



**NOTICE OF A  
REGULAR JOINT MEETING OF THE  
CALOPTIMA HEALTH BOARD OF DIRECTORS'  
MEMBER ADVISORY COMMITTEE AND  
PROVIDER ADVISORY COMMITTEE**

**THURSDAY, JUNE 13, 2024**

**12:00 P.M.**

**CALOPTIMA HEALTH  
505 CITY PARKWAY WEST, SUITE 109  
ORANGE, CALIFORNIA 92868**

**AGENDA**

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form(s) identifying the item(s) and submit to the Clerk. To speak on a matter not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors' Member Advisory and Provider Advisory Committees, you may do so during Public Comments. Public Comment Request Forms must be submitted prior to the beginning of the Approval of the Minutes portion of the agenda and/or the beginning of Public Comments. When addressing the Committee, it is requested that you state your name for the record. Address the Committee as a whole through the Chair. Comments to individual Committee Members or staff are not permitted. Speakers are limited to three (3) minutes per item.

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 Board of Directors' Regular Member Advisory and Provider Advisory Committees joint 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](http://www.caloptima.org).

**Register to Participate via Zoom at: [https://us06web.zoom.us/webinar/register/WN\\_c-bnjr4TSSK3S286jBpazA](https://us06web.zoom.us/webinar/register/WN_c-bnjr4TSSK3S286jBpazA) and Join the Meeting.**

**Webinar ID: 812 8813 0037**

**Passcode: 701004 – Webinar instructions are provided below.**

1. **CALL TO ORDER**

*Pledge of Allegiance*

2. **ESTABLISH QUORUM**

3. **MINUTES**

A. [Approve Minutes from the April 11, 2024 Regular Joint Meeting of the Member and Provider Advisory Committees](#)

4. **PUBLIC COMMENT**

*At this time, members of the public may address the Member and Provider Advisory Committees on matters not appearing on the agenda, but within the subject matter jurisdiction of the Member or Provider Advisory Committees. Speakers will be limited to three (3) minutes.*

5. **REPORTS**

A. Consider Recommendation of Member Advisory Committee Slate of Candidates

B. Consider Recommendation of Provider Advisory Committee Slate of Candidates

6. **INFORMATIONAL ITEMS**

A. [OneCare Program](#)

B. [California Advancing and Innovating Medi-Cal \(CalAIM\) Update](#)

C. Committee Member Updates

7. **CEO and Management Reports**

A. [Chief Executive Officer Update](#)

B. Chief Operating Officer Update

C. [Chief Medical Officer Update](#)

8. **COMMITTEE MEMBER COMMENTS**

9. **ADJOURNMENT**

## Webinar Information

Please register for the Regular Member Advisory and Provider Advisory Committees Joint Meeting on Thursday, June 13, 2024 at 12:00 p.m. (PDT)

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

[https://us06web.zoom.us/webinar/register/WN\\_c-bnjr4TSSK3S286jBpazA](https://us06web.zoom.us/webinar/register/WN_c-bnjr4TSSK3S286jBpazA)

Join from a PC, Mac, iPad, iPhone or Android device

On day of meeting, please click this URL to join:

<https://us06web.zoom.us/j/81288130037?pwd=O1hRGXCDkFP7PzS0wqObSv9aIKI04.1>

Passcode: **701004**

Or One tap mobile:

+16694449171,,81288130037#,,,\*701004# US

+17193594580,,81288130037#,,,\*701004# US

Or join by phone:

Dial(for higher quality, dial a number based on your current location):

US: +1 669 444 9171 or +1 719 359 4580 or +1 720 707 2699 or +1 253 205 0468 or +1 253 215 8782 or +1 346 248 7799 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 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

Webinar ID: **812 8813 0037**

Passcode: **701004**

# MINUTES

## REGULAR JOINT MEETING OF THE CALOPTIMA HEALTH BOARD OF DIRECTORS' MEMBER ADVISORY COMMITTEE, AND PROVIDER ADVISORY COMMITTEE

**April 11, 2024**

A Regular Joint Meeting of the CalOptima Health Board of Directors' Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC) was held on Thursday, April 11, 2024 at the CalOptima offices located at 505 City Parkway West, Orange, California.

### **CALL TO ORDER**

MAC Chair Christine Tolbert called the meeting to order at 12:05 p.m. and PAC Chair Jena Jensen led the Pledge of Allegiance.

### **ESTABLISH QUORUM**

#### **Member Advisory Committee**

Members Present: Christine Tolbert, Chair; Hai Hoang, Vice-Chair; Linda Adair; Josefina Diaz; Sandy Finestone (remote); Keiko Gamez; Sara Lee; Lee Lombardo; Nicole Mastin; Margie Moore; Brian Nelson; Iliana Soto-Welty; Alyssa Vandenberg

Members Absent: Meredith Chillemi

#### **Provider Advisory Committee**

Members Present: Jena Jensen, Chair; Junie Lazo-Pearson, Ph.D., Vice Chair; Alpesh Amin, M.D (12:16 p.m.); Tina Bloomer, WHNP (12:16 p.m.); Jennie Choi, L.Ac; Gio Corzo (12:22 p.m.); Andrew Inglis, M.D.; Timothy Korber, M.D.; Mary Pham, Pharm.D; Alex Rossel; Christy Ward

Members Absent: Patty Mouton; John Nishimoto, O.D.; Jacob Sweidan, M.D.

