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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan

Community Advisory Committee Meeting

Regular Meeting
Wednesday, October 28, 2020 4:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room
Camarillo, CA 93010
Executive Order N-25-20
Conference Call Number:1-805-324-7279
Conference ID Number: 393 135 190#
Para interpretación al español, por favor llame al: 1-805-322-1542 clave: 1234

AGENDA

CALL TO ORDER

ROLL CALL

PUBLIC COMMENT

The public has the opportunity to address the Community Advisory Committee (CAC). Persons wishing to address the Committee should complete and submit a Speaker Card.

Persons wishing to address the CAC are limited to three (3) minutes unless the Chair of the Committee extends time for good cause shown. Comments regarding items not on the agenda must be within the subject jurisdiction of the Committee.

Members of the public may call in, using the numbers above, or can submit public comments to the Committee via email by sending an email to ask@goldchp.org. If members of the public want to speak on a particular agenda item, please identify the agenda item number. Public comments submitted by email should be under 300 words.

OPENING REMARKS

Welcome and Introductions

Staff: Margaret Tatar, Chief Executive Officer
Marlen Torres, Executive Director of Strategy & External Affairs

CONSENT

1. Approval of Community Advisory Committee Regular Meeting Minutes of July 29, 2020.

Staff: Maddie Gutierrez, MMC – Clerk to the Commission

RECOMMENDATION: Approve the minutes.

2. Approval of the Community Advisory Committee 2021 Meeting Dates Schedule

Staff: Maddie Gutierrez, MMC – Clerk to the Commission

RECOMMENDATION: Approve the 2021 CAC meeting schedule.

UPDATES

3. Solvency Action Plan (SAP) Update

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Receive and file the update.

4. Population Needs Assessment Update

Staff: Lupe Gonzalez, MPH, PhD., Director of Health Education, Cultural & Linguistic Services

RECOMMENDATION: Receive and file the update.

5. Medi-Cal Rx Update

Staff: Anne Freese, PharmD., Pharmacy Director

RECOMMENDATION: Receive and file the update.

6. Community Relations Update

Staff: Marlen Torres, Executive Director of Strategy & External Affairs

RECOMMENDATION: Receive and file the update.

7. CAC New Member Applications Update

Staff: Marlen Torres, Executive Director of Strategy & External Affairs
Luis Aguilar, Member Services Manager

RECOMMENDATION: Receive and file the update.

PRESENTATION

8. Provider Communication Plan

Staff: Steve Peiser, Sr. Director of Network Management
Vicki Wrighster, Contracts Manager

RECOMMENDATION: Receive and file the presentation.

COMMENTS FROM COMMITTEE MEMBERS

9. CAC Feedback / Roundtable Discussion

ADJOURNMENT

Unless otherwise determined by the CAC Committee, the next regular meeting will be held on January 27, 2021 at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Community Room, Camarillo, CA 93010.

Administrative Reports relating to this agenda are available at 711 East Daily Drive, Suite #106, Camarillo, California, during normal business hours and on http://goldcoasthealthplan.org. Materials related to an agenda item submitted to the Committee after distribution of the agenda packet are available for public review during normal business hours at the office of the Clerk of the Commission.

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5512. Notification for accommodation must be made by the Monday prior to the meeting by 1:00 p.m. to enable the Clerk of the Commission to make reasonable arrangements for accessibility to this meeting.

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WELCOME & INTRODUCTIONS

TO: Community Advisory Committee

FROM: Margaret Tatar, Chief Executive Officer
Marlen Torres, Executive Director, Strategy & External Affairs

DATE: October 28, 2020

SUBJECT: Opening Remarks

VERBAL PRESENTATION

AGENDA ITEM NO. 1

TO: Community Advisory Committee

FROM: Maddie Gutierrez, MMC - Clerk to the Commission

DATE: October 28, 2020

SUBJECT: Approval of the Community Advisory Committee Meeting Regular Minutes of July 29, 2020.

