ferrari M, Antoni S, et al. Progress toward measles elimination—worldwide, 2000–2022. MMWR Morb Mortal Wkly Rep 2023;72:1262–8. https://doi.org/10.15585/mmwr.mm7246a3 PMID:37971951
7. Mathis AD, Raines K, Masters NB, et al. Measles–United States, January 1, 2020–March 28, 2024. MMWR Morb Mortal Wkly Rep 2024;73:295–300. https://doi.org/10.15585/mmwr.mm7314a1 PMID:38602886
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8. Fappani C, Gori M, Canuti M, et al. Breakthrough infections: a challenge towards measles elimination? Microorganisms 2022;10:1567. https://doi.org/10.3390/microorganisms10081567 PMID:36013985

9. Venkat H, Briggs G, Brady S, et al. Measles outbreak at a privately operated detention facility: Arizona, 2016. Clin Infect Dis 2019;68:2018–25. https://doi.org/10.1093/cid/ciy819 PMID:30256908

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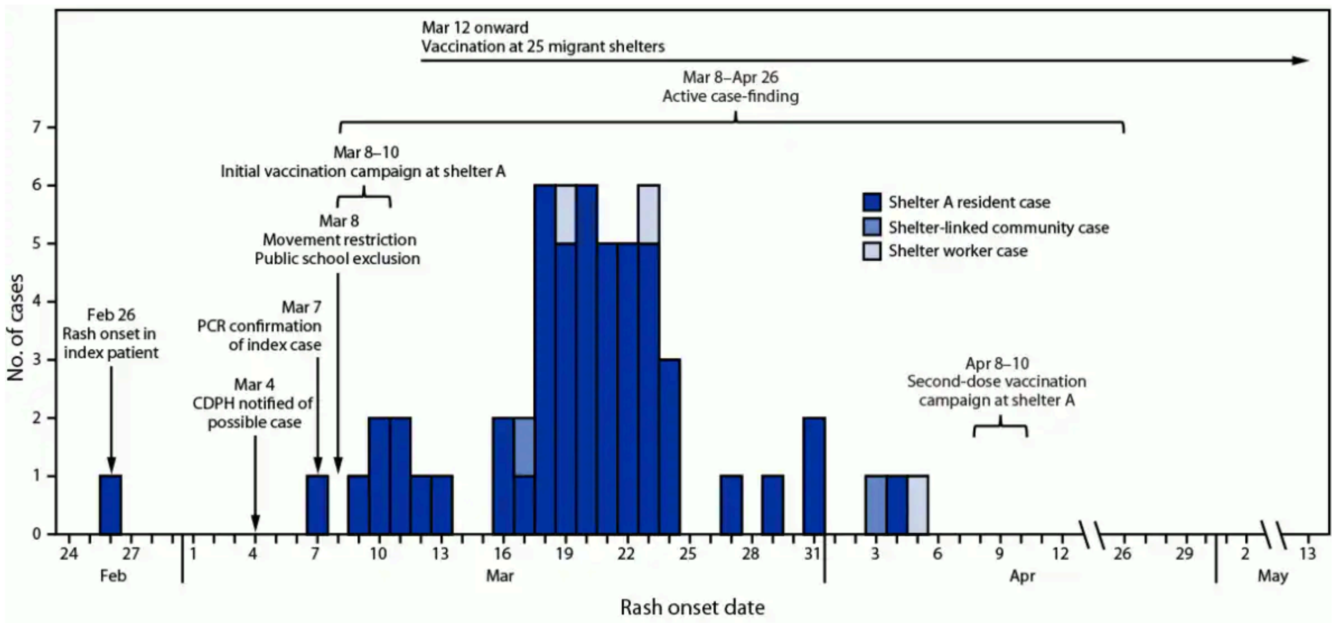
FIGURE. Measles cases associated with a migrant shelter (shelter A),* by rash onset date† and public health interventions§ — Chicago, Illinois, February 26–May 13, 2024



Abbreviations: CDPH = Chicago Department of Public Health; PCR = polymerase chain reaction.