Others Present: Michael Hunn, Chief Executive Officer; Richard Pitts, D.O., Ph.D, Chief Medical Officer; Donna Laverdiere, Executive Director, Strategic Development; Linda Lee, Executive Director, Quality Improvement; Tyronda Moses, Director, Grievance and Appeals; Javier Sanchez, Executive Director, Medicare; Troy Szabo, Outside Legal Counsel; Sharon Dwiers, Clerk of the Board; Cheryl Simmons, Staff to the Advisory Committees

## **MINUTES**

### **Approve the Minutes of the February 8, 2024 Regular Joint Meeting of the CalOptima Health Board of Directors' Member Advisory and Provider Advisory Committees**

**MAC Action:**     *On motion of Lee Lombardo, seconded and carried, the Committee approved the minutes of the February 8, 2024 Regular Joint Meeting by roll-call vote. (Motion carried 13-0-0; Member Chillemi absent)*

**PAC Action:**     *On motion of Christy Ward, seconded and carried, the Committee approved the minutes of the February 8, 2024 Regular Joint Meeting (Motion carried 8-0-0; Members Alpesh Amin, M.D.; Tina Bloomer; Gio Corzo; Patty Mouton; Jacob Sweidan, M.D., absent)*

## **PUBLIC COMMENTS**

There were no public comments.

## **REPORTS**

### **Consider Approval of MAC and PAC FY 2024-2025 Joint Meeting Schedule**

**MAC Action:**     *On motion of Hai Hoang and seconded the MAC approved the FY 2024-2025 Joint Meeting Schedule by roll-call vote. (Motion carried 13-0-0; Member Chillemi absent)*

**PAC Action:**     *On motion of Dr. Lazo-Pearson, seconded and carried, the Committee approved the minutes of the February 8, 2024 Regular Joint Meeting (Motion carried 8-0-0; Members Alpesh Amin, M.D.; Tina Bloomer; Gio Corzo; Patty Mouton; Jacob Sweidan, M.D., absent)*

## **INFORMATION ITEMS**

### **2023 CalOptima Health Quality Improvement Evaluation and 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan**

Linda Lee, Executive Director, Quality Improvement presented a summary of CalOptima Health's 2023 Quality Improvement Program and noted that for the ninth year in a row CalOptima Health had earned four out of five stars and was among the top-rated plans in the State of California for medical quality outcomes. Ms. Lee told the committees that Community Action Partnership of Orange County had presented CalOptima Health with an award for housing and food security program and the Eli Home presented its Humanitarian award for a contribution to serving abused and unhoused children and families. Ms. Lee reviewed the 2023 priority goals that were part of the quality

improvement evaluation. Ms. Lee also reviewed the 2024 Quality Improvement and Health Equity Transformation Program with the committees.

#### **Grievance and Appeals CY 2023 Review**

Tyronda Moses, Director, Grievance and Appeals presented a Grievance and Appeals CY 2023 Review and Member and Provider Trend report to the MAC and PAC. Ms. Moses reviewed the trends and actions taken for OneCare quality of care which included information on quality of care such as delays in treatment and reviewed actions taken throughout the year to address the quality-of-care issues for Orange County. Ms. Moses also reviewed second level provider disputes.

#### **FY 2025-2027 Strategic Plan Review**

Donal Laverdiere, Executive Director, Strategic Development presented on the FY 2025-2027 Strategic Plan draft and provided an overview of the refreshed FY 2025/2027 Strategic Plan. Ms. Laverdiere also reviewed the current FY 2023-2025 strategic priorities and asked the committees for their feedback on changes to the Mission and Vision statement. The committees were asked to review several items at the conclusion of the meeting and were asked to reply back to Ms. Laverdiere via email with their feedback.

#### **Committee Member Updates**

The MAC welcomed Margie Moore as the Medi-Cal Beneficiaries/Authorized Family Member Representative and Brian Nelson as the Social Services Agency Representative to the MAC.

The MAC and the PAC were both notified that the committee recruitment had been extended to April 19, 2024 and were reminded to please submit their applications if they had not already done so if they want to be considered for reappointment.

#### **ADJOURNMENT**

There being no further business before the Committees, PAC Chair Jena Jensen adjourned the meeting at 2:00 p.m.

/s/ Cheryl Simmons

Cheryl Simmons

Staff to the Advisory Committees

*Approved by MAC and PAC: June 13, 2024*



# Medicare and Medi-Cal in Orange County

Joint Member Advisory Committee and Provider Advisory Committee  
June 13, 2024

Cheryl Meronk, Director of Medicare Program Development

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CalOptima Health, A Public Agency