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the July 29, 2020 Community Advisory Committee regular meeting minutes.

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Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)

Community Advisory Committee (CAC) Minutes
July 29, 2020

CALL TO ORDER

Executive Director of Strategy & External Affairs, Marlen Torres, called the meeting to order via teleconference at 4:07 p.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

ROLL CALL

Present: Committee members Frisa Herrera, Paula Johnson, Laurie Jean Jordan, Curtis Updike and Pablo Velez.

Absent: Committee members Rita Duarte-Weaver, Norma Gomez, Ruben Juarez and Victoria Jump.

Attending the meeting for GCHP Executive team were Margaret Tatar, Chief Executive Officer, Marlen Torres, Michael Murguia, Exec. Director of Human Resources, Ted Bagley, Chief Diversity Officer, Kashina Bishop, Chief Financial Officer, Steve Peiser, Dr. Anne Freese, Luis Aguilar, Bryan Quijada, Robert Franco, Dr. Lupe Gonzalez, Kim Timmerman, Rachel Lambert, Annelie Ginn, Vicki Wrighster, Veronica Estrada and Susana Enriquez.

PUBLIC COMMENT

None.

OPENING REMARKS

1. Chief Executive Officer Opening Remarks

Staff: Margaret Tatar, Chief Executive Officer

Ms. Tatar welcomed the committee and thanked them for their participation. She announced the Commission has hired her to be the Chief Executive Officer for eighteen (18) months. She introduced the new Executive Director of Human Resources, Michael Murguia. Mr. Murguia gave a brief history of his professional background and work with the community.

CONSENT

2. Approval of the Community Advisory Committee Meeting Regular Minutes of April 29, 2020 and Special Meeting Minutes of May 27, 2020.

Staff: Maddie Gutierrez, CMC – Clerk to the Commission

RECOMMENDATION: Approve the minutes.

Committee member Paula Johnson motioned to approve the minutes. Committee member Curtis Updike seconded.

Roll Call vote as follows:

AYES: Committee members Frisa Herrera, Paula Johnson, Laurie Jean Jordan, Curtis Updike and Pablo Velez.

NOES: None.

ABSENT: Committee members Rita Duarte-Weaver, Ruben Juarez, Norma Gomez and Victoria Jump.

The motion carries.

UPDATES

3. State Budget Fiscal Year 2020-2021 Update

Staff: Marlen Torres, Executive Director of Strategy & External Affairs

RECOMMENDATION: Receive and file the update.

Marlen Torres, Executive Director of Strategy & External Affairs reviewed her PowerPoint presentation giving a high-level summary of the State budget. She reviewed the allocations to address COVID-19. The Governor has also prioritized funds to address the homelessness in our State.

Ms. Torres reviewed the Medi-Cal Program. She noted there has been an increase in enrollment. Benefits such as optional expansion benefits, the diabetes prevention program, CBAS, MSSP, as well as Prop. 56 will continue. There has been an increase in Supplemental Security Income/State Supplemental Payment grant by passing the federal cost of living adjustment to recipients. The Budget also maintains CalWORKS eligibility and grant levels. The Medi-Cal 20/20 is a waiver extension is an extended

time limit for aid to adult recipients from 48 months to 60 months, which includes the Whole Person Care program. There has been a delay in the implementation of CalAIM, as well as a delay of Medi-Cal expansion to undocumented seniors. DHCS has reduced capitation rate increments up to 1.5% retroactive to July 1, 2019.

4. Medi-Cal Rx – Member Communications

Staff: Dr. Anne Freese, Director of Pharmacy

RECOMMENDATION: Receive and file the update.

Dr. Freese stated she is seeking advice/feedback form the CAC. She is asking for input on member communications regarding the Rx transition that will occur January 1, 2021.

Dr, Freese reviewed the three (3) notices that are scheduled to go out to members: the 90-day written member notice which will be sent October 1, 2020, the 60-day notice scheduled for November 1, 2020 and the December 1, 2020 30-day notice. Dr. Freese would like to shar feedback with the State.