* Shelter A resident cases were defined as those among persons exposed while residing at Shelter A. Shelter-linked community cases were defined as those among persons exposed outside of shelter A and epidemiologically linked to a case in a shelter A resident. Shelter worker cases were defined as those among persons exposed while working at shelter A.

† Two persons with unknown or no rash onset were included by symptom onset date.

§ Interventions included active case-finding, vaccination events, and movement restriction.

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TABLE. Characteristics* of persons with confirmed measles infections associated with a migrant shelter (N = 57) — Chicago, Illinois, February 26–May 13, 2024 Return

Characteristic	No. (%)
Sex	
Female	30 (53)
Male	27 (47)
Age group	
<6 mos	4 (7)
6 mos–4 yrs	29 (51)

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Characteristic	No. (%)
5–19 yrs	6 (11)
20–49 yrs	17 (30)
≥50 yrs	1 (2)
No. of verified measles vaccine doses received[†]	
1	12 (21)
≥2	4 (7)
None or unknown	41 (72)
Country of origin[§]	
Venezuela	43 (84)
Peru	4 (8)
Ecuador	2 (4)
Chile	1 (2)
Unknown	1 (2)
Shelter resident status	
Shelter A resident	52 (91)
Shelter worker	3 (5)
Shelter-linked community member	2 (4)

* Race data were reported as other or unknown for 25 (44%) persons; all were of Hispanic or Latino ethnicity.
[†] Occurred ≥21 days before rash onset.
[§] Documented as the country of last residence before beginning migration. One U.S.-born shelter resident and five nonshelter residents were excluded.

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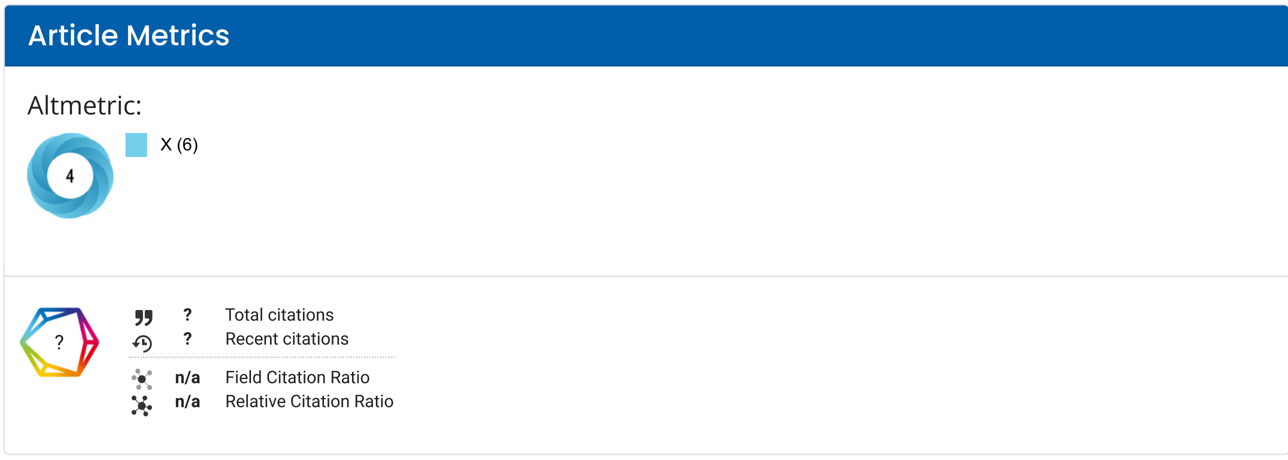

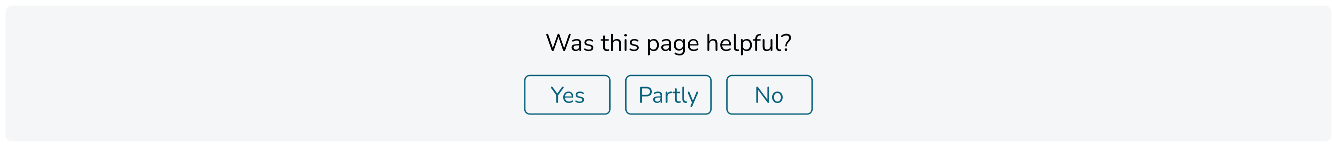

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