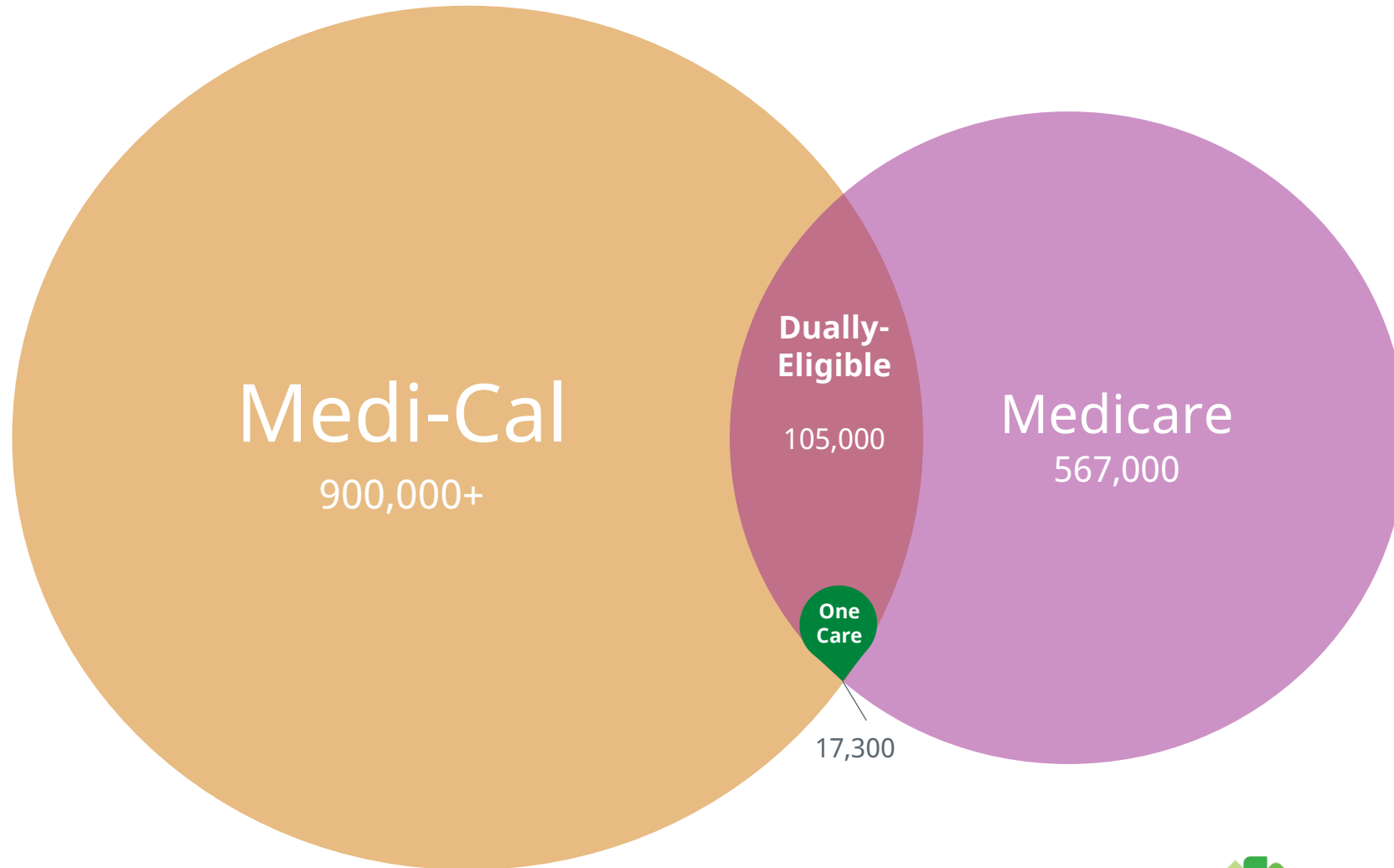
## Our Mission

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 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.

# OneCare Enrollment

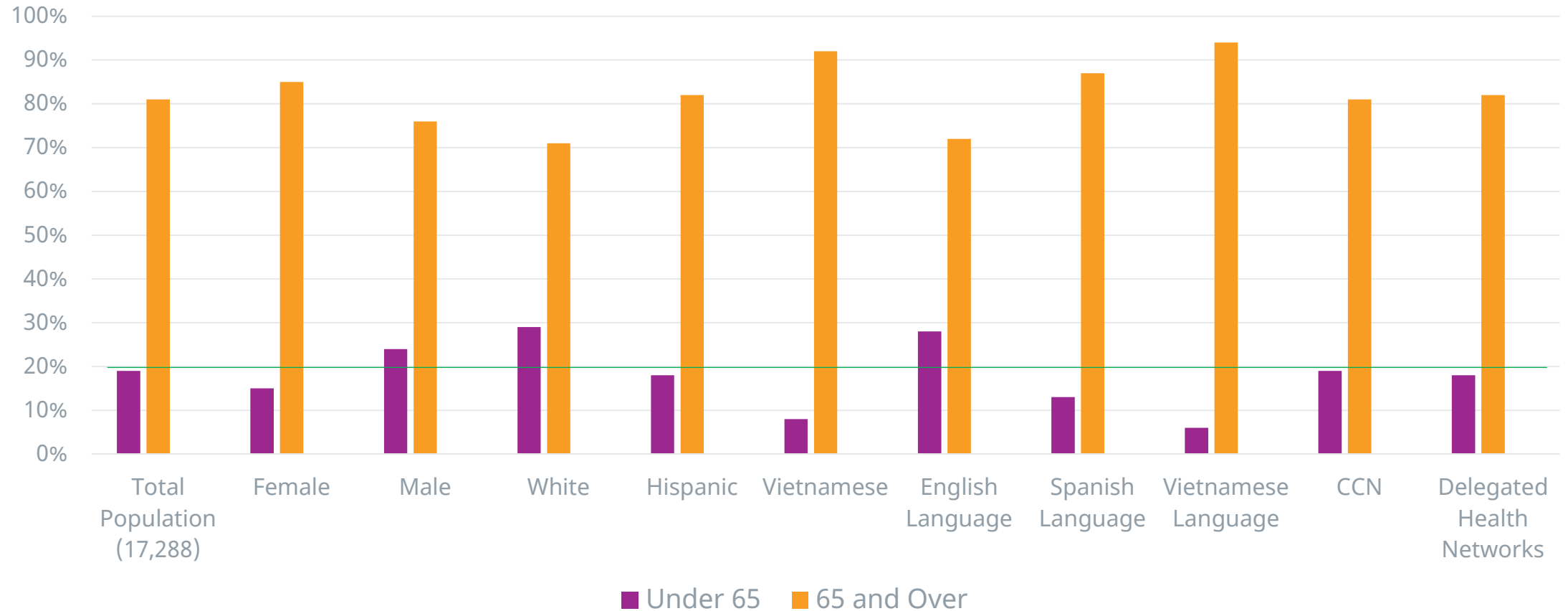
- CalOptima Health Medi-Cal members who become eligible for Medicare can enroll into OneCare and continue to receive services from CalOptima Health.
  - This includes eligible members aging out of Whole Child Model.
  - All Health Networks participate as OneCare networks, except CHOC.
  - The majority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