CAC member Velez asked if there was a Spanish version for these notices. Dr. Freese stated she does not have the Spanish version done yet, she is waiting for finalization of the documents before having them translated, but will share the Spanish version, once done, with the Committee.

CEO Tatar explained the changes in the pharmacy benefits. Currently, GCHP delivers pharmacy benefits to members, but beginning in January, the State will begin managing prescriptions, per Governor Newsom. CAC member, Curtis Updike, stated this is similar to what was done prior to GCHP, which was Fee for Service. Clients will go to local pharmacies which accept the benefit card and get their medications. The formulary may change but allows for a drive down in costs. The Governor believes this will save the State money.

Committee member Laurie Jean Jordan asked what will happen for clients who need fine-tuned medications which are already hard to get. Dr. Freese stated the policy is not finalized yet and more information will be presented on the transition in October. Committee member Updike asked if there will be a grandfather period for medications. CEO Tatar stated there will be a period to ensure a good transition. Committee member Paula Johnson asked if there is a transition policy. Dr. Freese stated that if the patient is taking medications prior to the transition, the medications will continue for six (6) months after the transition period.

Dr. Freese stated letters will go out 90, 60 and 30 days prior to the transition. The State has also prepared a script for telephone outreach to all members.

Committee member Frisa Herrera asked when will doctors and pharmacies have access to the new formulary. Dr. Freese stated it is already on the Medi-Cal website with minor changes. Committee member Updike aske if it was possible to put together a comparison. Dr. Freese stated currently there is an 80% match and is hoping the percentage will increase. We need to identify who will be at risk.

Kim Timmerman, Director of Quality Management, noted a sentence in the letter which could be alarming. She stated that clarification might need to be added on who is going to take over.

Marlen Torres, Executive Director of Strategy & External Affairs stated the committee can send feedback via email to Dr. Freese. She asked Dr. Freese if there was a deadline for the feedback. Dr. Freese responded she would like feedback by mid-August. Dr. Freese stated she will return at the next meeting and present an update on the transition.

5. Gold Coast Health Plan Website Re-Design Update

Staff: Susana Enriquez, Public Relations Manager

RECOMMENDATION: Receive and file the update.

Ms. Enriquez gave a quick tour of the updated website with the committee. Committee member Paula Johnson stated she would like to set up a meeting that would include her managers to review the changes. A meeting will be scheduled with Ms. Enriquez.

Committee member Curtis Updike motioned to approve Update Agenda Items 3 through 5. Committee member Pablo Velez seconded.

Roll Call vote as follows:

AYES: Committee members Frisa Herrera, Paula Johnson, Laurie Jean Jordan, Curtis Updike and Pablo Velez.

NOES: None.

ABSENT: Committee members Rita Duarte-Weaver, Ruben Juarez, Norma Gomez and Victoria Jump.

The motion carries.

PRESENTATIONS

6. Solvency Action Plan

Staff: Margaret Tatar, Chief Executive Officer
Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Receive and file the presentation.

Chief Financial Officer, Kashina Bishop gave a progress report on the GCHP Solvency Action Plan. She identified risks and challenges for the upcoming quarter. The GCHP outlier stated was reviewed. CFO Bishop noted the 1.5% rate reduction that is retroactive to July 1, 2019. She also noted the 10% increase to the Long-Term Care facility rate which became effective March 1, 2020. Efficiency adjustments to the upcoming rate year will be done beginning January 1, 2021.

CFO Bishop review the impacts to the TNE forecasts. She noted the Solvency Action Plan is done on a phased approach – currently GCHP is on Phase 2. Phase 3 is expected to be implemented February of 2021.

Risks and Challenges were reviewed. CFO Bishop noted receipt of revised capitation rates from the State, provider rate decreases and potential impact to the network and she noted unknown impacts to medical expenses with the pandemic.

