



A Public Agency

# CalOptima

Better. Together.

# Member Health Needs Assessment

Final Report

March 2018



# A LETTER FROM THE CEO

Because informal stories and casual anecdotes only tell so much, CalOptima has routinely sought insights about our member population through data. But the Member Health Needs Assessment (MHNA) you have in your hands is unique in our agency's 20-plus-year history. CalOptima has built upon existing data-gathering efforts and taken them much further.

The MHNA combines member surveys, focus groups, stakeholder interviews and provider surveys, and when brought together, the result is deeper insights about our members than we have had before. Yes, we knew that our low-income population struggles with concerns about food, transportation and work, but the MHNA makes clear the degree to which that affects their physical and mental health. Yes, we knew about members' challenges with navigating the complex health care system, but the MHNA shows how language and cultural barriers add another layer of difficulty. Again, having this data means CalOptima and the community can make more informed decisions about where to focus improvements.

There are many community organizations, providers and partners to thank for their support during this yearlong effort. Their names are listed in the back of the report. But truly the people to thank are the survey respondents and focus group participants — our members — more than 6,000 of them. They gave their time, shared their opinions and revealed their lives to us more than ever. You will read many of their candid comments on the pages ahead. Our members' honesty and trust mean a lot. We now intend to act on the information offered, and we will be pursuing ways to enhance the health care system and social services members rely on every day.

As champions of the MHNA effort, the CalOptima Board of Directors and I appreciate your interest in the report. We look forward to partnering with you as CalOptima strives to make positive changes for Orange County's most vulnerable residents.



Michael Schrader  
Chief Executive Officer

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# EXECUTIVE SUMMARY

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

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

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

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

## By the Numbers

**5,815**  
Surveys

**31**  
Focus Groups

**24**  
Stakeholder  
Interviews

**21**  
Provider  
Surveys

**10**  
Languages

**Birth–101**  
Years of Age

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

### The MHNA was designed to help CalOptima identify:

- 1 Unique needs and challenges of specific ethnic communities, including economic, social and environmental stressors, to improve health outcomes
- 2 Challenges to health care access and how to collaborate with community-based organizations and providers to address these barriers
- 3 Member awareness of CalOptima services and resources, and effective strategies to increase awareness as well as disseminate information within target populations
- 4 Ways to leverage outreach efforts by partnering with community-based organizations on strategic programs

## Our Partners

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

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

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



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

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

## More Comprehensive

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

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

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

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

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Hunger            | <input checked="" type="checkbox"/> Community engagement |
| <input checked="" type="checkbox"/> Child care        | <input checked="" type="checkbox"/> Family relationships |
| <input checked="" type="checkbox"/> Economic stress   | <input checked="" type="checkbox"/> Mental health        |
| <input checked="" type="checkbox"/> Housing status    | <input checked="" type="checkbox"/> Personal safety      |
| <input checked="" type="checkbox"/> Employment status | <input checked="" type="checkbox"/> Domestic violence    |
| <input checked="" type="checkbox"/> Physical activity | <input checked="" type="checkbox"/> Alcohol and drug use |

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

## More Engaging

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

### Member Survey

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

### Provider Survey

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

### Focus Groups

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

### Key Stakeholder Interviews

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

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

## More Personal

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

### Focus groups were held at:

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

## Methods

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

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

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

**Exhibit 1: Distribution of completed surveys and CalOptima population by language, region and age**

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

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

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

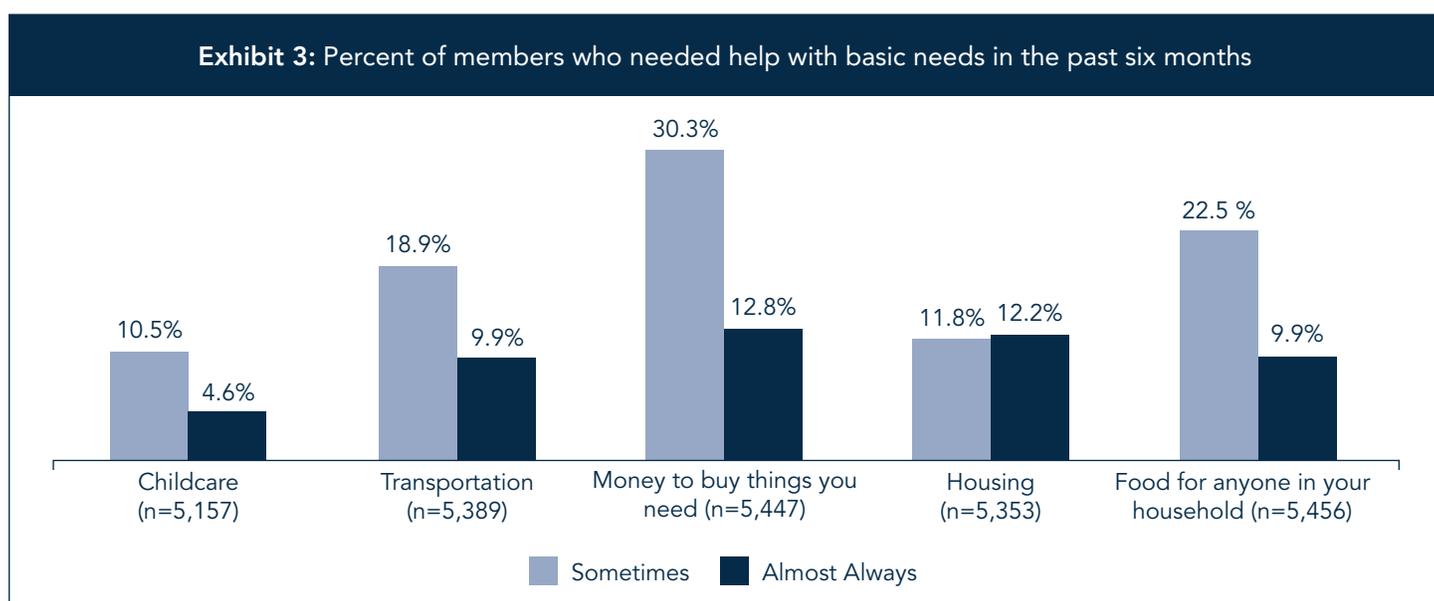
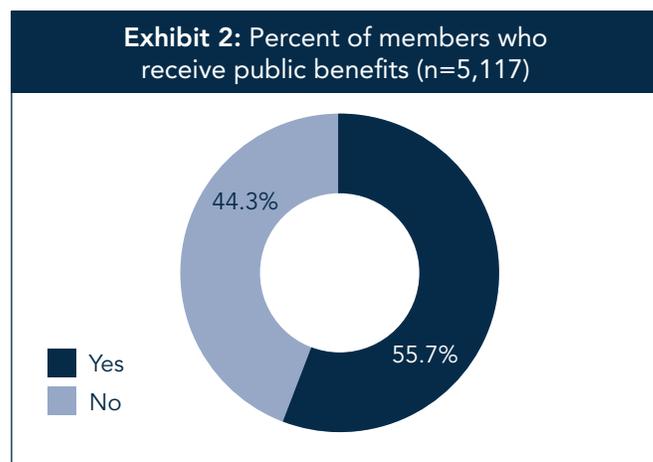
# KEY FINDINGS

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

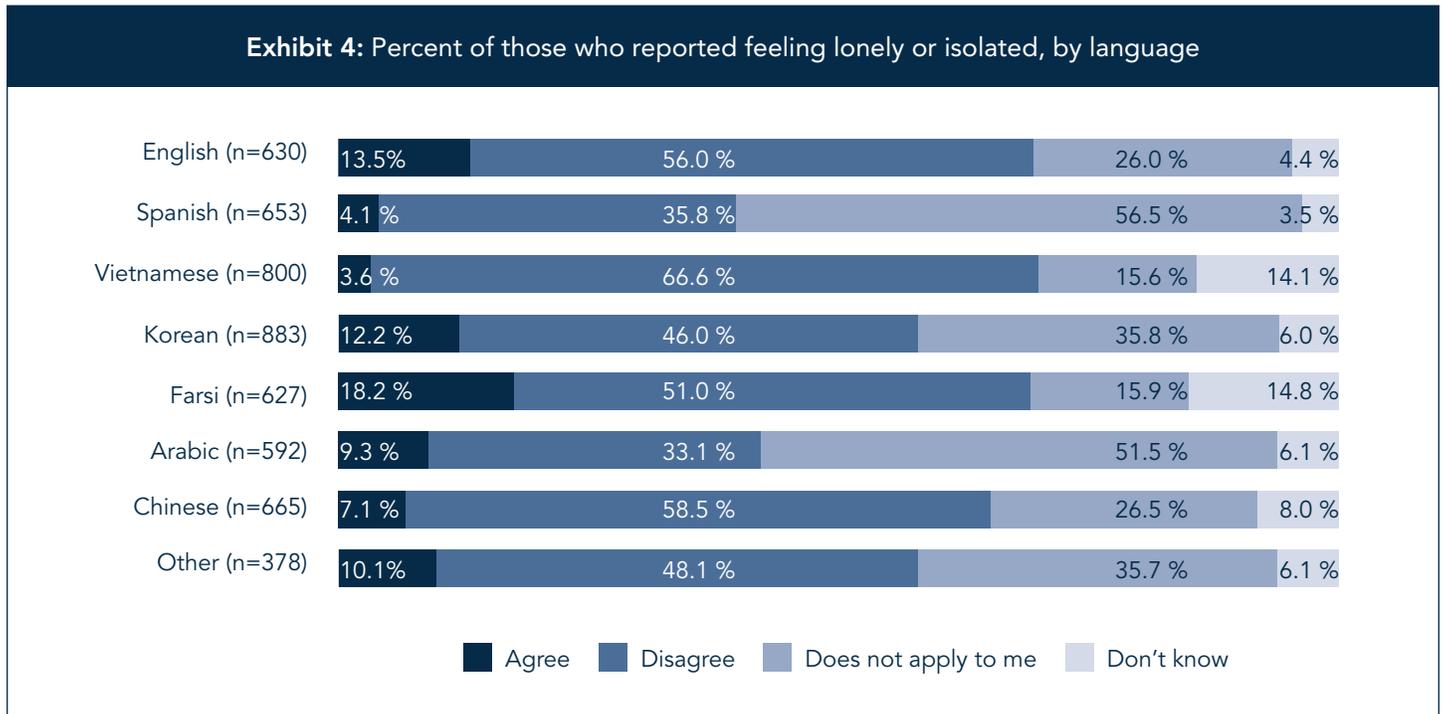
## KEY FINDING: SOCIAL DETERMINANTS OF HEALTH

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

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



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



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

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

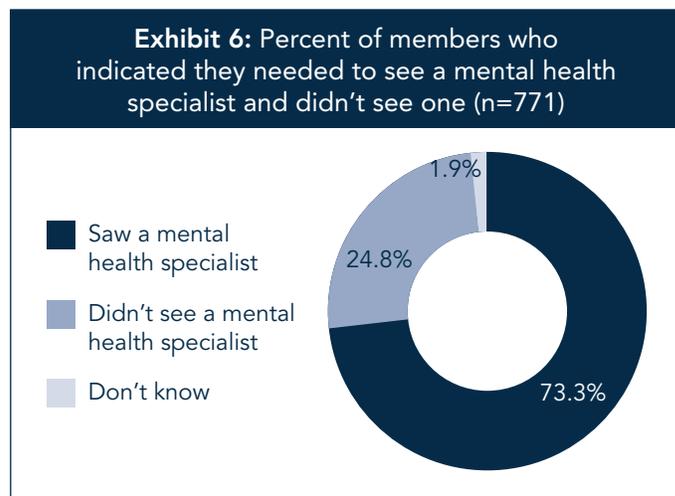
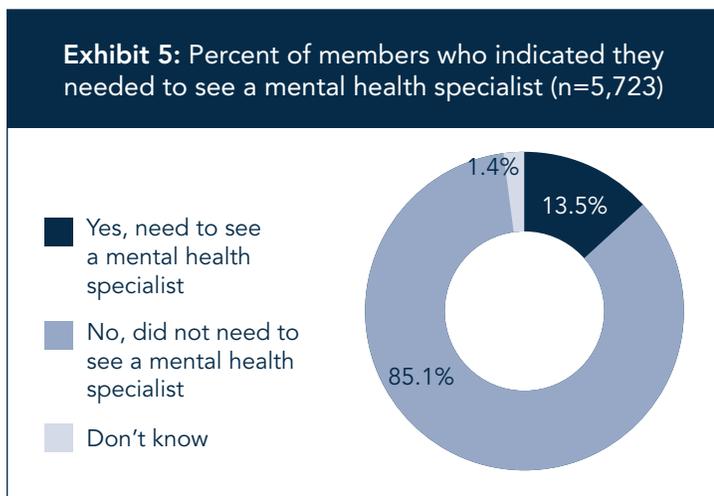
**Bright Spot:** CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health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

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

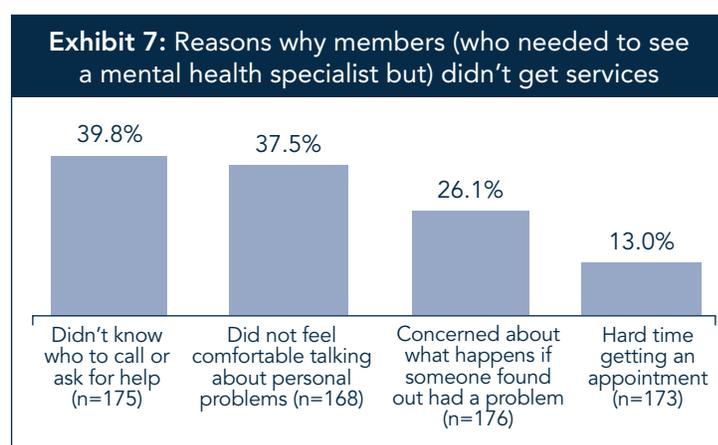
## KEY FINDING: MENTAL HEALTH

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

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



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



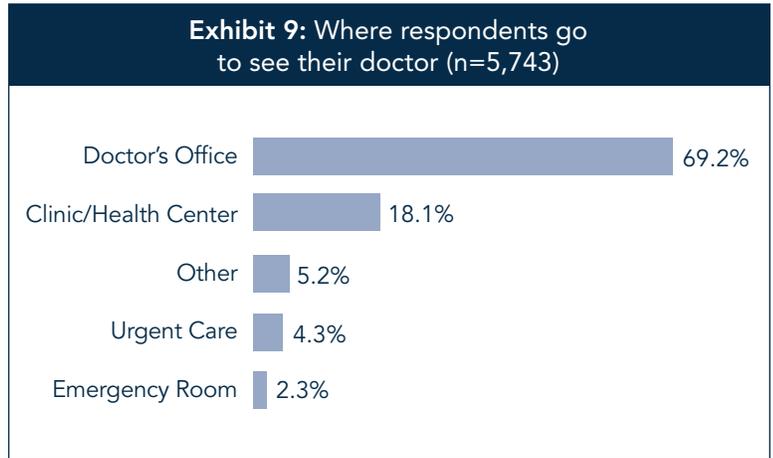
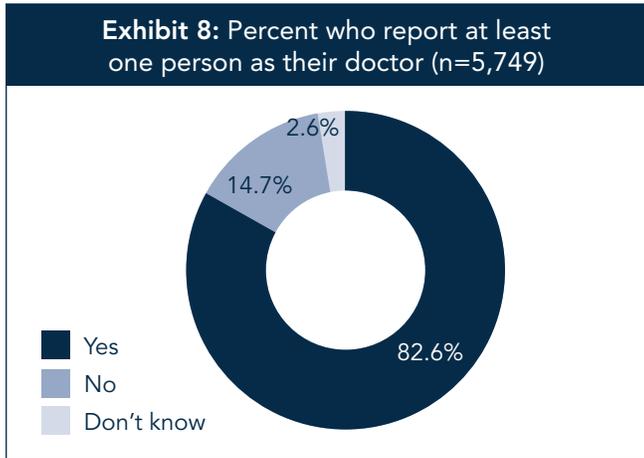
**Bright Spot:** CalOptima provides access to mental health services, which meets a clearly established need. Although members needing mental health services do not always connect with providers, many do not do so because of a lack of knowledge, an issue that can be addressed through strengthened connections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