# OneCare and OneCare Connect

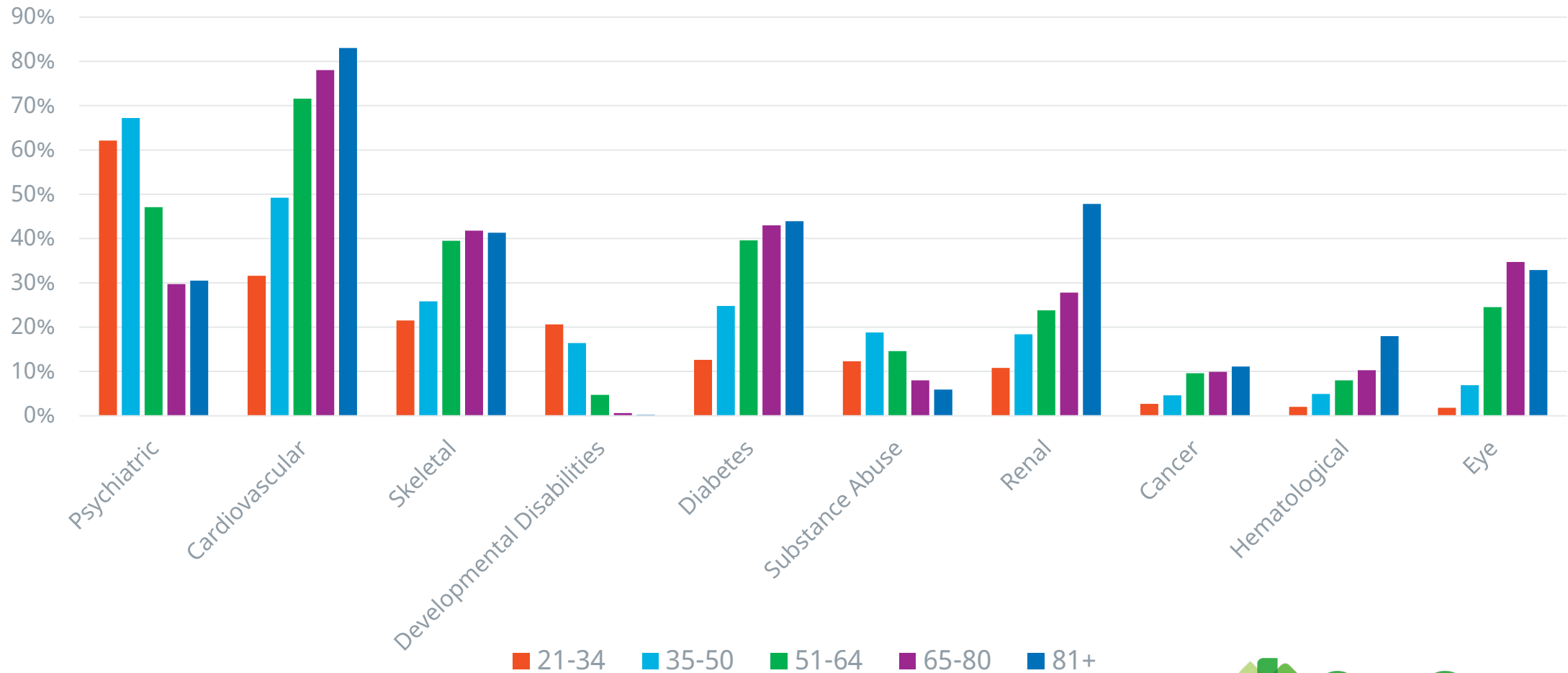
- CalOptima Health offered a plan called OneCare Connect from 2015-2022.
  - This was a pilot program that provided a high level of integration.
- OneCare is similar to OneCare Connect including the availability of Personal Care Coordinators, Supplemental Benefits, and Medi-Cal Wrap Around benefits.
  - 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.

# OneCare Population Overview

Age Distribution by Category



# OneCare Condition Prevalence by Age Groups



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# Care Coordination and Transitions