7. COVID-19 Federal Emergency Management Agency (FEMA) Grant Program

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Receive and file the presentation.

CFO Bishops reviewed the FEMA COVID-19 grant with the committee. Eligible applicants were state agencies, local governments, special districts, federally recognized Tribal governments and private non-profit organizations which own or operate a private nonprofit facility. Eligible expenses were reviewed. GCHP applied for the grant and the application was approved.

8. Strategies on How to Improve MCAS/HEDIS Quality Measures

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Kim Timmerman, Director of Quality Improvement

RECOMMENDATION: Receive and file the presentation.

Kim Timmerman, Director of Quality Measures, reviewed the PowerPoint presentation. Ms. Timmerman is requesting feedback/suggestions on how low performing measures can be improved. Committee member Curtis Updike suggested review the information with other groups/plans that have had better results and review how their scores are better.

Committee member Velez noted that due to the pandemic, members are hesitant to go to the doctor for well care child exams, and annual screenings.

9. New Risk Assessment Survey

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Rachel Lambert, Director of Care Management

RECOMMENDATION: Receive and file the presentation.

Rachel Lambert, Director of Care Management reviewed the Risk Assessment Survey with the committee. She gave an overview of the survey, the risk assessment scoring and reviewed the proposed updated survey.

Ms. Lambert noted that although some of the questions seem very personal, the staff is trained before doing the survey with the member in order to build a rapport with the member prior to taking the survey and answering questions.

Committee member Laurie Jordan asked if there was follow-up with the member after the survey was given. Ms. Lambert stated follow up continues up to one year.

Committee member Curtis Updike motioned to approve Presentation Agenda Items 6 through 9. Committee member Pablo Velez seconded.

Roll Call vote as follows:

AYES: Committee members Frisa Herrera, Paula Johnson, Laurie Jean Jordan, Curtis Updike and Pablo Velez.

NOES: None.

ABSENT: Committee members Rita Duarte-Weaver, Ruben Juarez, Norma Gomez and Victoria Jump.

The motion carries.

DISCUSSION

10. CAC Membership

Staff: Marlen Torres, Executive Director of Strategy & External Affairs
Luis Aguilar, Member Services Manager

Executive Director of Strategy & External Affairs, Marlen Torres, stated some committee members received an email requesting them to fill out a new CAC application because their terms were ending. Existing members will do a first round of review for new applicants and they will submit recommendations. The final approval is submitted to the Commission for approval of open seats that need to be filled. The open seats are open to the community, but she noted that the committee needs to abide by the government codes. New applicants will be reviewed by an AdHoc Committee, members of this committee are Curtis Updike, Victoria Jump and Ruben Juarez.

Luis Aguilar, Member Services Manager, stated the selection of a new Chair and Vice-Chair will be done at the next CAC meeting which will be held in October 2020. Renewal of terms will also be done at that time.

COMMENTS FROM COMMITTEE MEMBERS

11. CAC Feedback/Roundtable Discussion

Pauline Preciado, Sr. Director of Population Health, reviewed the MyStrength information which was sent to the committee. MyStrength is a resource for mental health through Beacon. The resources are free but are limited time. Members must log on by August 31, 2020 in order to receive assistance. Ms. Preciado stated she was available if committee members wanted to reach out to her for more information.

ADJOURNMENT

Committee member Pablo Velez motioned to adjourn the meeting. Committee member Curtis Updike seconded.

With no further business to discuss the clerk adjourned the meeting at 6:44 p.m.

Approved:

____

Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Community Advisory Committee

FROM: Maddie Gutierrez, MMC - Clerk to the Commission

DATE: October 28, 2020

SUBJECT: Approval of the 2021 Community Advisory Committee Meeting Calendar.

SUMMARY:

To establish the Community Advisory Committee (CAC) meeting dates for the 2021 calendar year.

RECOMMENDATION:

Approve the 2021 Community Advisory Committee (CAC) calendar as presented.