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

## KEY FINDING: PRIMARY CARE

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

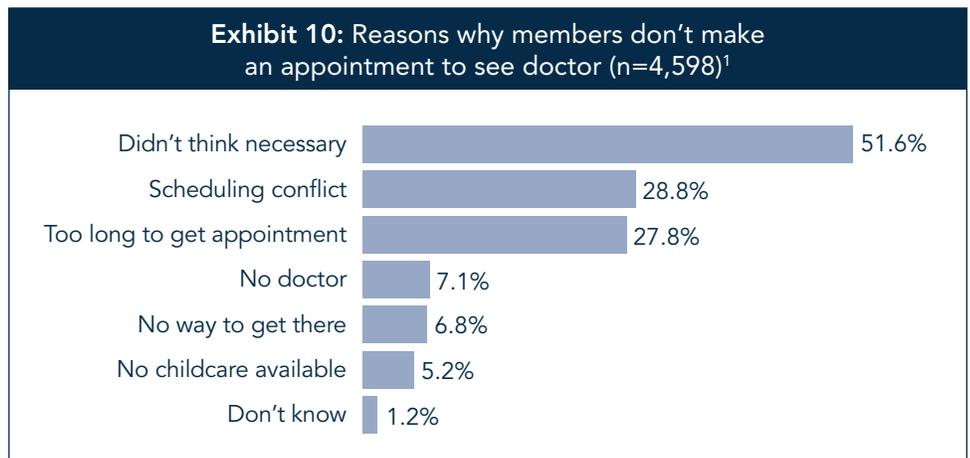
The majority of CalOptima members indicated that they are connected to at least one primary care doctor (82.6 percent), and most go to a doctor's office (69.2 percent) or clinic/health center (18.1 percent) when they need medical attention (Exhibits 8 and 9). However, navigating the health care system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



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

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

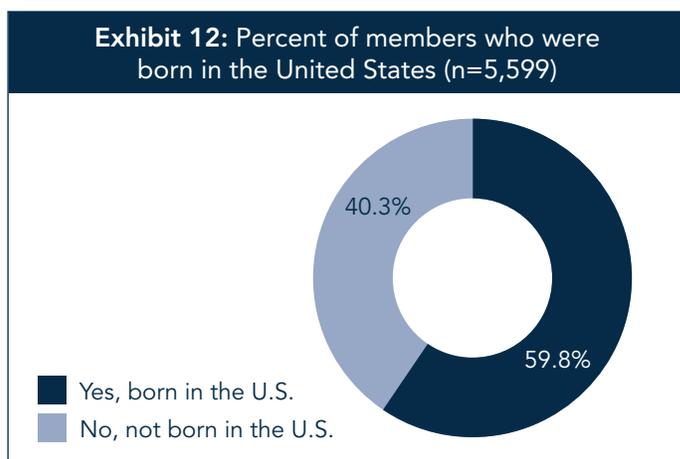
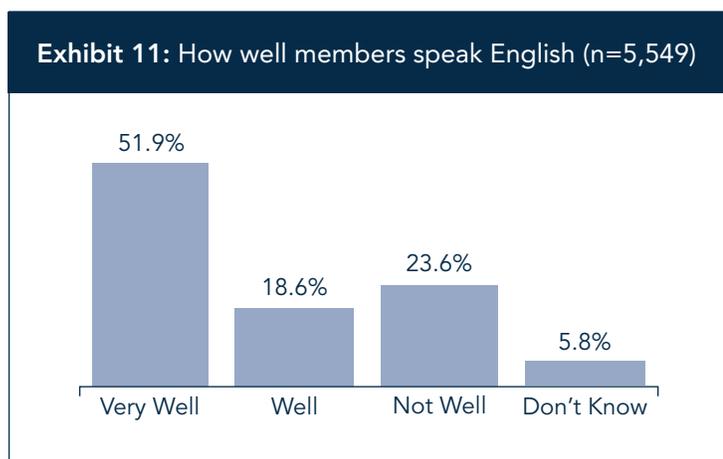
**Opportunity:** The challenge of maintaining a robust provider network never goes away, and CalOptima must carefully monitor members' access to care. The provider community may be ready to embrace innovations that enhance access, such as extended hours, weekend operations or telemedicine visits, to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



## KEY FINDING: PROVIDER ACCESS

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

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



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

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

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

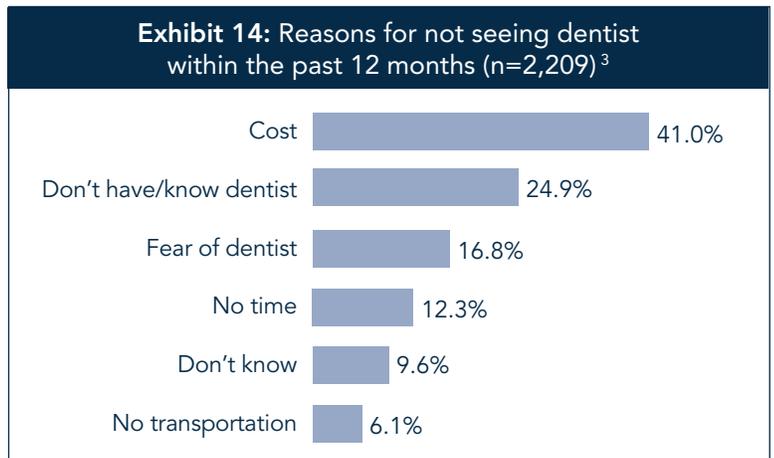
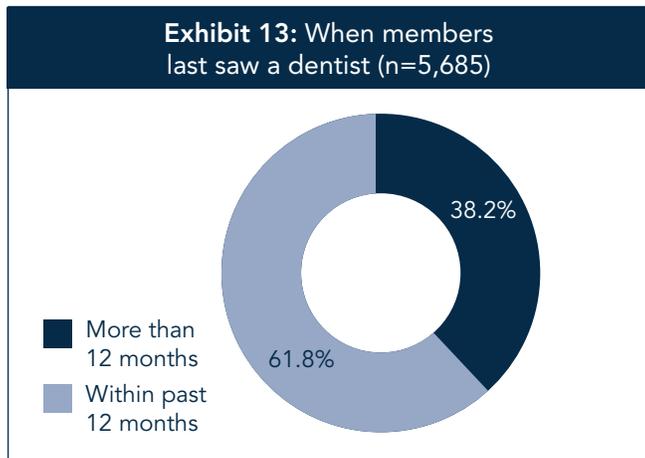
## KEY FINDING: DENTAL CARE

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

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

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

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





# MEMBER HEALTH NEEDS ASSESSMENT INTRODUCTION

In 2017, CalOptima recognized a need to develop a better understanding of the members it serves. CalOptima is a county-organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities in Orange County. Its mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima works closely with providers and community leaders to improve health care for members and the community. CalOptima participates in numerous efforts to assess the health of Orange County's residents and create community-driven plans for improving the health of the Medi-Cal population. These efforts have resulted in reports that provide an overall picture of health throughout Orange County, such as the following:

- **2013 Orange County Health Profile** shows key health indicators and social, economic and environmental indicators that impact health. Although Orange County's health indicators compare well to other county, state and national data, there are disparities in health conditions among groups of people based on economics, race, ethnicity, age and geography. The report includes more than 70 health and health-related indicators, such as life expectancy, obesity and housing status.
- **2017–19 Orange County Health Improvement Plan** outlines goals and strategies to address several priority areas: infant and child health, older adult health, obesity and diabetes, behavioral health, access to health care, oral health, and social determinants of health.
- **2017 Conditions of Children in Orange County Report** offers a comprehensive and detailed look at how children in Orange County are doing in the areas of health, economic well-being, educational achievement, and safe homes and communities.
- **2017 Orange County Community Indicators Report** tracks Orange County's health and prosperity. The report includes a core set of indicators on a range of topics that identify where the county is performing well and making progress, as well as where improvement is needed. Three topics that are pivotal to Orange County's future include children's mental health, housing and the opportunity gap.
- **2016 Orange County Older Adult Profile** provides an overview of the health and well-being of the older adult population in Orange County by highlighting key health, social and economic indicators. Notable areas of disparity and concern for the county's growing older adult population include income, housing and food insecurity; health insurance and access to geriatric specialists; chronic conditions and leading causes of death; age-related conditions and elder abuse; and mental health.

In addition, CalOptima periodically conducts assessments, such as the Group Needs Assessment, to identify the health risks, beliefs and practices of its Medi-Cal membership, as well as other reports and member satisfaction surveys. These reports provide a broad range of information about the nearly 800,000 CalOptima members throughout the county. However, such assessments focus almost exclusively on health outcomes of CalOptima members and lack detail about socioeconomic factors that impact members' health.

## As Orange County's largest health insurer, CalOptima provides coverage through four major programs.

- **Medi-Cal** (California's Medicaid Program) for low-income children, adults, seniors and people with disabilities
- **OneCare** (HMO SNP) (a Medicare Advantage Special Needs Plan) for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal
- **OneCare Connect** Cal MediConnect Plan (Medicare-Medicaid Plan) for people who qualify for both Medicare and Medi-Cal, combining Medicare and Medi-Cal benefits, adding supplemental benefits for vision, transportation and dental services, and providing comprehensive care coordination
- **Program of All-Inclusive Care for the Elderly** (PACE) for older adults, providing comprehensive health services through the CalOptima PACE center

In the context of this existing knowledge, the CalOptima Board of Directors wanted to conduct a comprehensive Member Health Needs Assessment (MHNA) that went beyond reports focusing on the county as a whole and general health conditions to examine barriers to access, gaps in service and disparities in health for CalOptima's diverse membership.

The goals of the MHNA were to:

- Understand the barriers and facilitators of physical and behavioral health that CalOptima members face
- Explore social and economic factors that affect health, such as housing, transportation and social isolation
- Focus the study on CalOptima's seven threshold language groups and ensure representation across the age spectrum

This report provides overall results from the needs assessment. The information in this report is intended to provide the CalOptima Board actionable recommendations to:

- Recognize and tailor opportunities specific to each ethnic community, with the goal of improving health outcomes
- Determine challenges to health care access, such as cultural values or beliefs
- Identify and establish opportunities for meaningful engagement regarding health and well-being, especially for underserved and difficult-to-reach populations
- Identify agencies and/or community-based organizations to leverage outreach efforts and/or to partner on programs

This report is also intended to be used as a resource for community-based organizations throughout Orange County. Community-based organizations can use this report to:

- Understand specific needs of Medi-Cal beneficiaries in Orange County
- Identify and implement recommendations that are applicable to the services they provide, including evidence-based practices
- Understand social, economic and environmental needs of their client population

## Overview of CalOptima Members

CalOptima has a diverse membership of nearly 800,000 members (Exhibit 15). Members are diverse demographically and linguistically, with the vast majority speaking one of seven threshold languages, most commonly English (56 percent), Spanish (29 percent) or Vietnamese (10 percent). In serving this population, CalOptima works to fulfill its mission of providing members with access to quality health care services delivered in a cost-effective and compassionate manner.

Providers surveyed identified a number of health problems (Exhibit 16) facing Medi-Cal beneficiaries like CalOptima members as most pressing, including obesity/overweight (72.7 percent), behavioral health issues (63.6 percent) and diabetes (40.9 percent). Moreover, nearly all surveyed providers reported that diabetes (90.9 percent) and obesity/overweight (90.9 percent) are “a big problem” (Exhibit 17). Though not ranked as high, about three-fourths of providers reported behavioral health issues (77.3 percent) as a “big problem.”

**Exhibit 15: Overview of CalOptima members**

**CalOptima Members**

**791,476**

**Age**

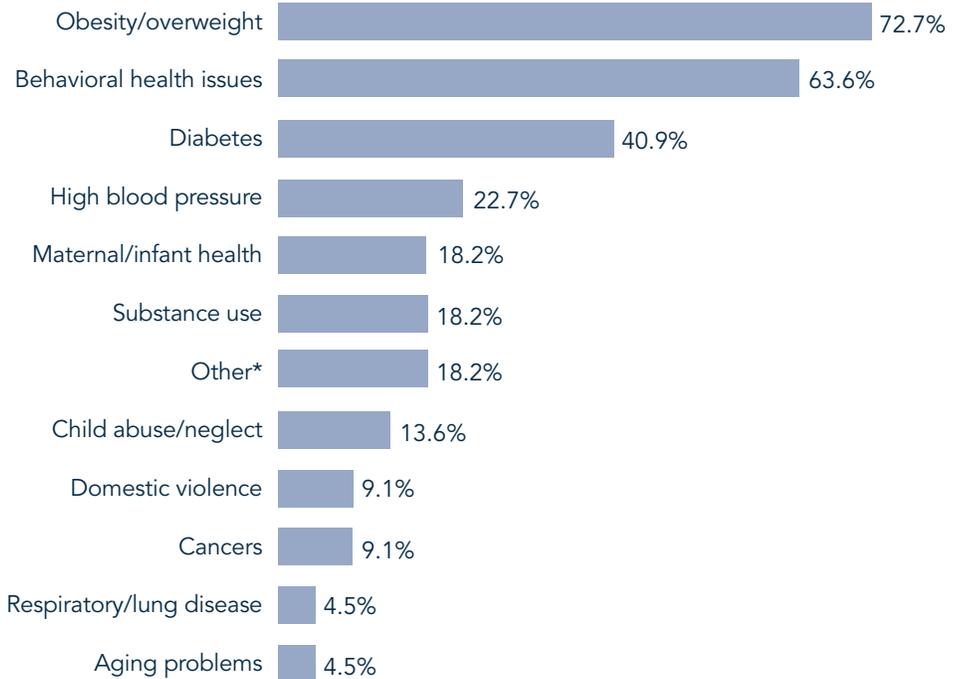
0-5	12%
6-18	30%
19-44	29%
45-64	18%
65+	11%

**Language Spoken**

English	56%
Spanish	29%
Vietnamese	10%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

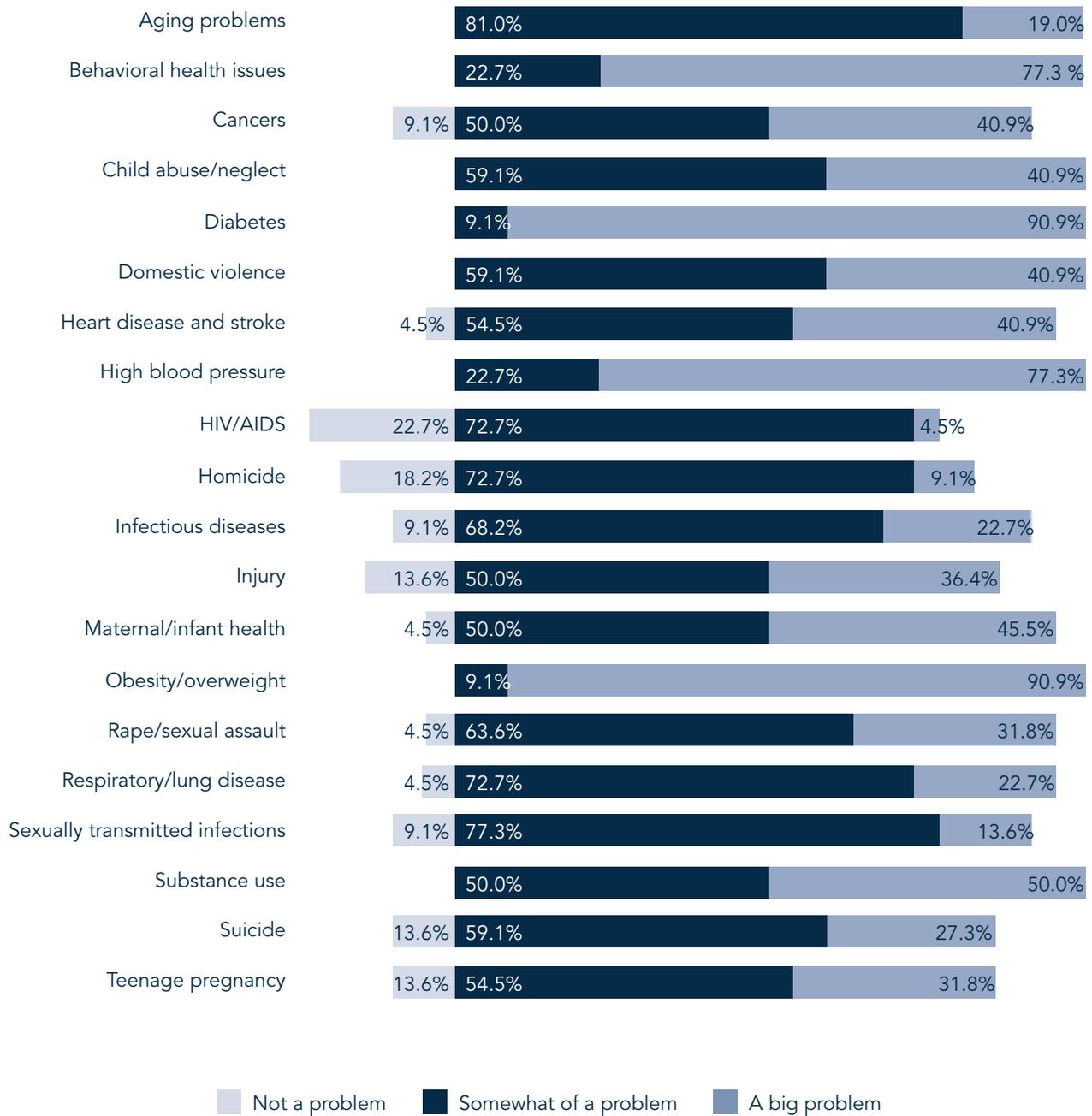
Data as of December 31, 2017

**Exhibit 16: Providers' reported important health problems facing Medi-Cal beneficiaries (n=22)**



\*Other includes all chronic but preventable diseases (obesity, type 2 diabetes, etc.) (n=1), autism and other developmental disorders (n=1), depression/anxiety (n=1) and trauma and mental health disorders (n=1).