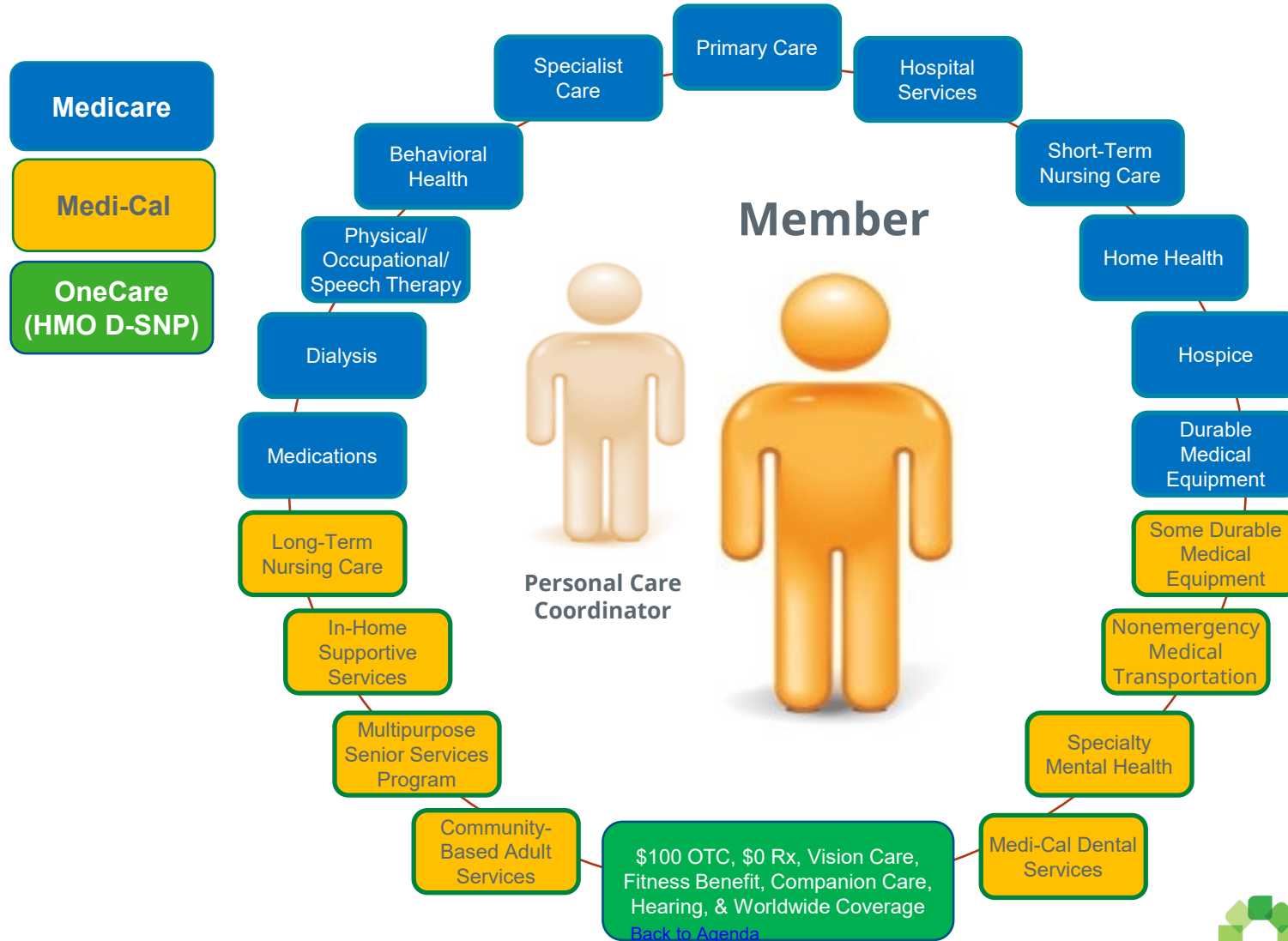
Hannah Kim, Director, Case Management

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# OneCare Care Coordination

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

# Integrated Benefits





# 2024 OneCare

Cheryl Meronk, Director of Medicare Program Development

# 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

# 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.



## Annual Physical Exam

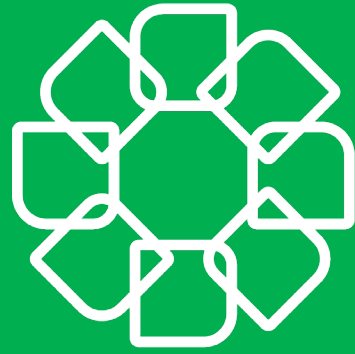
One physical exam per year.



## Dental Services

Dental care services provided by Medi-Cal Dental.

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# OneCare

CalOptima Health

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   @CalOptima



# CalOptima Health

## Member & Provider Advisory Committees

## CalAIM Update

### 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.

# CalAIM Timeline

- Medi-Cal Transformation will span a multi-year period, with the first reforms already underway effective January 1, 2022, and subsequent reforms to be phased in through 2027.
- All community supports and ECM populations of focus are live.

# Community Supports Highlights

- Launched all **14** Community Supports
- Contracted and onboarded **73** providers/vendors
- Provided over **48K** members with a CS service
- Helped house over **1,000** members
- Eliminated a wait-list for housing navigation services

# Enhanced Care Management (ECM) Highlights

- Completed 2 ECM Academy Cohorts
  - 3<sup>rd</sup> cohort to launch this Fall
- Contracted 50 ECM Providers
  - 30% Community Clinics
  - 57% Community Based Organizations
  - 13% Health Networks
- Provided over **5,000** members with ECM services



## Total Members Receiving CalAIM Services

**72,089**

# CalAIM Fast Facts



### Housing Transition Navigation Services

Members Served  
**7,099**

Months of Care Provided  
**33,878**



### Housing Deposits

Members Housed  
**2,676**

Dollars Distributed  
**4,085,610**



### Housing Tenancy and Sustaining Services

Members Served  
**2,186**

Months of Care Provided  
**15,897**



### Recuperative Care

Members Served  
**1,215**

Days of Care Provided  
**83,310**



### Medically Tailored Meals

Members Served  
**62,624**

Meals Provided  
**7,470,054**



### Post-Hospitalization Housing

Members Served  
**219**

Days of Housing Provided  
**16,986**



### Sobering Centers

Members Served  
**841**

Days of Care Provided  
**1,788**



### Personal Care/Homemaker Services

Members Served  
**1,089**

Hours of Care Provided  
**446,054**



### Day Habilitation Programs

Members Served  
**1160**

Hours of Care Provided  
**16,930**

## Other CalAIM Services

- Respite Services
- Environmental Accessibility
- Community Transition
- Asthma Remediation
- Nursing Facility Transition
- Enhanced Care Management

**Total Dollars  
Invested in CalAIM**

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**\$150,480,496**

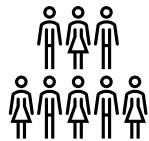


**CalOptima  
Health**

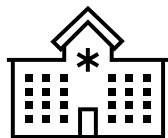
# Grant Partnership Highlights

- Housing and Homeless Incentive Program (HHIP) and Board designated dollars 99 grants totaling \$121M dollars
  - Equity
  - Capacity Building
  - Permanent Affordable Housing Development
  - System Change
  - Transitional housing Development
- Incentive Provider Program (IPP)
  - 63 grants totaling \$8.3M
  - Capacity building for ECM and community supports providers
  - Coming soon: CHW Academy

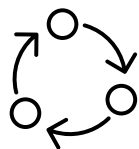
# 2024 and beyond...



Increase our CHW reach through the CHW Academy



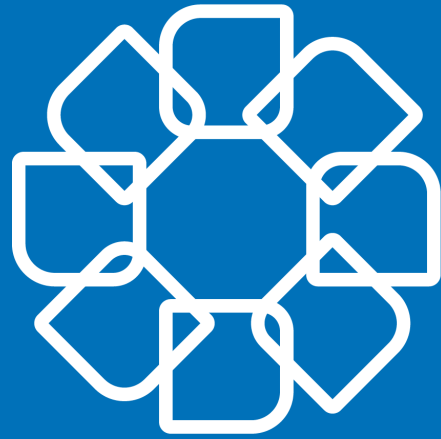
Work together with hospitals to link members to ECM



Integrate CalAIM services into our current operations.