ATTACHMENTS:

Copy of the 2021 Community Advisory Committee meeting calendar.

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CAC Meeting
4:00 PM - 6:00PM

2021 Community Advisory Committee Meeting Dates

January

Su	M	Tu	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
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31						

February

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28						

March

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July

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25	26	27	**28**	29	30	31

August

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September

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November

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December

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19	20	21	22	23	24	25
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Yearly Calendar Template by Vertex42.com
https://www.vertex42.com/ExcelTemplates/yearly-calendar.html
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AGENDA ITEM NO. 3

TO: Community Advisory Committee

FROM: Kashina Bishop, Chief Financial Officer

DATE: October 28, 2020

SUBJECT: Solvency Action Plan Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

Progress Report: Solvency Action Plan

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Progress Report: Solvency Action Plan

October 28, 2020

Kashina Bishop
Chief Financial Officer

Integrity
Accountability
Collaboration
Trust
Respect

Agenda:

1. Background:
   a. Required Tangible Net Equity (TNE)
   b. Comparison to California Public Plans
   c. State Budget and financial implications

2. Solvency Action Plan – Initiative Update

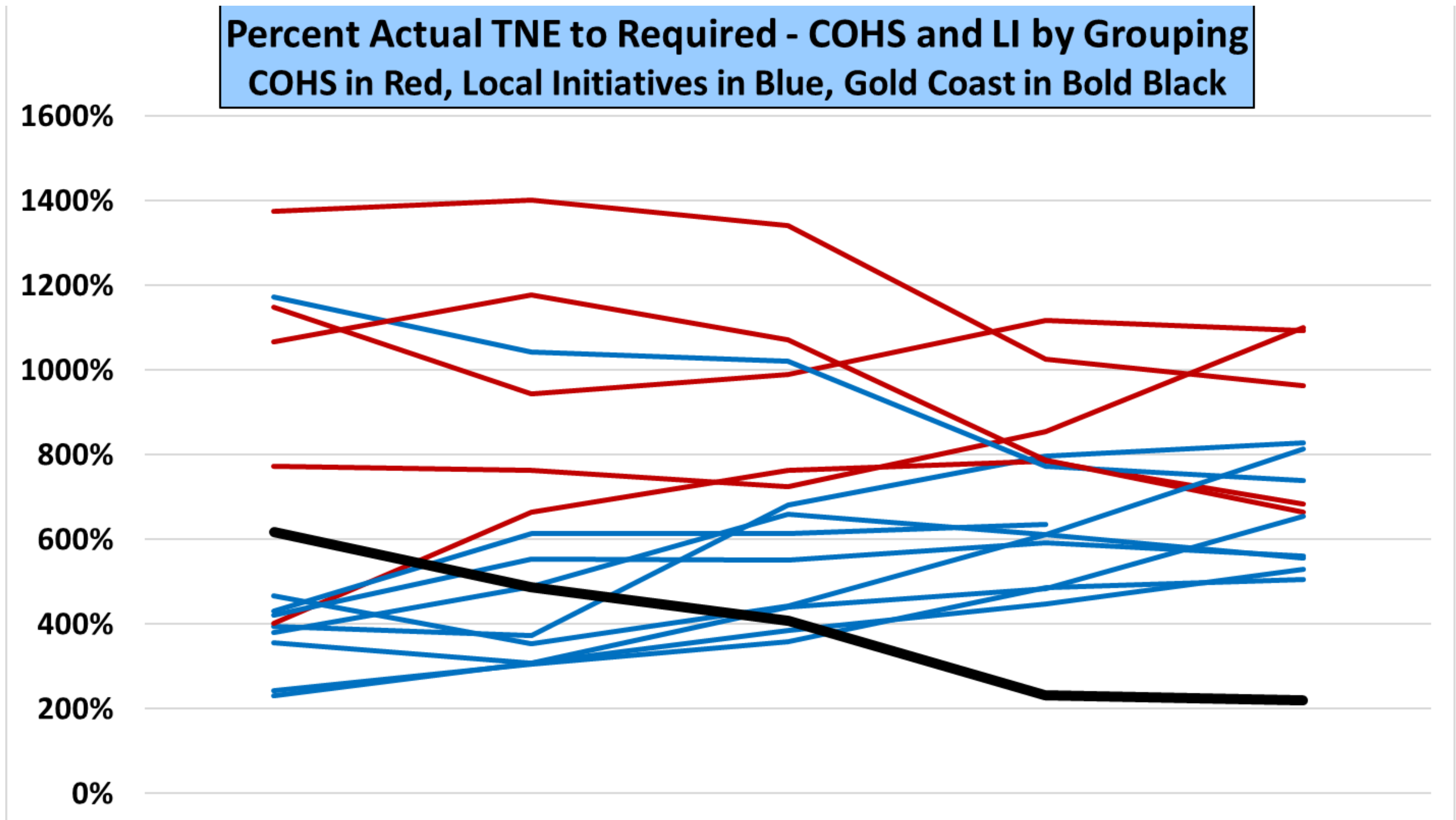
3. Identify risks and challenges for the upcoming quarter relating to ongoing progress for Solvency Action Plan