**Exhibit 17: Providers' ranking of health problems for Medi-Cal beneficiaries (n=22)**



# METHODS

This study built upon existing information from other Orange County health reports and went a step further by designing an assessment that was comprehensive and by using engaging methods that resulted in a personal experience for CalOptima’s members and the community. The MHNA captures the unique and specific needs of CalOptima members from the perspective of providers, community members and, most importantly, members themselves. The following is a brief description of the data collection methods, including a member survey, provider survey, focus groups and key stakeholder interviews.

## The Evaluation Team

Working in close and regular collaboration with CalOptima staff and the MHNA Advisory Committee, Harder+Company Community Research (Harder+Company) conducted the MHNA in partnership with the Social Science Research Center (SSRC) at California State University, Fullerton. Harder+Company was founded in 1986 and works with philanthropic, nonprofit and public sector clients nationwide to reveal new insights about the nature and impact of their work. Harder+Company has a deep commitment to amplifying the voices of marginalized and underserved communities and working across sectors to promote lasting change. In addition, Harder+Company offers extensive experience working with health organizations to plan, evaluate and improve services for vulnerable populations, along with deep experience assisting hospitals, health departments and other health agencies on a variety of efforts, including conducting needs assessments, engaging and gathering meaningful input from community members, and using data for program development and implementation.

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



## Comprehensive Approach

This study provided a more comprehensive view of the needs of CalOptima members across Orange County by:

- Gathering responses from all geographic areas of Orange County
- Engaging members from all age groups
- Offering the member survey in seven languages
- Hosting focus group conversations in 10 languages
- Exploring issues that affect members' everyday lives, including:
  - ✓ Hunger
  - ✓ Child care
  - ✓ Economic stress
  - ✓ Housing status
  - ✓ Employment status
  - ✓ Physical activity
  - ✓ Community engagement
  - ✓ Family relationships
  - ✓ Mental health
  - ✓ Personal safety
  - ✓ Domestic violence
  - ✓ Alcohol and drug use

## Summary of Methods

The following is a brief overview of each method used in the MHNA.

**Member Survey.** A mixed-mode survey (mail, phone and online) was the cornerstone of the study and captured the perspectives of CalOptima's diverse membership. The survey included 51 questions about members' experiences with the health care system, housing and basic needs, mental health, and substance abuse.

The evaluation team developed a representative sample of CalOptima members to capture a breadth of perspectives, as well as to focus on the specific needs of key populations. The team planned to collect 4,000 surveys to ensure a representative sample of CalOptima members. The team purposefully over-sampled members designated as speaking one of the seven threshold languages to obtain 95 percent confidence that the true population parameters for any particular subgroup will fall between +/- 5 percent of the observed sample estimate. The team's comprehensive survey methods resulted in 5,815 surveys collected between September 1, 2017, and November 5, 2017, with 86 percent administered by mail and smaller proportions completed by phone (9.2 percent) and online (4.8 percent).

Exhibit 18 shows the breakdown of survey responses, by language, region and age. To achieve representation of all language groups, Vietnamese, Korean, Farsi, Arabic and Chinese speakers were oversampled and English and Spanish speakers were undersampled.

**Exhibit 18: Distribution of completed surveys and CalOptima population by language, region and age**

Language	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
English	658	11.3%	55.5%
Spanish	715	12.3%	28.6%
Vietnamese	981	16.9%	10.3%
Korean	940	16.2%	1.4%
Farsi	743	12.8%	1.1%
Arabic	648	11.1%	0.6%
Chinese	731	12.6%	0.5%
Other	399	6.9%	2.0%
Region	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
Central	2,315	39.8%	51.5%
North	1,947	33.5%	32.4%
South	1,538	26.4%	15.1%
Out of County	15	0.3%	1.0%
Age	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
0–18 years old	1,665	28.6%	41.8%
19–64 years old	2,453	42.2%	47.2%
65 or older	1,697	29.2%	10.9%

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

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

**Provider Survey.** The online provider survey was distributed to a broad sample of medical providers in the CalOptima network to capture the unique perspective they bring to understanding members’ health needs, as well as social determinants of health, existing assets and community strengths.

CalOptima shared the provider survey link via multiple platforms: CalOptima website, CalOptima provider portal, provider newsletters and fax communications. The link was shared with all providers who are part of the CalOptima system, which includes primary care physicians, specialists, hospitals and health networks.

A total of 22 providers completed the survey, many of which serve children (77.3 percent), immigrants (50 percent) or older adults (45.5 percent). The provider survey response rate was low, despite it having been distributed widely to CalOptima providers.

**Focus Groups.** The team conducted focus groups with community members from a variety of geographic areas, age and language groups, and demographic backgrounds. The purpose of the focus groups was to gather in-depth information and feedback from CalOptima’s member constituency.

A total of 31 focus groups were conducted in 10 different languages, targeting each threshold language and underrepresented groups, such as older adults and parents of children with disabilities. Approximately, 339 people attended the focus groups hosted by community partner organizations across Orange County.<sup>4</sup> Focus groups included perspectives from seniors, parents, adolescents with autism and individuals who have experienced homelessness. These various stakeholder groups allowed facilitators to hear from underrepresented communities about barriers to health care access and the needs of their community.

Focus groups were facilitated by Harder+Company staff, as well as staff from CalOptima, volunteers from the host organizations and students from SSRC, all of whom received training from Harder+Company. Community organizations recruited member participants and all participants received a modest incentive.

**Key Stakeholder Interviews.** CalOptima staff and the MHNA Advisory Committee members identified stakeholders who could provide insight into the health needs and barriers facing CalOptima members in various regions of Orange County. The team conducted 24 phone interviews with stakeholders from community-based organizations representing a variety of groups and interests (Exhibit 19).

**Exhibit 19: Key stakeholder interviewees, by type of organization (n=24)\***

Type of organization represented	Number of interviews completed
Social service provider	13
Advocacy organization	6
Health care provider	5
Public agency	4
CalOptima Board member	4
CalOptima customer service	1

*\*Stakeholders may appear in more than one category.*

## Personal Experience for Members

The MHNA aimed to give CalOptima members a more personal experience by hosting focus group conversations in familiar, comfortable locations at convenient times for members. Below is a list of locations where focus groups were held.

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

## Data Analysis

To identify major themes, the team coded and analyzed qualitative data from interviews and focus groups using Atlas, a software program for data analysis. The team entered quantitative data from the member and provider surveys and performed a quality check to determine the amount of missing data. Basic frequencies were initially computed for each question by language, region and age. To adjust for the oversampling built into the sampling frame, comprehensive analysis was then completed applying weights to each variable. Additional analysis using the Statistical Package for the Social Sciences (SPSS) included aggregating questions, construction of scale scores and cross-tabulations.

## Data Books

Additional data is available online for the member survey, provider survey and focus groups. These three data books are at [www.caloptima.org/communitygrants](http://www.caloptima.org/communitygrants).

# KEY FINDINGS

This report highlights key findings across the following five topic areas:

- **Social Determinants of Health:** Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.
- **Mental Health:** Lack of knowledge and fear of stigma are key barriers to using mental health services.
- **Primary Care:** Most members are connected to primary care, but barriers can make it challenging to receive timely care.
- **Provider Access:** Members are culturally diverse and want providers who both speak their language and understand their culture.
- **Dental Care:** Many members are not accessing dental care and are often unsure about what dental services are covered.

## How to Read this Report

Charts and graphs display member survey data estimates by language, age or region (unweighted data) and CalOptima population estimates (weighted data). Weighted data are adjusted for oversampling of certain populations and provide overall estimates for the entire CalOptima population. Unweighted data highlight responses for specific populations (e.g., Farsi speakers, older adults or North Orange County residents) and highlight nuances in the data for specific populations.

Each section highlights bright spots and opportunities. Bright spots are CalOptima and community-based resources that already serve to support health behaviors and outcomes, or favorable factors about members' attitudes or behaviors. CalOptima can nurture, leverage and build upon these assets. Opportunities are areas that CalOptima and its partners can strengthen to positively impact the health and well-being of members. Each section concludes with a brief sketch to focus on some of the key issues that members face. These summaries draw from member survey data, provider survey responses, and input from focus groups and key stakeholder interviews.

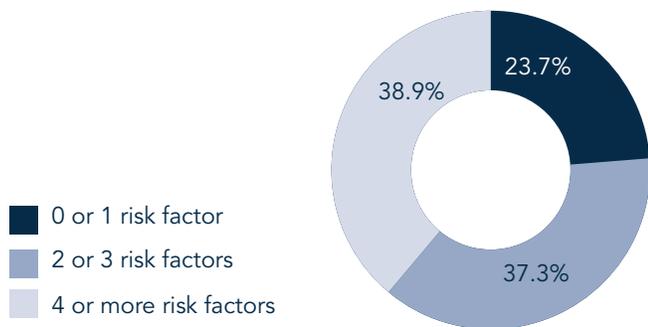
## KEY FINDING: SOCIAL DETERMINANTS OF HEALTH

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

Many overlapping factors and forces impact the health of individuals and communities. Economic, social and environmental influences can facilitate good health by enabling access to care, providing supportive networks, and encouraging positive health behaviors, among other pathways.<sup>5,6</sup> These determinants of health can also act as barriers if individuals or communities are poor or underresourced, people are socially isolated or feel unsafe, or environmental conditions are hindrances to healthy activities and behaviors.<sup>7</sup>

Members identified and discussed financial stressors, social isolation, and feeling unsafe and unstable in their homes and communities as important factors affecting their health. While these factors are discussed individually, many members experience overlapping and intersecting influences that can put their health at risk. To understand how multiple risk factors affect individual members, a scale was created aggregating responses across 16 questions on the member survey that assess financial need, feelings of safety, community connections and health behaviors. Investigation of this scale found that nearly one in four members (38.9 percent) faced four or more risk factors, more than one-third (37.3 percent) had two or three, and about one-quarter of members (23.7 percent) had one or no risk factors (Exhibit 20). Such analysis underscores the importance of considering the full universe of circumstances and situations that interact to impact health.

**Exhibit 20:** Number of risk factors for member survey respondents (n=4,145)



Both surveyed medical providers and interviewed community providers echoed members' concerns about health determinants. Nearly three-quarters of medical providers selected poverty as one of the top three social and economic problems affecting the health of Medi-Cal beneficiaries in Orange County. About one-third (31.8 percent) of medical providers selected homelessness as among their top three issues and just over one-quarter (27.3 percent) selected lack of healthy foods, reflecting that the connections among economic, social and environmental determinants and health are evident to many stakeholders.

## Risk Factor Scale

The following data points were used to create a risk factor score for each member who responded to the member survey:

- Food insecurity
- Drug use within the past 30 days
- Housing insecurity
- Alcohol use within the past 30 days
- Financial strain
- Member indicated he/she did not speak English well
- Unreliable transportation
- Member who is homeless or lives in a shelter or hotel
- Unmet need for childcare
- Member who is unable to work or out of work
- Feeling unsafe in the home
- Member with two or more jobs
- Feeling lonely and isolated
- Member with some high school or less education
- Member feels he/she is not treated equally because of ethnic and cultural background
- Member who was not born in the U.S. and has been living here less than two years

“All bills bring anxiety to the parents and that makes them deprive their children of other things. For example, because the rents are very expensive, we will be obliged to rent a house in an unsuitable and unhealthy place for the family so that we decrease the expenses a little bit.”

–Focus Group Participant

*\*Note: Quote translated from Arabic to English*

*Financial strain causes members to make difficult tradeoffs that can impact their health*

Economic insecurity and financial stress impact members' emotional and physical health and well-being. One community stakeholder described the toll of economic pressures, saying:

"I think that it's underreported, understudied. I don't think we realize how much stress impacts our overall health. There's a lot that our community is carrying on their shoulders because of their socioeconomic status, because of where they live, because of all the barriers to healthier lifestyles. There's not a lot being done proactively to increase health care. By the time that a physical issue manifests itself, it's somewhat too late to prevent. Obviously, we want to be there to manage going forward, but I would say that the stress would be the No. 1 issue that contributes to exacerbating the chance that they'll get diabetes and hypertension and all of these chronic conditions that come with that. I think if we were able to mitigate all of the other socioeconomic factors to get folks more peace, more hope, a more positive outlook on life, I think that folks would be able to better manage the situations that they deal with."

According to focus group participants, inadequate financial resources cause both stress and emotional strain and limit their ability to seek treatment. One Arabic-speaking focus group participant shared: "I can't go to a doctor to treat my psychological condition if I'm broke. He can't treat me unless he gives me money as a prescription."

To deal with stretched finances, many families described tradeoffs they make to stay within their budget. Housing is too expensive for many members, leading some to double up or triple up with other families or compromise housing quality for affordability. In addition, due to the high cost of fresh food options, many members buy more affordable fast food that they know is less healthy. One English-speaking CalOptima member shared:

"People are like, 'Just eat healthy.' It's not that easy. Food is really expensive. It's so expensive to go to the grocery store to buy food just for one meal, to cook for one night. There's five of us in my family. It's not convenient to go out every week and get groceries for a meal every night. It's not convenient for us whatsoever."

“When you don’t have money, everything is harder — even buying groceries. I need to work like a full-time job to find, to hunt those good deals. Sometimes I go to five different stores to buy healthy food.”