# Questions?

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## MEMORANDUM

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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

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### **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

- 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](https://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.

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

**928,430**

\*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*
<b>Total Net Assets</b>	<b>\$1,943.8</b>

\*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 not 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		Language Preference		Medi-Cal Aid Category	
0 to 5	8%	English	55%	Temporary Assistance for Needy Families	39%
6 to 18	23%	Spanish	30%	Expansion	38%
19 to 44	36%	Vietnamese	9%	Optional Targeted Low-Income Children	7%
45 to 64	20%	Other	2%	Seniors	10%
65 +	13%	Korean	2%	People With Disabilities	5%
		Farsi	1%	Long-Term Care	<1%
		Chinese	<1%	Other	<1%
		Arabic	<1%		



# CalOptima Health

## 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.





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

# 58

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**58 → 132**

**First 4 months  
of 2024**



# 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

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### Vaccination Status

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

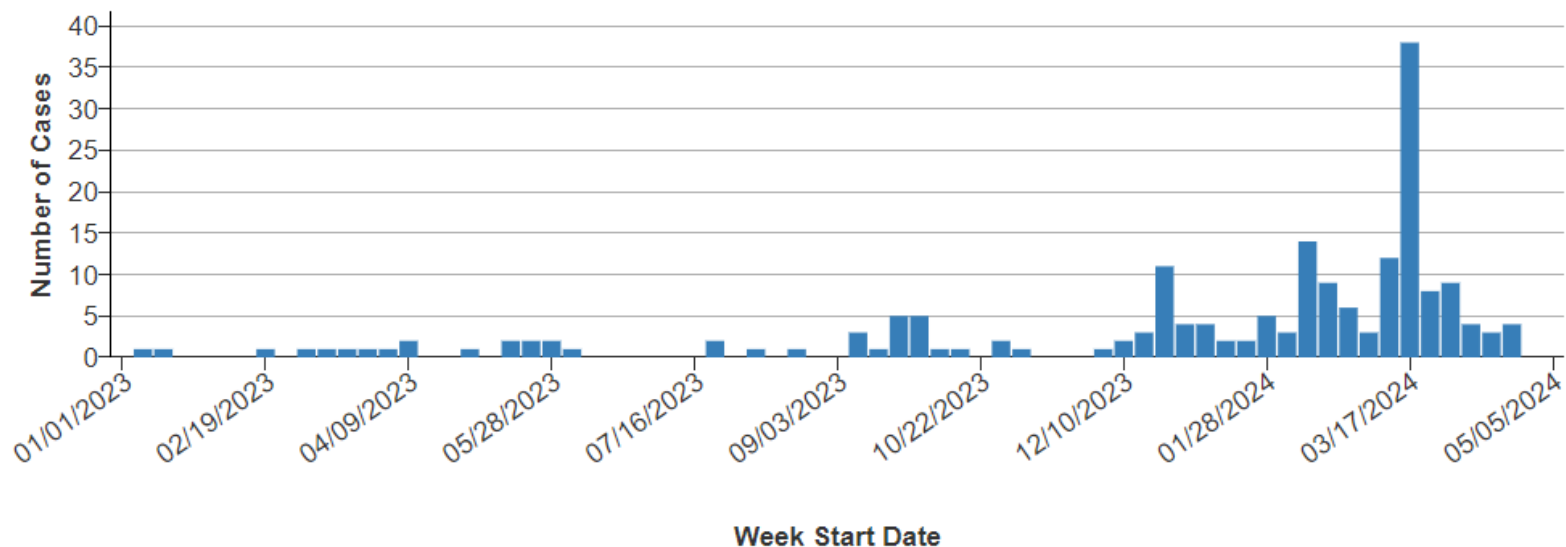
### Age

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

# CDC as of May 9<sup>th</sup> 2024

## Weekly Measles Cases by Rash Onset Date

2023-2024\* (as of May 9, 2024)