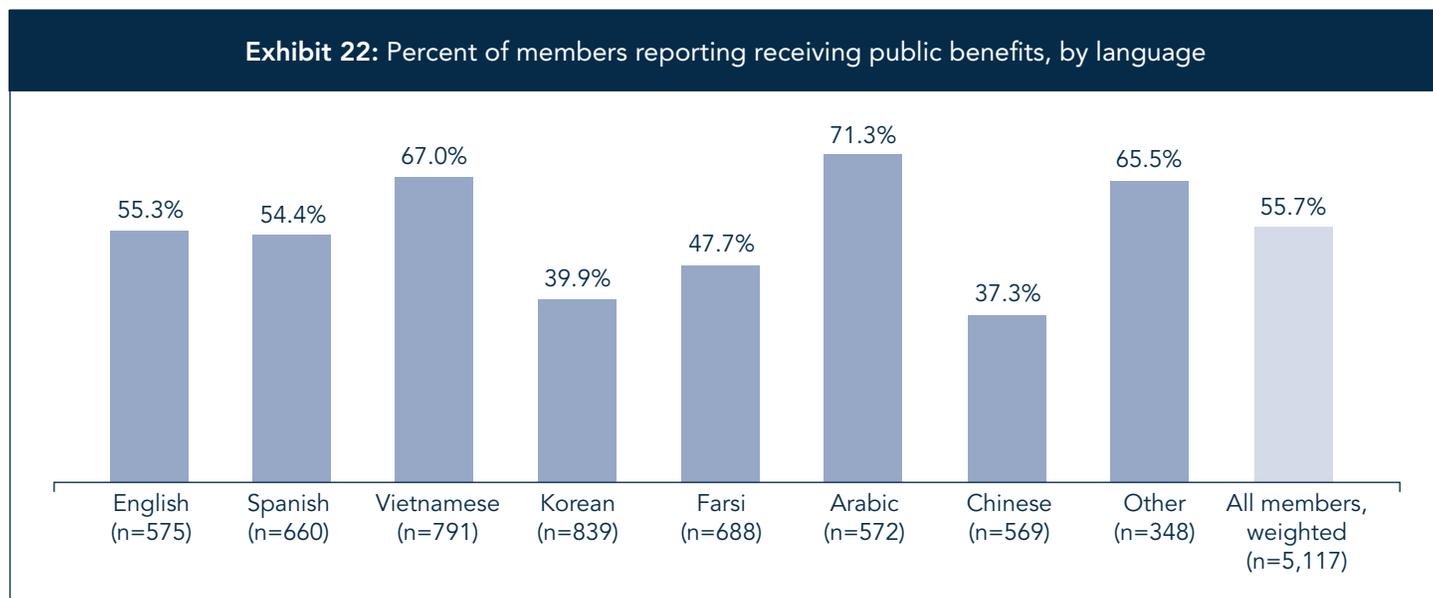
–Focus Group Participant

Member survey responses reflected these struggles. Based on the weighted CalOptima population estimate, nearly one-third reported needing help affording food either “sometimes” or “almost always” in the past six months (Exhibit 21). In addition, one-quarter of members reported needing help affording housing in the past six months either “sometimes” or “almost always,” including more than 40 percent of both Farsi- and Vietnamese-speaking respondents. More than 43 percent of members reported needing help with money to buy essentials, including more than half of Korean, Farsi and Arabic speakers. Nearly 29 percent of members reported needing help with transportation, including approximately 45 percent of Farsi speakers and speakers of other languages.

**Exhibit 21: Percent of members reporting needing help meeting basic needs “sometimes” or “always” in the past six months, by language**

	English Percent (n)	Spanish Percent (n)	Vietnamese Percent (n)	Korean Percent (n)	Farsi Percent (n)	Arabic Percent (n)	Chinese Percent (n)	Other Percent (n)	All members, weighted Percent (n)
Food	33.9% (631)	25.1% (666)	37.4% (819)	40.4% (832)	35.8% (632)	27.6% (580)	24.2% (644)	35.4% (373)	32.4% (5,456)
Housing	26.0% (627)	12.2% (637)	42.5% (804)	28.6% (789)	40.4% (629)	23.2% (577)	25.0% (644)	28.5% (361)	24.0% (5,353)
Money to buy things you need	47.8% (638)	30.8% (659)	46.3% (786)	58.7% (840)	54.6% (639)	54.9% (594)	32.3% (643)	47.8% (370)	43.1% (5,447)
Transportation	29.3% (629)	24.3% (650)	37.6% (792)	37.4% (805)	45.3% (631)	35.0% (589)	36.5% (668)	44.4% (376)	28.8% (5,389)

Reflecting members' expressed need for support meeting basic needs, many receive support from public assistance programs. Based on the weighted CalOptima population estimate, more than half (55.7 percent) of all members report receiving public benefits, including more than two-thirds of Vietnamese and Arabic speakers and speakers of other languages (Exhibit 22). These benefits include CalFresh, Temporary Assistance for Needy Families, CalWORKS, Supplemental Security Income, Social Security Disability Insurance, and Women, Infants and Children.



While 44 percent of working-age members are employed, many other members struggle with the financial and emotional stress of unemployment and overwork (Exhibit 23).

**Exhibit 23: Member employment status, by age**

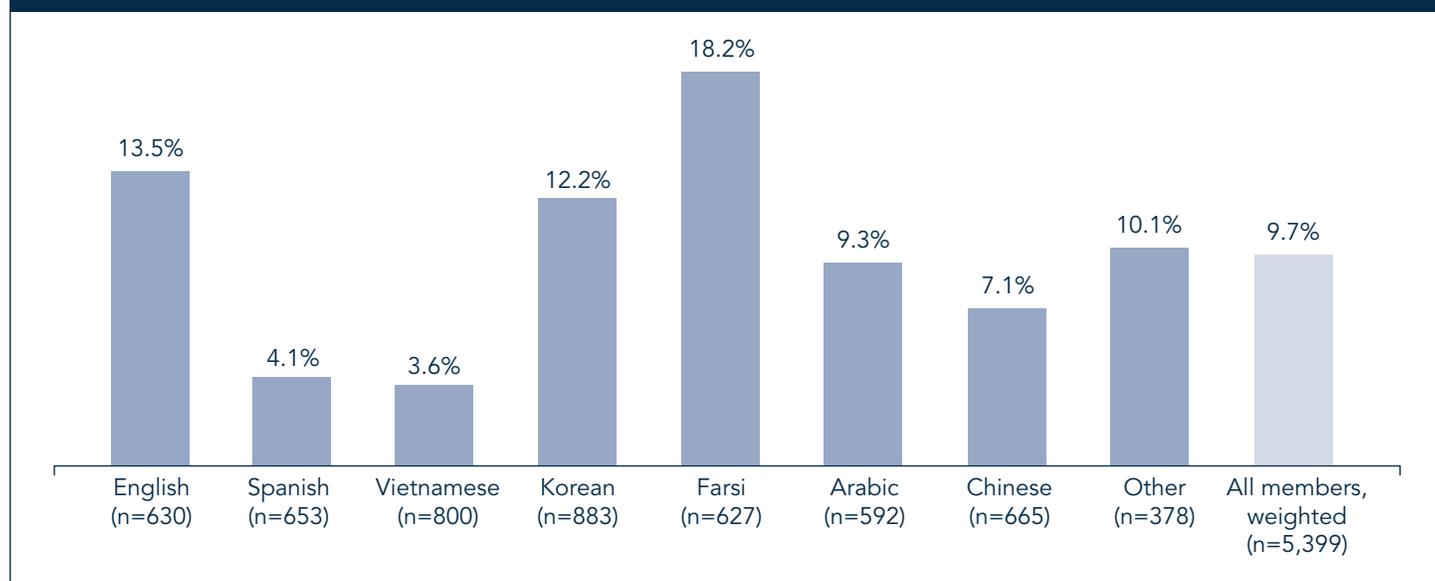
Age	Employed	Self-employed	Homemaker	Student	Retired	Out of work	Unable to work	Total
19–64	35.8%	8.3%	17.5%	10.9%	5.9%	17.6%	15.3%	2,370
65 and older	4.1%	1.7%	10.1%	0.7%	53.7%	10.5%	33.3%	1,601
All members, weighted <sup>8</sup>	34.5%	8.3%	9.5%	8.6%	13.9%	16.6%	21.3%	3,244

Taken together, one-third of members 19 years of age or older report that they are out of work or unable to work. In addition, of those who are employed, 14 percent report working two or more jobs, and 10 percent report working more than 40 hours per week. Focus group participants discussed the impact of unemployment and underemployment, and working multiple jobs to make ends meet, on their emotional and physical health, linking unemployment to idleness and loneliness, and overwork to mental and physical exhaustion.

*Social isolation and lack of community connections can lead to feelings of depression and disengagement from needed care and services*

While positive family and community networks can support overall health, social isolation and lacking a sense of belonging in the community can negatively affect mental and physical health. A number of overlapping factors can lead to feelings of isolation and loneliness, even within a supportive community. Members and community stakeholders described language barriers, immigration status, age, ability and sexual orientation as contributors to their sense of isolation. For example, 18.2 percent of Farsi speakers responding to the member survey reported feeling lonely or isolated, along with 12.2 percent of Korean speakers and nearly 14 percent of English speakers (Exhibit 24). When looking at the CalOptima population as a whole, the weighted population estimate indicates that nearly 10 percent of members feel lonely or isolated.

**Exhibit 24:** Percent of members reporting feeling lonely or isolated, by language



Community members described how such feelings of being disconnected from the community can lead to depression, lack of follow-up with a doctor when they are in need of care and negative health behaviors. When speaking about youth in non-English-speaking families, one community stakeholder shared: “When it comes to individuals who are struggling with substance abuse or gambling, you usually see the younger generation often is kind of a lost generation. They feel unaccepted. They feel unsupported. They feel misunderstood.” A second community provider shared similar concerns about young people in immigrant families adjusting to life in their communities: “The lifestyle is different here than from the islands, and [it causes trouble] if they’re not able to talk about it or befriend someone to share that concern. Depression is very prominent among ... the young, as we increase stress on our young. I think that’s a major concern.”

Older adults, especially those living alone and non-English speakers, echoed feelings of isolation and disconnection. Across age groups, community members also identified self-imposed isolation linked to immigration status as a factor that can negatively impact health. One community provider described how some undocumented residents can be largely invisible: “Shame and stigma also [affect] the undocumented population we just don’t know. We have estimates, but unlike other communities that are very open about their undocumented population, the undocumented just don’t come forward in the Asian community.”

In focus groups, community members linked immigration status to stress and identified it as a barrier to accessing care. Community stakeholders also discussed this barrier, with one stakeholder sharing:

“We get a lot of people who are in need of mental health services or medical care, and they are not willing to reach out because they’re afraid of deportation, and especially in our county where that’s a significant issue as far as illegal immigration. I think our political climate over the past six or seven months has greatly impacted people’s willingness to reach out to services, even if they have [papers]. That’s definitely an issue here in this county.”

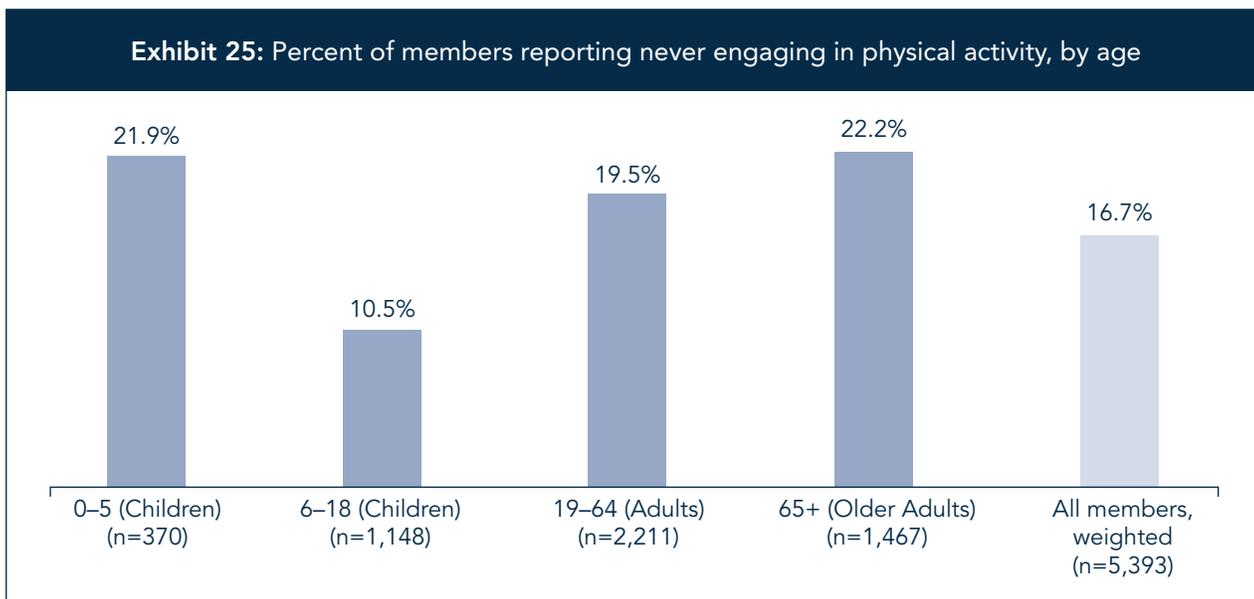
*Concerns about affordable and safe housing options are top of mind for members and providers*

Unsafe homes and neighborhoods and poor housing conditions are among the environmental factors impacting members’ health. For some members, the sense of being disconnected from their community included not only feelings of loneliness but fear as well. Members described concerns about and experiences of verbal and physical abuse at home, at school, in the community and online. Focus group participants discussed feeling unsafe in their environment because of homophobia, racism, anti-immigrant sentiment and gang violence. Along with community stakeholders, focus group participants recognized the complicated social factors that can spur violence and keep it hidden. Several stakeholder interviewees and focus group participants shared that economic frustrations, particularly within immigrant communities, were a catalyst for abuse within families, while economic dependence on one breadwinner made family members hesitant to report abuse.

In addition to the direct impacts abuse and violence have on mental and physical health, members described how the general sense of fear in neighborhoods was a major barrier to getting outside to exercise. Community members identified a lack of accessible, family-friendly parks as a key barrier to outdoor activity and exercise. One Spanish-speaking parent shared, “It’s difficult to go out with our children, and if we want to go to a park, we have to go by car because there are very few parks in our community.” In focus group conversations, parents were concerned about their children playing in busy streets full of cars and in parks they did not feel were safe (if any existed nearby). Community stakeholders echoed these sentiments. One stakeholder said: “The idea of getting out and going for a walk or playing ball for 15 minutes is not going to work in their neighborhoods. If we ask them to do that, again, they’re not going to be compliant because they just can’t be.” Another community leader linked this issue back to health: “In terms of health, it’s safety, and it

all has to do with where they live. Our participants primarily earn [less] than \$30,000 a year so they're living in very high density areas where, unfortunately, it's also unsafe. So [that] is limiting their ability to be active."

Indeed, based on the weighted CalOptima population estimate, nearly 17 percent of respondents to the member survey reported never engaging in physical activity, including more than one-fifth of members responding for a child under the age of five (Exhibit 25).



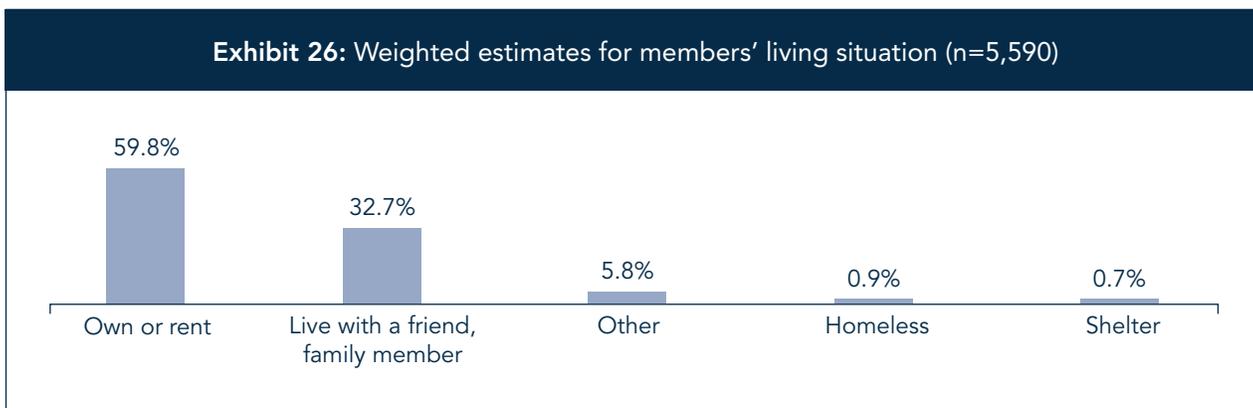
Inside homes, health concerns include sanitation, cleanliness, pests and proper ventilation. One Spanish-speaking parent discussed worries about both indoor and outdoor air quality:

"When I arrived to this country, I started to rent ... but there were many problems with the paint. It was very wet, and that gave me severe asthma. I had to move, but the new place was next to the freeway, and that affected my lungs even more. And now, I've been fully diagnosed with asthma. I'm under treatment, and ... [the] medicines are very expensive."

For individuals and families facing homelessness, environmental factors are a major health concern. Community stakeholders serving this population noted air quality, limited access to fresh food and water, lack of sanitation options, and exposure to violence when living unsheltered as the significant health impacts of homelessness. As one provider shared, for both homeless individuals and those seriously struggling to afford their housing, even much needed care becomes a lower priority:

"The lack of housing across the board in this county is a huge barrier for every kind of service and every service provider. If somebody is either on the streets or at risk of losing their housing, that's the priority as far as the hierarchy of needs. Every other issue, whether they're accessing medical resources or mental health or drug treatment, is always going to get pushed further down in the line. This is a very expensive place to live, and I think our vacancy rate is very low, but there's not a lot of options for people looking for somewhere to live. If they don't have access to another place to go, if they're getting kicked out or evicted, or if their mental health or medical issues preclude them from working, then it becomes a big focus."

Based on the weighted CalOptima population estimate, very few members surveyed reported they were living in a shelter, hotel or motel, or were experiencing homelessness. However, housing affordability is a major concern and, as previously mentioned, many members are doubling up (Exhibit 26).



Both members and providers discussed the need for more affordable housing. Stressing the link between housing and health, one older Arabic-speaking focus group participant shared: “In order to live a healthy life, we need houses. Especially at our age, we need to ensure having a house. Even though we have money from SSI, it barely covers the cost of our house rent, which is neither healthy nor good.” In addition, 71 percent of medical providers surveyed identified affordable housing as one of the three most important factors to improve the quality of life in a community — by far the highest share of any response. Given these connections between economic, social and environmental factors and overall health, strategies to improve health that target such determinants have the potential to make deep, community-level impact.

## Summary of Findings, Bright Spots and Opportunities for CalOptima

While economic, social and environmental determinants of health can seem daunting to address, the potential improvement in health and well-being from successful strategies can be significant. Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

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

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

## Healthy Food Choices Are Not Always Available to Members

For many low-income families in Orange County, maintaining a healthy, balanced diet is not always easy. Across many focus groups, members emphasized that they know how important it is to eat high-quality, nutritious food. They talked about their goals to purchase healthy things such as “vegetables and boneless chicken breast” and “different kinds of fruit” at their local stores. But they said they often have limited options that stretch their already tight budgets. One older adult shared: “We have very limited resources economically, and our supermarkets often do not offer us food that is economical and healthy. Yes, at times they do offer such foods, but they sell the worst cucumber or the worst tomato, and they are [expensive].”

Given the selection and price at grocery stores, families often turn to fast food options where their money goes further. As one teenager shared: “You can get a large pizza at 7-Eleven for five bucks. Five bucks would buy you five apples.” One parent echoed: “They sell you a bottle of water for \$1.25 and a can of soda for 50 to 75 cents. What do you prefer to buy?” Even though many fast food restaurants offer healthier options, they are usually more expensive. One member said: “On the dollar menu, [a hamburger] is cheaper than a salad at McDonald’s. A salad is four bucks, and a hamburger or French fries, 69 cents. So the cheaper, the worse the food is.”

Despite these constraints and challenges, community members continue to try to provide healthy options for themselves and their families. CalOptima already supports members’ efforts to eat healthy by offering nutrition support and links on its website. And with its renewed focus on combating childhood obesity by funding nutrition education and fitness programs for children and families, CalOptima can help connect members to healthy, affordable food options and invest in proven community-based solutions.

## KEY FINDING: MENTAL HEALTH

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

Across the United States, about 40 percent of people with serious mental illness do not receive care despite the availability of effective treatment.<sup>9</sup> Fear of public stigma remains one of the primary barriers to receiving care. Public stigma occurs when pervasive stereotypes about people with mental illness lead to prejudice. Subsequently, fear of public stigma may cause individuals to avoid seeking treatment, or to drop out of treatment to avoid being associated with negative stereotypes, such as the belief that people with mental illness are dangerous and unpredictable. Fear of stigma may also influence the beliefs and behaviors of friends, family members and care providers, which can pose further barriers to care for people experiencing mental illness. Stigma around mental illness is often more pronounced for recent immigrants, especially from those countries with more highly stigmatized views of mental illness.<sup>10</sup>

*Stigma may lead to underreporting  
of mental health needs*

Based on the weighted CalOptima population estimate, about 14 percent of members reported the need for mental health services in the past year. This number likely underrepresents the actual level of need, based on both national and local data. According to the National Institute of Mental Health (NIMH), each year approximately 19 percent of adults and 21 percent of youth ages 13–18 experience mental illness nationwide.<sup>11 12</sup> Furthermore, 64 percent of CalOptima providers identified mental/behavioral health as one of the most important health problems facing Medi-Cal beneficiaries.

This potential gap between the number of members reporting mental health needs and those who genuinely have a need may indicate a lack of knowledge about mental illness and its treatment. However, research suggests that the fear of stigma plays a larger role than knowledge in determining if individuals will report need and/or pursue treatment.<sup>13</sup> Community leaders and members acknowledge the role that stigma plays in members' willingness to admit to experiencing a mental health challenge. A key stakeholder described the situation:

*"Often times, people may be aware that they're under stress ... and the stress is compromising their health, but as far as reaching out for support and help, they may not go in the direction of mental health care because of the stigma of receiving mental health care."*

CalOptima providers reported that upward of 50 percent of Medi-Cal recipients "rarely" or "never" access mental and behavioral health services when they are needed, further suggesting a substantial level of unmet need may exist among members.

*Access to mental health services is varied across member subgroups*

Based on the weighted CalOptima population estimate, nearly one-quarter (24.8 percent) of members who recognized the need for mental health services did not see a mental health specialist. This percentage varied quite widely for different subgroups based on age, language and region of the county (Exhibit 27). Children ages 5 years and under were the group least likely to see a mental health specialist when needed (47.6 percent), potentially because parents may not be aware of mental health resources available for young children, such as the Regional Center of Orange County. Among language groups, Vietnamese speakers were most likely to see a mental health specialist if needed (only 12.8 percent did not), potentially due to the presence of specialized providers in the Orange County Vietnamese community (Exhibit 28).

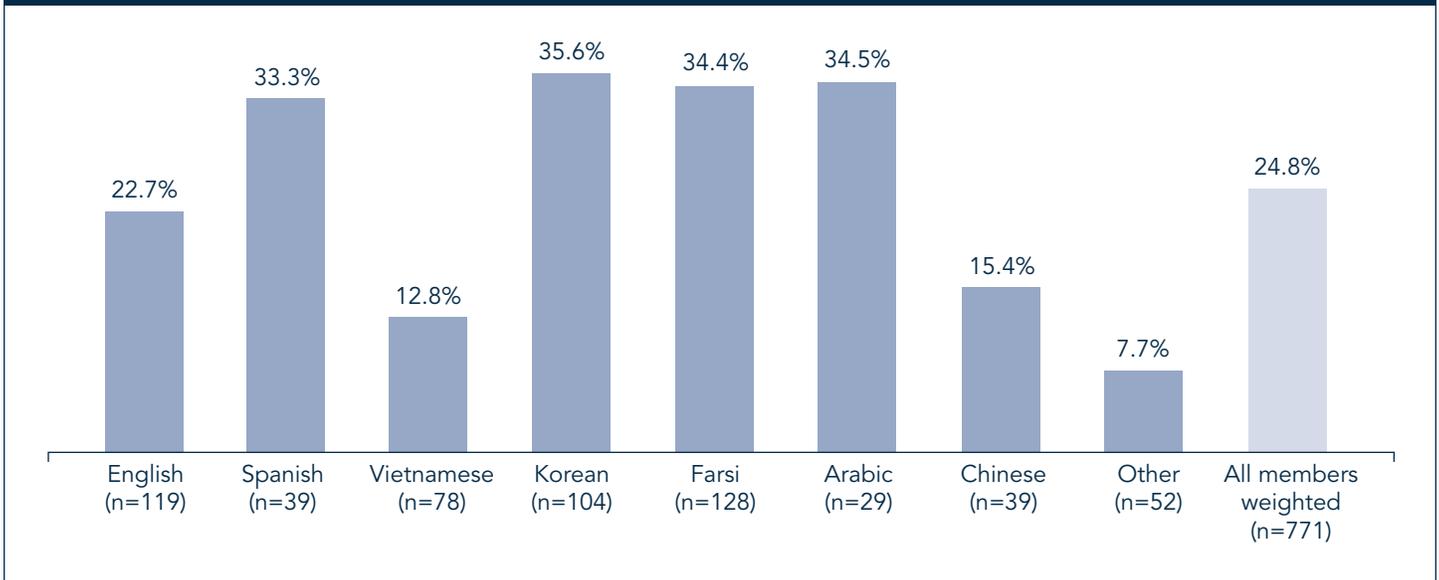
<b>Exhibit 27: Groups least likely to see a mental health specialist</b>		
<b>Group</b>	<b>Percent with mental health need who did not see a mental health specialist</b>	<b>(n)</b>
1. Children ages birth through 5 years	47.6%	21
2. Korean-speaking members	35.6%	104
3. Children younger than 18 years old	35.5%	110
4. Arabic-speaking members	34.5%	29
5. Farsi-speaking members	34.4%	128
6. Spanish-speaking members	33.3%	39
7. North Orange County members	31.3%	178
8. All members, weighted	24.8%	771

Parents of children experiencing developmental disabilities reported unique challenges navigating and coordinating their child’s behavioral therapy between the dual systems of Regional Center and CalOptima. Parents do not always understand how to use CalOptima and Regional Center services in tandem to get the most appropriate care for their children. For some, it is not clear which agency should coordinate and pay for the wide range of services their children need, such as speech, occupational, physical and applied behavior analysis (ABA) therapy. As a result, parents are concerned that their child’s treatment is compartmentalized and may not effectively address needs. One parent described the difficulty:

“I’m coordinating as a parent. So I called a meeting with the psychiatrist, the psychologist, the ABA team, the school, a person at Regional Center of Orange County and a social worker. But I called that meeting. I would love ... to have a person in place who says, ‘Let me look at the whole patient.’”

This challenge was especially concerning for parents of young children with diagnoses on the autism spectrum, where timely behavioral interventions impact lifelong trajectories. It is worth noting that in some cases, parents are also navigating multiple health care systems themselves — the disabled child may be the only household member who is a CalOptima member.

**Exhibit 28:** Percent of members who needed to see a mental health specialist but did not see one, by language



In general, focus group participants and key stakeholder interviewees felt that there are not enough mental health providers in the region and that it can be difficult to get an appointment when needed. Some members were unclear about the mental health services and benefits available to them as CalOptima members.

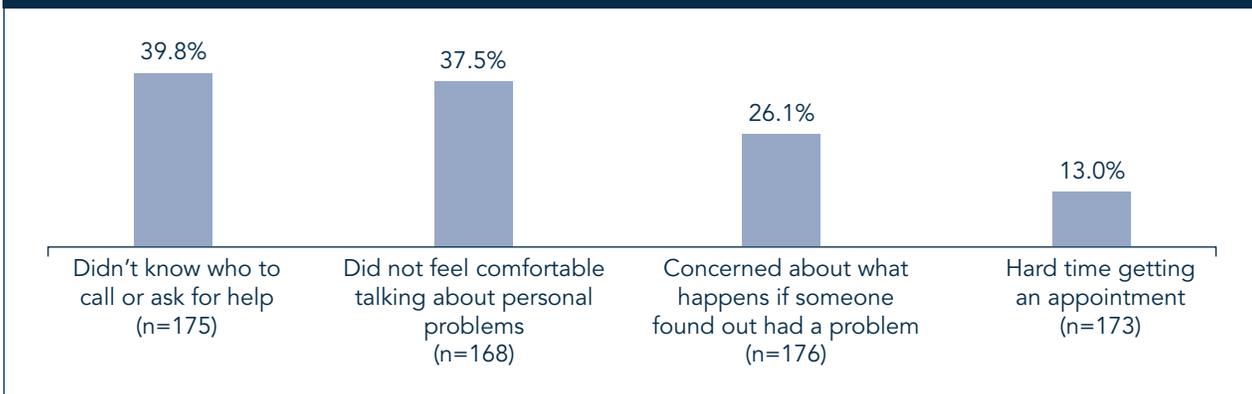
Parents of children with disabilities acknowledged the benefits of peer support groups for providing guidance and reducing caregiving stress and wish there were more of these types of resources available to them. As one parent described:

“Sometimes I wish that there was someone I could talk to ... Our therapist is pretty good, but sometimes she’s booked. It would be nice to have a friend or person to talk to and say, ‘I’m going through a situation right now, and I just need someone to walk through it [with me].’”

## Lack of knowledge and stigma are key barriers to utilizing services

Nearly 40 percent of members who did not receive mental health services when they needed them reported that they did not know who to call or how to ask for help in securing an appointment with a mental health specialist (Exhibit 29). Providers also reported that members do not always readily recognize mental health concerns and are not aware of how to get care through their primary care doctor or CalOptima. Fear of stigma also appeared to play a role in the decision to access care. More than one-third of members who did not seek mental health care when they needed it said they did not seek care because they did not feel comfortable talking about personal problems (37.5 percent). More than one-quarter were concerned about what would happen if someone found out they had a problem (26.1 percent). These two categories, which are indicative of fear of stigma, account for 64 percent of the reasons given for not seeing a mental health specialist. In contrast, only 13 percent of members with a mental health issue reported having a hard time getting an appointment when they needed one.

Exhibit 29: Weighted estimates for reasons why members did not see a mental health specialist<sup>14</sup>



In focus groups, community members often acknowledged the fear of being stigmatized if they sought mental health services. One Spanish-speaking focus group participant shared:

"I think it's a hard and difficult problem because, in the case of men, many men especially have a lot of depression problems, but they, especially in our Latino community, do not open up to talk to someone. It's very difficult ... because sometimes they think people with mental illnesses are crazy people."

Providers and community leaders also noted fear of stigma as a barrier to identifying mental health challenges and receiving services. More than three-quarters of providers (76 percent) reported that stigma and negative social attitudes are "somewhat of a problem" or a "big problem."

*Fear of stigma may be especially problematic among some language and cultural groups*

Findings revealed that the fear of stigma may be particularly acute among some language and cultural groups. For example, Chinese-speaking members (66.7 percent) were more likely to indicate discomfort with talking about personal problems and express concern about what others might think if they found out about a mental illness than speakers from other language groups. In comparison, fewer Korean- (46.9 percent), Vietnamese- (22.2 percent) and English- (37.5 percent) speaking members reported these concerns.

Key stakeholder interviewees often contextualized their comments about stigma within their own cultural and/or language group. One key stakeholder noted:

“[C]ommon themes in the Korean community are shame or stigma. In most Asian cultures that becomes a barrier. The shame or stigma of having cancer or when it comes to mental illness, that’s huge. Sometimes preventive care becomes harder to do when you’re trying to hide things.”

Community members also identified the importance culture plays in mediating stigma around seeking mental health services. One Arabic-speaking focus group participant stated:

“In my opinion, what prevents getting services the most is shyness about speaking of their psychological or behavioral condition. For example, a family member in their house may have a condition, but they are shy to talk about it. I think this is the most challenging thing for Arabs.”

This suggests that efforts to increase awareness of mental health services and reduce fear of stigma will be most successful when taking culture and language into account.

“I’m afraid of what others would think of me if I go to psychiatry.”

–Focus Group Participant

*\*Note: Quote translated from Arabic to English*

## Summary of Findings, Bright Spots and Opportunities for CalOptima

Overall, lack of knowledge and fear of stigma are key barriers to utilizing mental health services. Language and cultural norms make members from some subgroups less likely to access mental health services than others.

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

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

## Parents Need Help Navigating Multiple Systems to Access Care and Services for Children With Developmental Disabilities

Parents of children with developmental disabilities — including autism, cerebral palsy, epilepsy and intellectual cognitive disabilities — face the challenge of navigating multiple systems to ensure their child’s needs for behavioral and physical health services are met. Families are often unsure about when to turn to Regional Center of Orange County and when to turn to CalOptima, especially when their child is in crisis. Parents also experience frustration at the lack of coordination between doctors and mental/behavioral health professionals and schools. This can be extremely stressful. Parents see tremendous opportunities to improve outcomes for their children with stronger coordination among the systems that serve them, including CalOptima. As one parent of a teenage son with autism described earlier in this section, it can be challenging to coordinate with all of the various providers and how helpful it would be to have someone to help coordinate and align services to meet the overall needs of her child.