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

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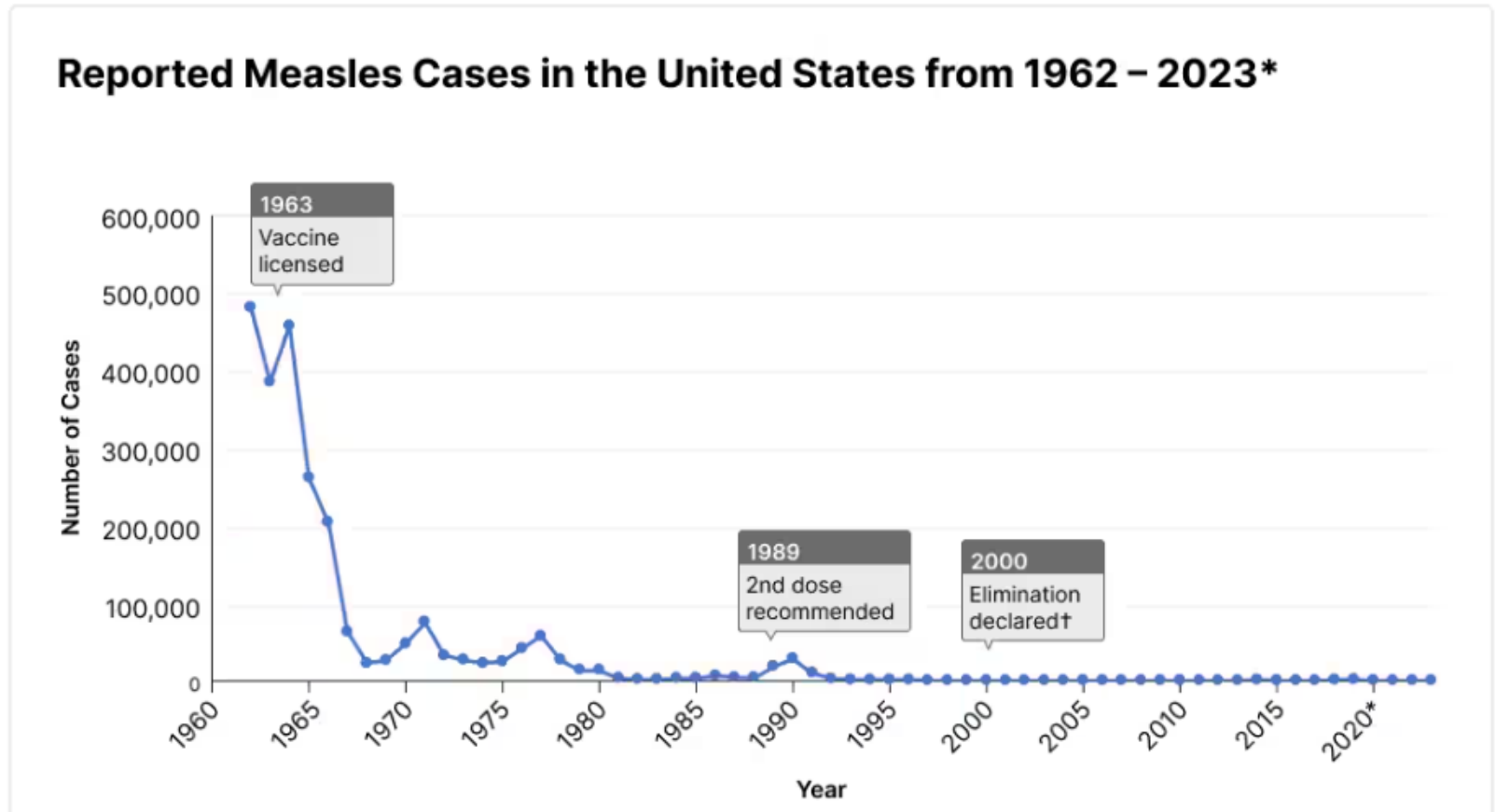
# Complications of measles

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

# 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

# Does Measles vaccine work?



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

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# Measles Cases in the US

**58 cases all of 2023**

**132 cases**

**First 4 months of  
2024**

# 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

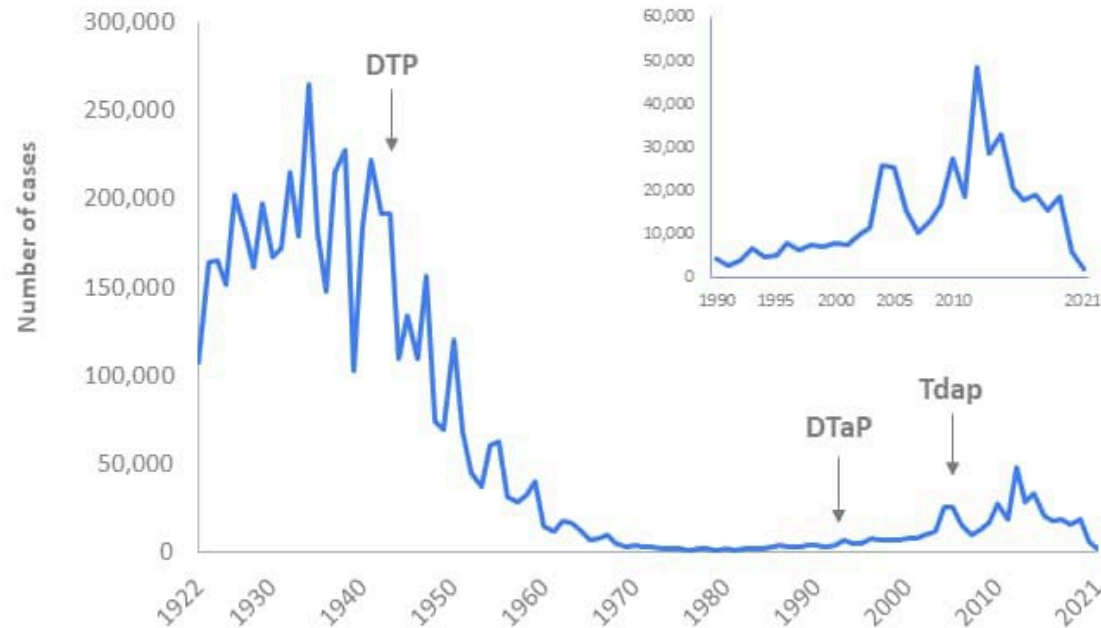


# Pertussis 2024 Outbreak

- < 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

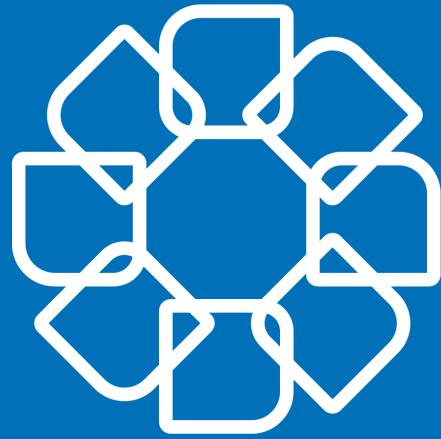
# Cases prior to VAX

## Reported NNDSS pertussis cases: 1922-2021



SOURCE: CDC, National Notifiable Diseases Surveillance System

1



# CalOptima Health

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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