Families caring for developmentally disabled children often experience severe financial hardship that adds to caregiver stress. One family reported moving to the United States from China, where both parents had good paying jobs, in order to secure better care for their child. Most families choose to get by on one income so one parent can focus on ensuring the best care possible for their child.

Parents find peer support especially useful in dealing with the everyday stress of caregiving and would value more opportunities to receive it. While some parents find support through community-based organizations, they would welcome connecting with other parents through parent support groups.

## KEY FINDING: PRIMARY CARE

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

Access to regular medical care is important as it can lead to better health outcomes. Access to care includes having insurance coverage, having a location where one can receive regular preventive services (medical home) and finding a trusted health care provider.<sup>15</sup> Barriers to accessing care, such as lack of insurance coverage, high costs of care, lack of available services or lack of culturally competent services, can lead to delays in receiving needed care, lack of preventive care, financial burden or preventable hospitalizations.<sup>16</sup>

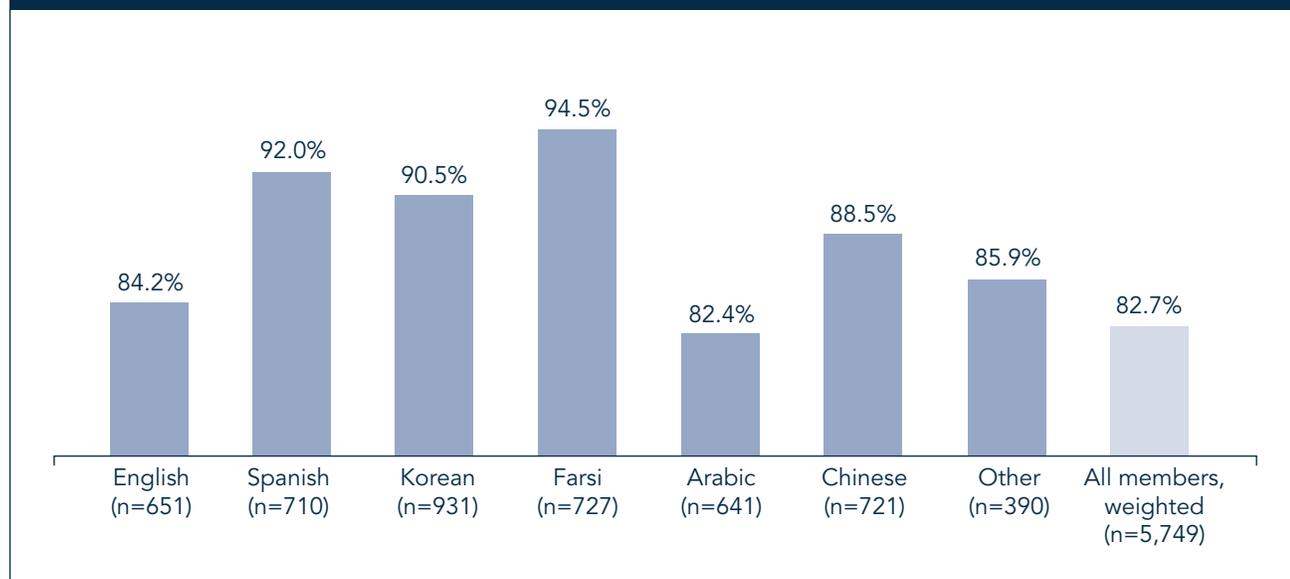
*Most members are connected to care,  
although barriers still exist*

CalOptima works with medical groups, health networks, hospitals, pharmacies and more than 7,000 physicians. The majority of CalOptima members reported that they have at least one person they think of as their doctor (Exhibit 30). Based on the weighted CalOptima population estimate, nearly 83 percent of members have at least one person as their doctor (n=5,749), Farsi speakers had the highest percentage of members who have a doctor (94.5 percent) and Arabic speakers have the smallest percentage of members who have a doctor (82.4 percent) (Exhibit 30).

When looking at this by age group, only 77 percent of adults age 18–64 have at least one person they think of as their doctor compared with more than 85 percent for all other age groups. The implementation of the Affordable Care Act increased membership among people 18–64 years old. It is possible that these members are still getting used to having health insurance so they have not fully utilized the coverage to see a primary care doctor.

Fewer members from the Central region are connected to a primary care physician (73.5 percent) compared with more than 85 percent in the North and South regions.

**Exhibit 30: Percent of members who report at least one person as their doctor, by language<sup>17</sup>**



The majority of respondents across all language groups primarily receive care at their doctor’s office or a clinic/community health center. Less than 5 percent of respondents across all language groups reported that they primarily received care at the emergency room, indicating they are connected to appropriate sources for regular care (Exhibit 31).

**Exhibit 31: Where members go when they are in need of medical attention, by language**

Language	Doctor’s Office	Clinic/Health Center	Emergency Room	Urgent Care	Alternative medicine provider/herbalist	Other	Don’t know	Total
English	71.8%	11.9%	2.0%	6.6%	0.5%	6.4%	0.8%	653
Spanish	59.7%	32.3%	3.4%	1.0%	0.3%	3.1%	0.1%	699
Vietnamese	86.3%	12.0%	0.1%	0.2%	0.0%	1.0%	0.3%	965
Korean	87.8%	4.3%	0.9%	1.1%	0.7%	4.1%	1.2%	938
Farsi	84.0%	6.5%	3.0%	0.8%	0.1%	5.0%	0.5%	737
Arabic	65.3%	15.8%	4.6%	5.4%	0.3%	8.0%	0.5%	625
Chinese	77.2%	11.4%	0.3%	0.8%	0.4%	6.6%	3.3%	727
Other	72.2%	12.6%	1.5%	3.0%	0.0%	9.6%	1.0%	396

“There’s not a lot [of mental health care] in my city, I don’t think. There are therapists, but it’s really hard to reach out and see what insurance they take, or how much they cost. There’s always those out-of-pocket fees, which really get to me. It’s kind of hard. You have to reach out, and sometimes there’s no one really there guiding you where to go.”

–Teen Focus Group Participant

Although the majority of members are connected to a primary care provider and have insurance coverage through CalOptima, focus group participants highlighted other issues that can make it challenging to navigate the health care system and access needed medical care. Focus group participants from a Chinese-speaking focus group, for example, indicated that they sometimes call to make an appointment but get redirected or told to call another number. This can be frustrating and confusing for members, especially if English is not their primary language. In addition, several participants from an Arabic-speaking focus group and an Asian/Pacific Islander focus group indicated that doctors do not have enough time to spend with patients and they feel rushed. This may make people less likely to seek care or return for follow-up appointments because they do not end up having much time with the doctor anyway.

Key stakeholders also noted the general difficulty people face in navigating the health care system and finding the right provider. One interviewee shared: “For a lot of clients, it’s just access to health care. It’s pretty difficult to navigate the health care system and then try to find a provider.” Another summarized several of the issues shared by focus group participants:

“It sounds like there’s just this huge cycle of, you want to seek the care but it takes a long time to get there, it takes a long time to make the appointment, to get to the appointment. And by the time you get to the appointment, you’re only seeing the doctor for 10 minutes or so.”

Navigating the health care system can be even more challenging when trying to find a doctor with specific skills or experience. Referral to the right provider was important to many focus group participants. One group of parents who have children with developmental delays said it can be difficult to find a doctor who has experience working with kids with developmental delays.

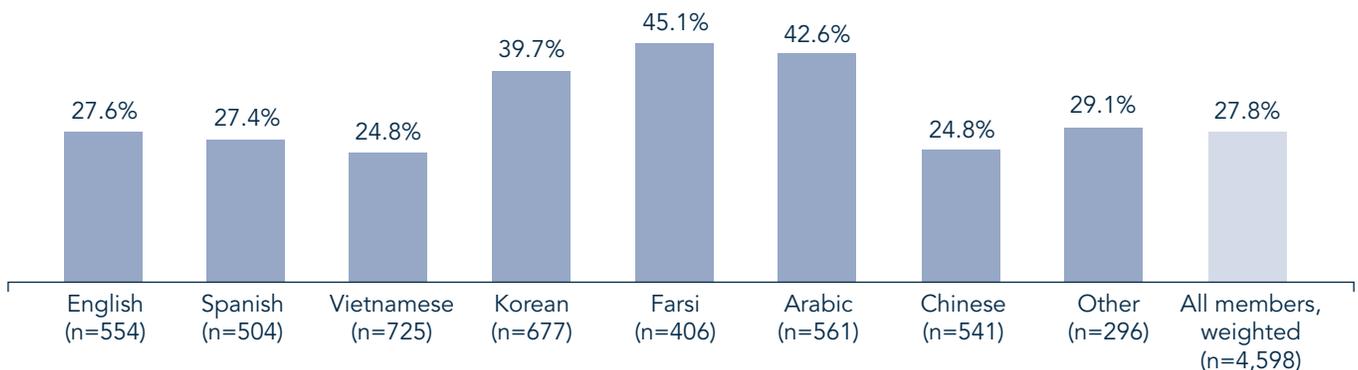
*Additional barriers such as long wait times, available appointment times and lack of reliable transportation deter members from seeking or completing care*

Both focus group participants and key stakeholder interviewees indicated that it can take a long time for people to get an appointment to see a doctor, and even longer to make an appointment to see a specialist. This can cause people to get frustrated or lose patience. As one participant from an Arabic-speaking focus group noted:

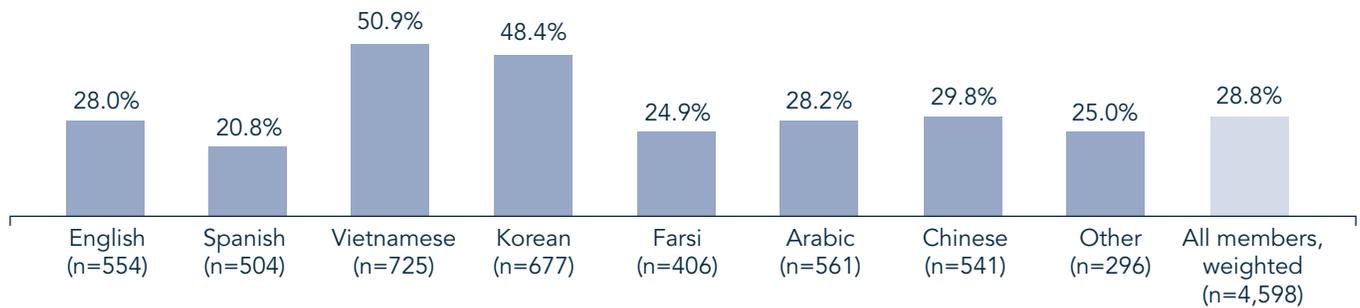
“This is the most crucial thing. We see in some countries that people are able to access medical consultations or analysis immediately without a need for appointments. Here, everything is based on appointments, which are given on a distant date. Consultation appointments and analysis appointments and even echography are given on distant dates. When we suffer from a severe condition, we need to have [further tests] immediately so that the doctor can diagnose our condition before it worsens. They leave the patient for days and then their health worsens because he lacks any kind of treatment and isn’t able to do anything about it.”

Member survey respondents were asked why they do not make an appointment when they needed to see a doctor or a specialist. More than 24 percent of respondents across all language groups indicated that a key reason is because it takes too long to get an appointment. For Korean, Farsi and Arabic speakers, around 40 percent or more indicated that the amount of time it takes to get an appointment prevents them from seeing a doctor (Exhibit 32). In addition, approximately half of Korean (48.4 percent) and Vietnamese speakers (50.9 percent) said that scheduling conflicts prevent them from making an appointment to see a doctor (Exhibit 33).

**Exhibit 32: Percent of members who do not make an appointment to see a doctor because it takes too long, by language**



**Exhibit 33: Percent of members who do not make an appointment to see a doctor because of a scheduling conflict, by language**



While the majority of respondents did not feel that lack of transportation prevented them from seeing their primary care doctor, nearly 20 percent of Farsi speakers did indicate that sometimes they do not see their doctor because they lack transportation. When asked why they do not see a specialist, more than 10 percent of Korean, Farsi and Chinese speakers indicated that they do not have transportation. For adults 65 or older, 13 percent indicated that transportation was a reason they did not make an appointment to see a doctor. Community members and community providers also identified transportation as an issue for some in Orange County, since there is not a lot of accessible public transportation.

*Members are not always aware of the resources that are available to them*

Although there are many resources available to CalOptima members and the community in general to help access health care services, members are not always aware of available services or how to get connected to them. As indicated above, sometimes members cannot find the right doctor for their child with special needs or would prefer to receive counseling services from a female provider but cannot find one. One community stakeholder shared that sometimes there can be a disconnect between CalOptima members and customer service providers, which leads to challenges in linking members to the appropriate resources.

Some community stakeholders recommended services to connect CalOptima members and the community in general to available resources. They recommended a centralized database, although there are additional strategies that can be employed to connect members to needed services.

## Summary of Findings, Bright Spots and Opportunities for CalOptima

Overall, most members are connected to primary care. However, additional barriers include long wait times, inconvenient hours and unreliable public transportation, all of which can make it challenging to receive timely care.

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

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

"... There are many different resource [guides] but [they are not kept up to date]. We constantly have to put our own resource lists together, and we have to update them ourselves, and a lot of times we don't have all the [information]. CalOptima knows who all the players are, so if they can actually fund a resource directory ... that would be great."

–Key Stakeholder

## Navigating the Health Care System Is a Challenge for Some CalOptima Members

Community members from the Access California Services focus group highlighted how long wait times and limited transportation can keep them from getting the health care they need. Their stories show how navigating the system can be, in their words, “tiresome.”

Members shared that it can be very difficult to schedule an appointment, as they often wait for months for the next available appointment. Members expressed concern that their medical condition could worsen if they can’t receive treatment in a timely manner.

Once a member schedules an appointment, getting there is often challenging. Members without a car often rely on Orange County Transportation Authority (OCTA) busses to get around, which can be unreliable. As one member expressed, “When we want to reach a clinic, we may be late [for] our appointment when going with busses.”

To help with transportation, CalOptima began offering a non-medical transportation benefit in July 2017. This service provides Medi-Cal members with roundtrip transportation to locations offering Medi-Cal services covered by CalOptima, along with dental and specialty mental health appointments. To access this service, members can call CalOptima Customer Service.

Additional strategies can provide further support to members. For example, scheduling multiple appointments in one day for individual members can limit transportation time and costs. In addition, health care navigators can help schedule appointments, arrange for transportation, help members get answers to medical questions, and follow-up with members after appointments to make sure the member feels that his/her health concerns have been addressed.

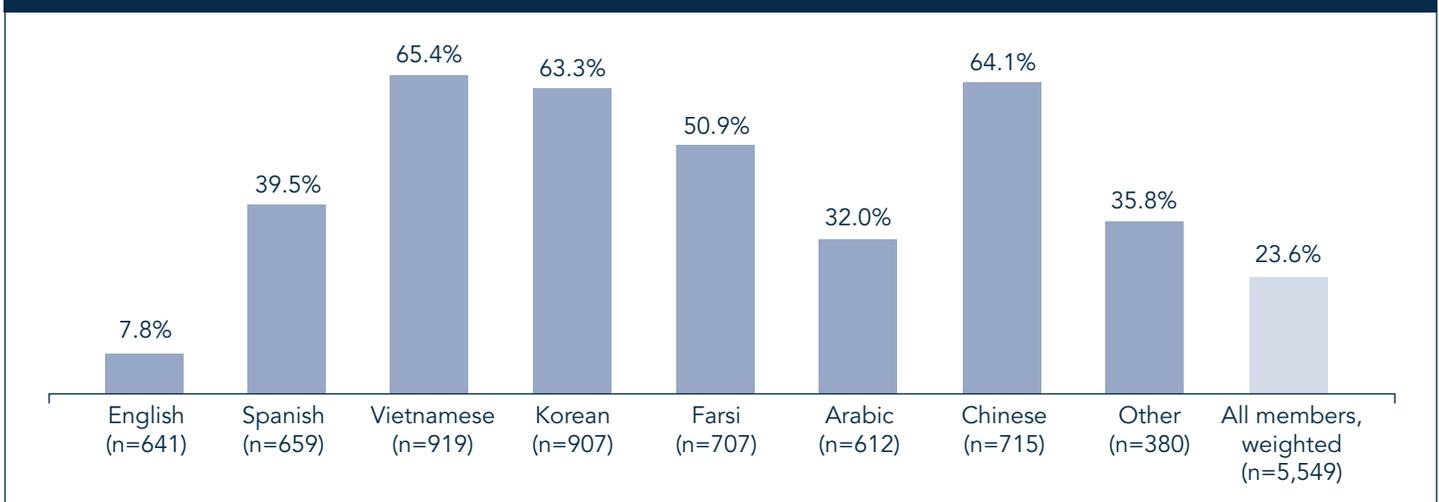
## KEY FINDING: PROVIDER ACCESS

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

Research has shown that improving cultural competency can improve overall quality of care and reduce health disparities.<sup>18</sup> Throughout the United States, health disparities exist where certain populations, including Hispanic/Latinos, Asian/Pacific Islanders and African-Americans, have higher incidences of diseases compared with non-Hispanic whites.<sup>19</sup> In Orange County, disparities exist in disease outcomes, both across different ethnic groups and regions in the county. For example, Hispanic adults have the highest rate of diabetes, followed by whites and Asians. African-American adults have the highest rate of obesity, and Hispanics and Hawaiian/Pacific Islander young adults have the highest rate of obesity. Cities with a lower median household income, such as Santa Ana, Stanton and Westminster, have high rates of diabetes, obesity and babies born with low birth weight.<sup>20</sup>

CalOptima serves a diverse low-income population that experiences many of the health disparities described above. Many are also immigrants to the United States. Based on the weighted CalOptima population estimate, 40 percent of members were born outside of the United States, about 14 percent have been in the United States less than five years and 24 percent indicated they did not speak English well. When looking at the same data by language group, more than one-third of non-English speakers felt they did not speak English well and more than 50 percent were born outside of the United States (Exhibits 34, 35 and 36). These factors can present challenges for members to find a well-paying and fulfilling job, safe and affordable housing, and healthy and familiar food. CalOptima, along with many other organizations, realizes the importance of providing culturally competent services to members in order to best serve such a diverse population and to address and reduce health disparities that members face.

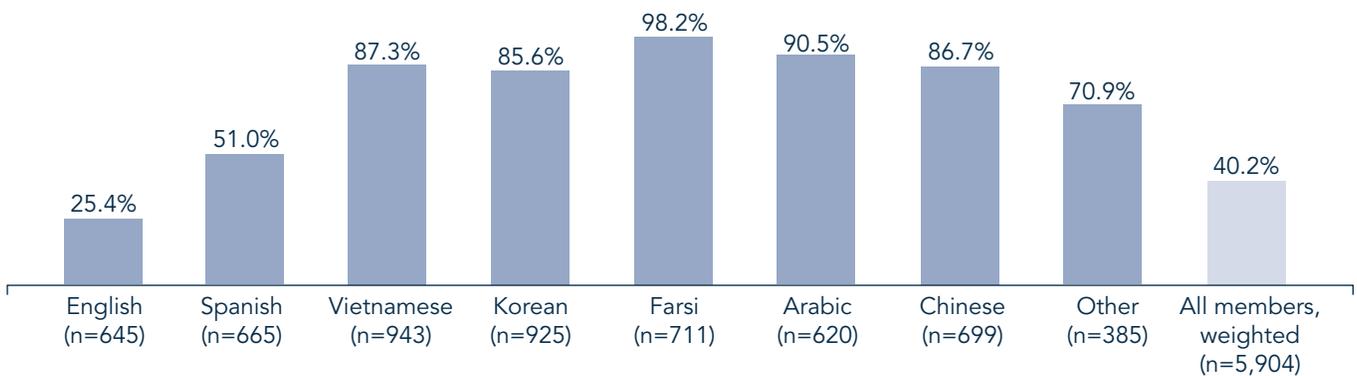
**Exhibit 34: Percent of members who reported that they speak English "not well," by language**



“There is variation within each ethnic group as far as different people’s ability to assimilate. The most successful immigrants will work quickly. But the ones who don’t have the skills, or the personality, or the aptitude to assimilate more quickly get further and further behind. And then, of course what comes with that is frustration, loneliness and isolation. As they get older, multiply that through the generational gap. Now the complexity becomes exponential.”

–Key Stakeholder

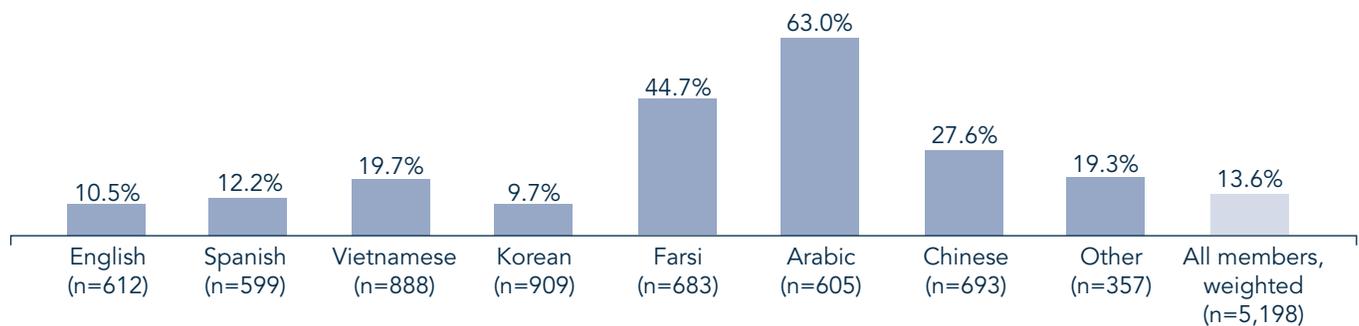
**Exhibit 35:** Percent of members who were born outside of the United States, by language



## Members face challenges assimilating to a new culture

With the exception of English and Spanish speakers, more than 85 percent of members from other CalOptima threshold language groups were born outside of the United States (Exhibit 35). In addition, some language groups, including Farsi, Arabic and Chinese speakers, are more recent immigrants. Many have lived in the United States for five years or less (Exhibit 36) and have had less time to adjust to a new culture.

**Exhibit 36:** Percent of members residing in the United States for five years or less, by language



Not only do these members face language barriers, they also confront challenges assimilating to a new culture in general and, more specifically, to the way medicine is practiced in the United States compared with other countries. This issue of cultural adaptation impacts many aspects of members' lives and makes it especially challenging for members to navigate the health care system. One key stakeholder interviewee said, "Only the people who can navigate our government and our system will be able to know where to look [for resources]." Other key stakeholders shared that adapting to a new culture is challenging on so many levels and ultimately can lead to frustration, loneliness and isolation, especially for those who have a harder time adapting. In fact, member survey respondents who were born outside of the United States were significantly less likely to have a doctor. In addition, those who have lived in the United States for five years or less were more likely to report feeling lonely and/or isolated.

"The personal problem I have had is that I often want a female psychologist, because sometimes what I may want to tell is not something that I feel comfortable telling a man, and many times, there is not [a female provider available]."

—Focus Group Participant

\*Note: Quote translated from Spanish to English

Cultural norms also matter when thinking about specific services. For example, it may not be culturally appropriate for a woman to see a male doctor or vice versa. One Spanish-speaking focus group participant described how she did not feel comfortable sharing mental health issues with a male psychologist. A key stakeholder also highlighted how challenging it can be for someone to share a mental health concern, let alone through an interpreter who they do not know.

Taking into account the current political environment, both community members and stakeholders indicated that individuals might be reluctant to seek services or medical care because of immigration concerns and fear of deportation. One key informant interviewee provided an example of how this played out in the health care setting in the past where "... pharmacies in Orange County [were] requiring parents specifically to produce some sort of California identification to pick up prescriptions for their children. Many of these families had Mexican consular visas, but the pharmacy at the time was not allowing that ...". Although the issue has since been resolved, this example shows how immigration concerns can have lasting effects and impact the way members view and interact with the health care system.

*Members rarely have a provider who speaks their preferred language*

Both members and key stakeholder interviewees indicated that there are not always doctors and other medical staff who speak members' preferred language. Often, members have limited options when it comes to having providers who speak their language or understand their culture and even fewer when they need to see a specialist. Some members may also rely on family members to translate during appointments. However, as one key stakeholder indicated, this is not a "true translation," because the family member may not know medical terms in either or both languages.

As one focus group attendee from an Arabic-speaking focus group shared, medical appointments can even be challenging for those who speak English relatively well: "Even when they want to consult a doctor, they can't express their ideas. I noticed that some people, even if their language is good enough when it comes to medical terms, can't explain their medical condition because it differs from social language." Key stakeholder interviewees echoed this idea and emphasized that even with translation services and patient navigators, things can get lost in translation.

Only 33 percent of CalOptima providers indicated that language or other communication barriers were among the top barriers to accessing services. This shows a discrepancy between member and provider perspectives regarding how language impacts access to needed care. CalOptima members and focus group participants feel that language is an important factor in receiving adequate medical care, whereas not all providers felt this was a major barrier, likely because most providers have interpreters available.

Although focus group participants and CalOptima members indicated that there is a lack of services in members' preferred languages, they did acknowledge that there are interpretation services available to members and sometimes even patient navigators. However, community providers expressed the importance of having providers and staff who are not only bilingual, but also bicultural and who bring a level of cultural sensitivity to their practice.

*Members face challenges finding staff who are bilingual, bicultural and understand cultural sensitivity*

Cultural competence is beyond providing basic translation and interpretation services; it ensures there are staff who understand the cultural practices of patients and that providers have in-depth and regular trainings about the influence of culture on health and health practices (see Principles of Cultural Competence, Page 58). One key stakeholder indicated that depending on location, some physicians might be better equipped and prepared to work with a diverse population:

**"I feel that when a lot of health care providers contact our clients, they speak in English. There is no translation for clients and even when they go to see the provider, they suffer. And they come to us, and we can't help because we can't leave our offices to go translate for them. We have thousands of clients so we can't translate for every single client. Maybe just have someone who speaks Arabic or Farsi."**

–Key Stakeholder

"It depends on where you are in the county. If you're in Garden Grove, if you're in Westminster, I would say many of the physicians' offices are pretty aware of their cultural and language needs. If you're in Seal Beach, if you're in Huntington Beach, if you're in Surfside, I would say the majority of those folks are not necessarily aware of the demographics and the needs throughout Orange County."

Providers were asked to rate their knowledge on different sociocultural issues as they relate to health (Exhibit 37). More than 40 percent of respondents indicated that they were not very familiar with different health traditions (52.4 percent), Title VI Prohibition as it affects persons with limited English proficiency (42.9 percent) and ethnopharmacology (42.9 percent). Providers were somewhat more familiar with the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care and the historical and contemporary impact of racism, bias, prejudice and discrimination in health care experienced by various population groups in the United States. However, around one-third still indicated they were not very familiar with these topics. These findings highlight areas where training and information could further support providers who work in diverse communities.

**Exhibit 37: Percent of providers who are “not at all” or “a little” familiar with sociocultural issues related to health (n=21)**



## Principles of Cultural Competence

The CDC National Prevention Information Network defines cultural competence as “integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of services thereby producing better outcomes.”

Principles of cultural competence include:

- Define culture broadly.
- Value clients’ cultural beliefs.
- Recognize complexity in language interpretation.
- Facilitate learning between providers and communities.
- Involve the community in defining and addressing service needs.
- Collaborate with other agencies.
- Professionalize staff hiring and training.
- Institutionalize cultural competence.

Source: <https://npin.cdc.gov/pages/cultural-competence>

“[Organizations] need more funding to have truly diverse staff. There’s just not enough funds to pay for what you would really, in a perfect world, need to be culturally competent and do everything that you really wanted to do. We would love to have that kind of diversity.”

–Key Stakeholder

The team asked key stakeholders if they felt medical and behavioral health providers are aware of the historical and contemporary impact of racism, bias, prejudice and discrimination in health care experienced by various population groups in the United States. Responses varied and some key stakeholders were not sure how to answer this question. Generally, they felt that some providers do understand these issues but may be less familiar with experiences of specific populations, such as refugees. Several stated that more training and information could help providers understand these nuanced issues. Recommendations for how to further engage providers in trainings around cultural competency included incentivizing training programs so physicians will participate, having more tailored trainings about specific populations, ensuring that trainings are face-to-face events and ensuring the training is appropriate. One stakeholder highlighted:

“You can just imagine that giving 10 guidelines as to how to approach the population will not really be enough. And in fact, it may encourage stereotyping. So to me, the training has to focus on how to raise awareness about the staff’s own biases, their own cultural experiences and how that is going to come into play when they’re dealing with people of other cultures that they’re not familiar with, rather than stereotyping one culture and saying Hispanics are like this, Iranians are like that, Arabs are like this. That drives me insane, but that’s the training most people are getting nowadays.”

## *Community organizations want to support and partner with CalOptima to provide needed resources to members*

Key stakeholder interviewees also highlighted that many community-based organizations provide services to the CalOptima member population and other community members from various cultural backgrounds. These organizations have gained the trust and respect of community members and therefore may be important resources for connecting CalOptima members to appropriate medical services and helping them navigate the system. However, many of these organizations, like medical providers, also struggle finding staff who are bilingual and bicultural because of limited funding to find and hire the appropriate individuals.

### Summary of Findings, Bright Spots and Opportunities for CalOptima

Overall, members are culturally diverse and want providers who both speak their language and understand their culture.

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

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

## Immigrant Communities Need Specific Support for Better Health Outcomes

Many key stakeholders underscored the unique experience of immigrants who live in Orange County. Service providers and local leaders talked about the difficulties of assimilating to a new culture where everything — the food, the neighborhood, the language — is different. Add to that the challenge of navigating a fragmented and scattered health care system. It is challenging to know where to call for what service even for patients who have experience with the American medical system and who speak English. And while there are plenty of resource guides, it can be challenging for members to find the information they need.

Stakeholders said that immigrants are focused on family needs over their own health and so many may not seek care until they already feel sick. When they do seek care, language interpretation services are often limited and talking through an unfamiliar translator can hamper a true dialogue with doctors, especially during an already rushed doctor visit. Some patients prefer to use family members to translate, particularly when talking about sensitive medical issues, but family members don't have the same knowledge of medical terminology so a lot gets lost in translation.

Providers were also quick to say that translation and interpretation services are not enough to ensure culturally competent care. For example, immigrants may have been exposed to violence in their home countries or lived in refugee camps before they settled in Orange County. This exposure to trauma can heighten mental health issues as well as mistrust of the health system. As one stakeholder shared, members benefit from providers who “understand the historic context, the traumatic experiences, the oppression, and the conditions that our population has gone through.”

One way to strengthen the connection between members and providers is to facilitate conversations with patients about their goals, values and preferences for care, and providing them with the information and support they need to manage their health conditions. CalOptima can be a strong voice in demonstrating a commitment to patient and family engagement and promoting policies and practices that involve patients and family members in their own care decisions.