## 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](#) 

Kimberly Gressick, MD<sup>1,2,\*</sup>; Amy Nham, PharmD<sup>1,2,\*</sup>; Thomas D. Filardo, MD<sup>3</sup>; Kendall Anderson, MS, MPH<sup>2</sup>; Stephanie R. Black, MD<sup>2</sup>; Katherine Boss, MPH<sup>2</sup>; Maribel Chavez-Torres, MPH<sup>2</sup>; Shelby Daniel-Wayman, MPH<sup>2</sup>; Peter DeJonge, PhD<sup>2,4</sup>; Emily Faherty, PhD<sup>1,2</sup>; Michelle Funk, DVM<sup>2</sup>; Janna Kerins, VMD<sup>2</sup>; Do Young Kim, MD<sup>2</sup>; Alyse Kittner, MPH<sup>2</sup>; Colin Korban, MPH<sup>2</sup>; Massimo Pacilli, MS, MPH<sup>2</sup>; Anne Schultz, MPH<sup>2</sup>; Alexander Sloboda, MD<sup>2</sup>; Shane Zelencik, MPH<sup>2</sup>; Arti Barnes, MD<sup>5</sup>; Joshua J. Geltz, PhD<sup>5</sup>; Jodi Morgan<sup>5</sup>; Kyran Quinlan, MD<sup>5</sup>; Heather Reid<sup>5</sup>; Kevin Chatham-Stephens, MD<sup>6</sup>; Tatiana M. Lanzieri, MD<sup>3</sup>; Jessica Leung, MPH<sup>3</sup>; Chelsea S. Lutz, PhD<sup>1,3</sup>; Ponesai Nyika, MPH<sup>1,6</sup>; Kelley Raines, MPH<sup>3</sup>; Sumathi Ramachandran, PhD<sup>3</sup>; Maria I. Rivera, MPH<sup>3</sup>; Jordan Singleton, MD<sup>1,7</sup>; Dennis Wang, MD<sup>1,7</sup>; Paul A. Rota, PhD<sup>3</sup>; David Sugerman, MD<sup>3</sup>; Stephanie Gretsck, MPH<sup>2</sup>; Brian F. Borah, MD<sup>2</sup>; Chicago Department of Public Health Measles Response Team (VIEW AUTHOR AFFILIATIONS)

[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  $\geq 1$  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  $\geq 1$  measles vaccine dose  $\geq 21$  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<sup>†</sup>; he had no recent travel or known exposure to measles. Upon confirmation of wild-type measles infection by measles vaccine assay (MeVA)<sup>§</sup> 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.<sup>¶</sup>

## 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  $\geq 6$  months without documentation of previous measles vaccination and residents aged  $\geq 1$  year who had received a first dose  $\geq 28$  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  $\geq 1$  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,<sup>55</sup> 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  $\geq 1$  dose of measles vaccine  $\geq 21$  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  $\leq 6$  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  $\geq 1$  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



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  $\geq 12$  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<sup>¶¶</sup> (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.

<sup>†</sup> 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.

<sup>§</sup> 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.

<sup>¶</sup> 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>

<sup>††</sup> Symptoms concerning for measles included fever, rash, cough, coryza, or conjunctivitis.

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

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

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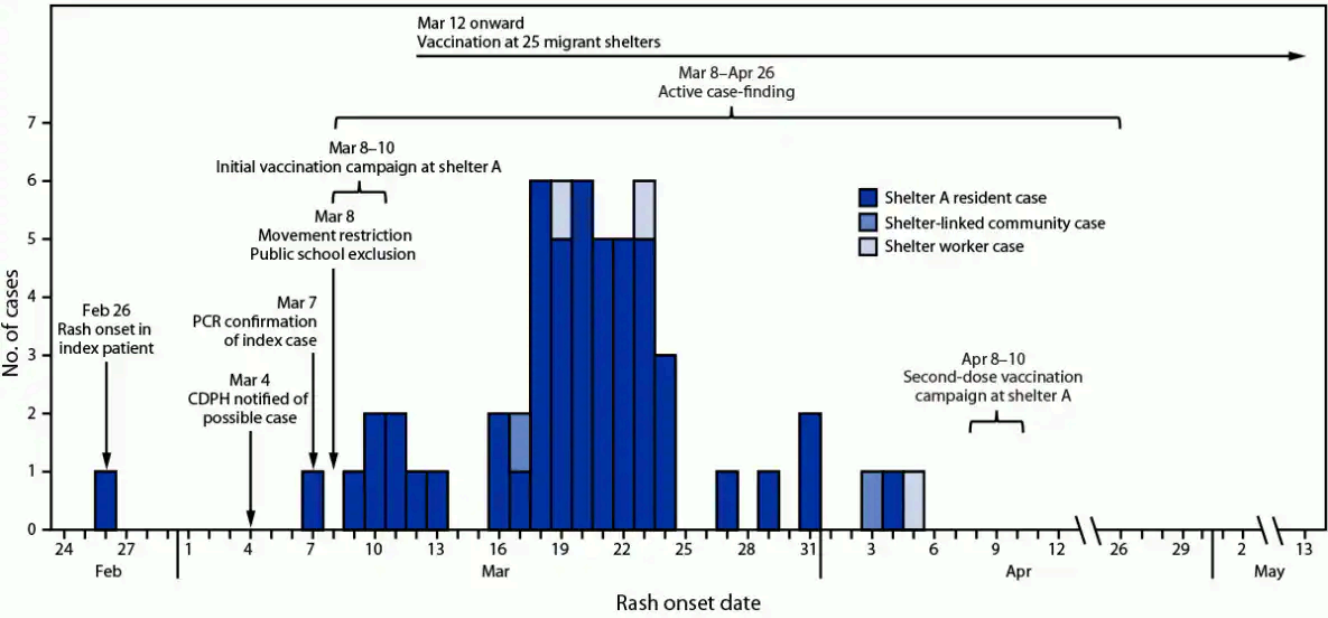
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**FIGURE. Measles cases associated with a migrant shelter (shelter A),\* by rash onset date† and public health interventions§ — Chicago, Illinois, February 26–May 13, 2024**



**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**

Characteristic	No. (%)
<b>Sex</b>	
Female	30 (53)
Male	27 (47)
<b>Age group</b>	
<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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