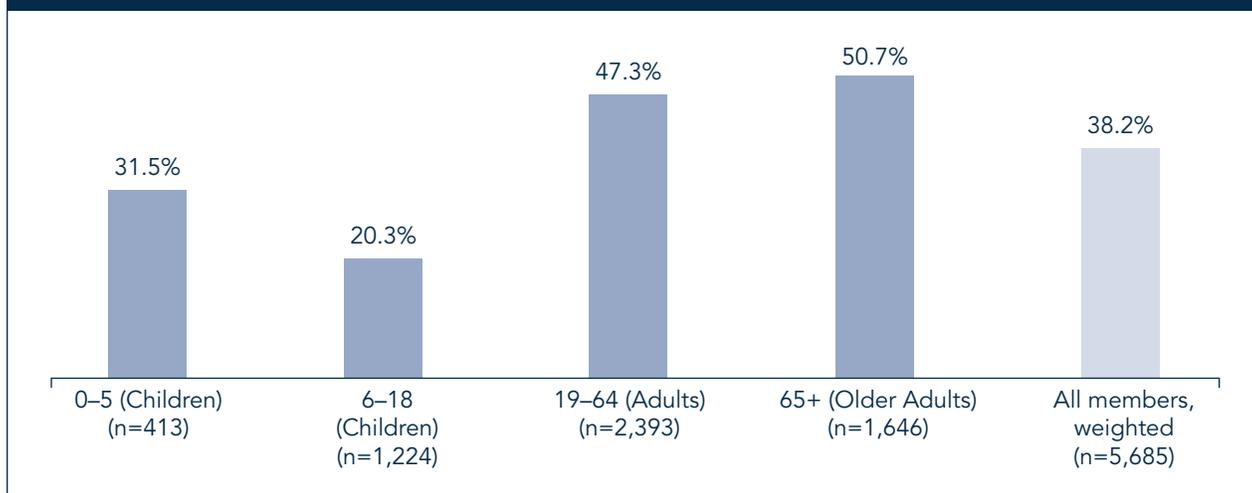
## KEY FINDING: DENTAL CARE

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

CalOptima provides coverage for oral health care for members under its OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE) plans. For CalOptima members who do not participate in one of these plans, oral health care is provided by the state's Denti-Cal program for both adults and children.

Despite available coverage, many CalOptima members reported not visiting a dentist in more than 12 months (Exhibit 38). Based on the weighted CalOptima population estimate, more than 38 percent of members reported not seeing a dentist in the past year, including more than half of members age 65 and older — the highest share among all age groups. For children 0–5, nearly 32 percent have not seen a dentist within the past year. This may indicate a need to educate parents on the importance of early oral health care and ensuring they understand it is a covered benefit for young children.

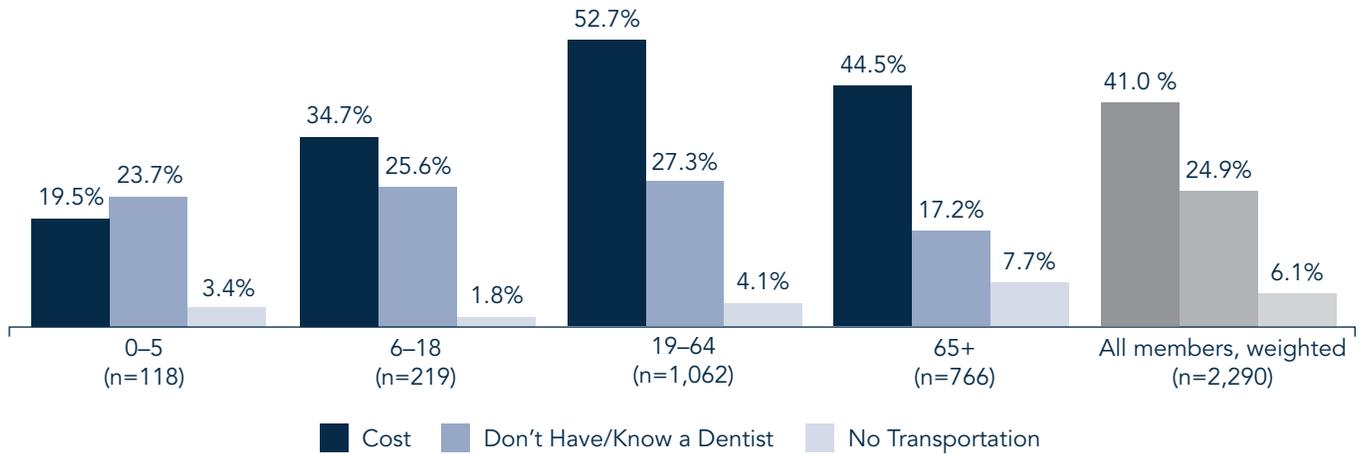
**Exhibit 38:** Percent of members who have not seen a dentist within the past 12 months, by age



Of the members who had not seen a dentist in the past 12 months, 41 percent cited cost as a key reason, and nearly one-quarter cited not having or knowing a dentist (Exhibit 39).

Generally, members face similar challenges accessing oral health services as they do in accessing general and behavioral health services; it can be challenging to navigate the oral health care system and it can be hard to find the right dentist who accepts insurance or provides the needed services. In a focus group discussion, one Spanish-speaking parent discussed their frustration getting the care they felt their family needed from a dentist when services they wanted would not be adequately reimbursed or covered. In another focus group, several parents discussed difficulty finding dental providers who would accept their insurance, especially if they had any additional needs, such as a provider who spoke a language other than English or was familiar working with patients with special needs. Without other options, members in this focus group and others sought dental care from hospitals or paid out of pocket. These costs were a financial and mental burden.

**Exhibit 39: Reasons for not seeing a dentist within the past 12 months, by age<sup>21</sup>**



One Arabic-speaking focus group participant shared: “Dentists’ costs are very high. Medicare takes huge amounts from us, and I suffer from this matter. When we visit the dentist, they take \$800 for composite [fillings] only, a small bridge costs \$1,500. Going to our countries to repair them would cost less than here.”

One community provider highlighted a lack of basic education and understanding around oral health needs and practices, including families not owning toothbrushes or understanding the importance of seeking preventive care before experiencing pain and needing emergency care. Another key stakeholder highlighted issues with reimbursement and costs associated with oral health care:

“Reimbursement is a big concern. It is such a barrier. Problems occur when you are not understanding what your benefits are, and you’re not understanding what your co-pay would be, or you don’t have a co-pay or you don’t even know what bill goes where.”

“Whether it’s a dental screening or a medical screening ... a lot of the ER visits can be reduced if we’re in the forefront of wellness and prevention and outreach.”

–Key Stakeholder

## Summary of Findings, Bright Spots and Opportunities for CalOptima

The gap in dental health care is striking and pronounced. There is general confusion about benefits and costs, which could be clarified to help members improve their oral health.

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

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

## Young Children Experience Gaps in Dental Care

Nearly 32 percent of children age 0–5 covered by CalOptima have not seen a dentist in the past year. One community provider shared many reasons why young children may not be accessing oral health services.

First, parents often are not aware that even young children should see a dentist. They may assume that because children will lose their baby teeth, they don't need to be monitored or cleaned like adult teeth. Some dentists may even be reinforcing this misperception that very young children do not need to see a dentist. The community provider shared, "I think that there are a lot of dentists in our area who believe — and actually practice — the notion that kids under 3 years old could not or should not be seen by a dentist." However, regular dental visits can teach parents and their children how best to care for their teeth and monitor children for common problems. Without education and screening, parents might not recognize that their child has tooth decay until the child is in pain, often leading to an emergency department visit. Furthermore, kids with untreated tooth decay may miss school, have problems with eating and speaking, and develop infections.

Parents may also hesitate to take their children to the dentist due to concern about cost. Parents in a focus group shared that they had to pay out of pocket for dental care. One parent reported that they had to pay \$2,000 for their child's dental surgery since their insurance does not cover dental work. Other parents were not sure what oral health services were covered for their children. Dental care for Medi-Cal eligible children is provided by Denti-Cal.

CalOptima can work with their partners to educate parents about the importance of pediatric dental care and reinforce preventive measures, such as brushing baby teeth and encouraging good nutrition. Education can also create an opportunity to emphasize which oral health services are covered. Working with parents to establish early dental care habits can ensure strong and healthy teeth for growing children.

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## Endnotes

<sup>1</sup> Members could choose multiple answers; thus, the total does not equal 100 percent.

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

<sup>3</sup> Members could choose multiple answers; thus, the total does not equal 100 percent.

<sup>4</sup> For two of the 31 focus groups, facilitators did not collect sign-in sheets.

<sup>5</sup> Gehlert, S., Sohmer, D., Sacks, T., Mininger, C., McClintock, M., & Olopade, O. (2008). Targeting health disparities: A model linking upstream determinants to downstream interventions. *Health Affairs*, 27(2), 339-349.

<sup>6</sup> Israel, B. A. (1982). Social networks and health status: Linking theory, research, and practice. *Patient Counseling And Health Education*, 4(2), 65-79.

<sup>7</sup> Ahnquist, J., Wamala, S. P., & Lindstrom, M. (2012). Social determinants of health—a question of social or economic capital? Interaction effects of socioeconomic factors on health outcomes. *Social Science & Medicine*, 74(6), 930-939.

<sup>8</sup> The weighted average only includes members who are 19 years of age or older.

<sup>9</sup> SAMHSA, 2012 as cited in Corrigan et al., 2015.

<sup>10</sup> Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., & Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal*, 183(12), E959-E967.

<sup>11</sup> Any Disorder Among Children. (n.d.) Retrieved December 18, 2017, from <http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml>.

<sup>12</sup> Ibid.

<sup>13</sup> Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, 15(2), 37-70.

<sup>14</sup> A total of 191 members indicated that they needed to see a mental health specialist but did not see one; n's below each bar represent number of respondents who answered each individual question.

<sup>15</sup> Office of Disease Prevention and Health Promotion, Healthy People 2020. Access to Health Services. Accessed at <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>.

<sup>16</sup> Ibid.

<sup>17</sup> Vietnamese speakers were excluded from this chart because of inaccurate translation of this question from English to Vietnamese, making interpretation of results difficult.

<sup>18</sup> Betancourt, J.R. et al., "From the Field: Cultural Competence and Health Care Disparities: Key Perspectives and Trends," *Health Affairs*. 24, no. 2 (2005): 499-505. Accessed at <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.24.2.499>

<sup>19</sup> Centers for Disease Control and Prevention. National Prevention Information Network. Cultural Competence. Accessed at <https://npin.cdc.gov/pages/cultural-competence>.

<sup>20</sup> Orange County Healthier Together. Health Care Disparities Report. [http://www.ochealthiertogether.org/content/sites/ochca/Hospital\\_Logos/OC\\_Health\\_Disparities\\_Report\\_June\\_2016.pdf](http://www.ochealthiertogether.org/content/sites/ochca/Hospital_Logos/OC_Health_Disparities_Report_June_2016.pdf).

<sup>21</sup> Members could choose multiple answers; thus, the total does not equal 100 percent.

# OVERALL CONSIDERATIONS

The MHNA was one of the most extensive and inclusive member health needs assessments undertaken by CalOptima in its 20-plus-year history. The MHNA engaged more than 6,000 members, providers and community stakeholders by utilizing methods that were comprehensive, engaging and personal. Findings from the MHNA provided data critical to ensuring that CalOptima can continue to meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. This section summarizes key findings as well as strategies that CalOptima, health care providers and community partners might consider in ongoing efforts to strengthen the system of care in Orange County.

**Members are culturally diverse and want providers who both speak their language and understand their culture.** There is an opportunity to build on existing resources in Orange County and deepen cultural competence of providers and services. Partners in culturally focused, community-based organizations can help tailor and implement trainings for providers around specific populations. Such trainings can build language and sensitivity skills and increase content knowledge in areas such as ethnopharmacology (i.e., variations in medication responses in diverse ethnic populations) for staff across the spectrum of care, improving member/provider interactions and strengthening the workforce. Additionally, patient navigators can provide culturally sensitive assistance and care coordination to link members to services.

**Lack of knowledge and fear of stigma are key barriers to utilizing mental health services.** Language and cultural norms make members from some subgroups less likely to access mental health services than others. Although CalOptima provides mental health coverage, fear of stigma may prevent CalOptima members from seeking mental health services. This presents an opportunity to continue to provide culturally relevant education around mental health to improve understanding of available services and to address fear of stigma many people face. Community partners with deep knowledge of specific cultural communities are eager to offer support to providers to increase the use of mental health services. Additional evidence-based strategies include integrating behavioral health into primary care practice, infusing trauma-informed care into services and providing Mental Health First Aid training throughout the community.

**Most members are connected to primary care but unsure about what oral health services are covered by CalOptima.** In addition to uncertainty, barriers including long wait times, inconvenient hours and unreliable public transportation can make it challenging to receive timely care. CalOptima and its partners can build on foundational resources and strengthen members' linkages to systems of care. Supporting a centralized organization, such as 211, to link members to available services can help connect members to providers who speak different languages and identify specific services and treatments covered by various plans. When services are not covered, 211 or a similar organization can also connect members to community-based organizations that can support the member in making new connections and accessing appropriate subsidized care. Additionally, patient navigators can provide culturally sensitive assistance and care coordination to link members to services. Remote services, such as telemedicine and school-based health centers, can provide primary, dental and mental health care on-site to students and their families to improve access to care and reduce barriers, such as lack of transportation or long wait times.

**Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.** CalOptima has already taken steps to strengthen the safety net for its members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand this work would likely impact health outcomes in the long run. Helping providers and community partners understand the social and economic issues that may impact health-related behaviors of CalOptima members will encourage programs and services to be adapted to meet members where they are.

Individually, discussions of the social determinants of health, lack of knowledge and stigma around mental health services, barriers to receiving timely and culturally sensitive primary care, and uncertainty around dental health coverage amplify important concerns. These findings are more impactful, however, when considered together. As demonstrated by the risk factor scale reported earlier, it is valuable to remember that members lead complex lives impacted by many overlapping experiences and circumstances. For example, the emotional stress related to economic challenges can negatively impact members' mental health, while stigma and cultural barriers prevent them from seeking care to alleviate this stress. Additionally, members with inadequate financial resources may stretch their finances to keep within a budget by eating more affordable fast food, despite the impact on their overall health and their desire to eat fresh foods. As such, strategies that address overlapping and intersecting issues are best suited to meet members' needs.

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## MHNA Advisory Committee

Thank you to all who served on the advisory committee that guided the development of the MHNA. We appreciate your counsel and input to ensure a comprehensive and inclusive assessment process.

**Veronica Carpenter**

*Deputy Chief of Staff,  
Office of Supervisor Andrew Do,  
First District*

**Kyle Chang**

*Research Analyst IV,  
Orange County Health Care  
Agency, Behavioral Health  
Services*

**Donna Fleming**

*Chief, Public Health Operations,  
Orange County Health Care  
Agency*

**Claudia S. Hernandez**

*Manager, Strategic Development  
CalOptima  
MHNA Project Lead*

**Pshyra Jones**

*Director, Health Education  
and Disease Management  
CalOptima*

**Tiffany Kaaiakamanu**

*Manager, Community Relations  
CalOptima*

**Erlinda Magbanua**

*Program Assistant,  
Strategic Development  
CalOptima*

**Cheryl Meronk**

*Director, Strategic Development  
CalOptima  
MHNA Project Lead*

**Paul Murray**

*Director, Enterprise Analytics  
CalOptima*

**Maria Nguyen**

*Program/Policy Analyst, Sr.,  
Strategic Development  
CalOptima*

**Michael Peralta**

*Program/Policy Analyst, Sr.,  
Strategic Development  
CalOptima*

**Mallory Vega**

*Executive Director,  
Acacia Adult Day Services*

**Chris Wangsaporn**

*Chief of Staff,  
Office of Supervisor  
Andrew Do, First District*

## Community Partners

We extend special thanks to all of the organizations who hosted a focus group, recruited community members to participate, helped to gather data or participated in an interview.

- Abrazar Inc.
- Acacia Adult Day Services
- Access California Services
- Alzheimer's Orange County
- Boat People SOS
- Boys & Girls Club of Garden Grove
- CalOptima Customer Service
- CalOptima PACE Center
- Cambodian Family Community Center
- Center for Autism & Neurodevelopmental Disorders
- Chinese Parents Association for the Disabled
- CHOC Children's
- Coalition of Orange County Community Health Centers
- Council on Aging – Southern California
- Dayle McIntosh Center
- Healthy Smiles for Kids of Orange County
- Illumination Foundation
- Korean Community Services
- La Habra Family Resource Center
- Latino Health Access
- The Center OC
- Mercy House
- MOMS Orange County
- OMID Multicultural Institute for Development
- Orange County Asian Pacific Islander Community Alliance
- Orange County Health Care Agency
- Orange County Board of Supervisors
- Pacific Islander Health Partnership
- Project Access
- Santa Ana Child Guidance Center
- SeniorServ
- South County Outreach
- Southwest Senior Center
- State Council on Developmental Disabilities
- Vietnamese Community of Orange County



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505 City Parkway West, Orange, CA 92868

[www.caloptima.org](http://www.caloptima.org)