4. Questions and comments

Background: Tangible Net Equity Requirements

1. TNE is a health plan's total assets minus total liabilities reduced by the value of intangible assets and unsecured obligations of officers, directors, owners, or affiliates outside of normal course of business.
2. Required TNE for a plan is the greater of 1 million dollars or a % of premium revenues or a % of healthcare expenses.
3. Excess TNE is the difference between total TNE and required TNE.

Background:
GCHP Outlier Status Among Public Plan



Background:
Financial Implications of State Budget

As a response to the public health emergency and the negative economic consequences to California, budget proposals include managed care rate reductions and program efficiencies.

1. 1.5% rate reduction retroactive to July 1, 2019 ($8.5 million)
2. Increase of 10% to Long Term Care facility rate effective March 1, 2020 through the emergency (FYTD Through August - $3.5 million)
3. Efficiency and acuity adjustments to upcoming rate year beginning January 1, 2021 ($8+ million)

Update on the Solvency Action Plan:

Actions	Annualized impact in savings
Continued focus on interest expense reduction	$500,000
Reduction of LTC facility rates to 100% of Medi-Cal rate	$1.8 million
Sent notification to providers regarding reduction of Adult Expansion PCP rates	$4.5 million
Revision to Non-Pharmacy Dispensing Site policy	$2-3 million
Contract signed – rate reduction to tertiary hospital	$1.3 million
Optum contract rate reduction	$150,000
TOTAL ANNUAL SAVINGS	**$10.3 – 11.3 million**

Next steps - Phase 2: Solvency Action Plan

- WORK/ANALYSIS ON SOLVENCY ACTION CONTINUES
- HOWEVER, IMPLEMENTATION OF ANY PROVIDER RATE/CONTRACT CHANGES WILL ON HOLD THROUGH THE SYSTEM CONVERSION
- GCHP remains committed to preparation and planning for CY 2021

Next steps -
Phase 2: Solvency Action Plan

Current Focus - includes but not limited to	Annualized $ Savings
Outlier contract rates	TBD
Implementation of HMS	$1-3 million
Improved contract language	TBD
Expansion of capitation arrangements	Required TNE and risk reductions
LANE/HCPCS analysis	TBD
Consideration of across the board reductions	TBD

Next steps -
Phase 2: Solvency Action Plan Planning and Preparation

1. Outlier rate analysis
2. Contract reviews
3. Input from the Provider Advisory Committee
4. Financial analysis

Solvency Action Plan – risks and challenges:

1. Coordination with system conversion
2. Provider acceptance of rate decreases and potential impact to network
3. Unknown impact to medical expense with the pandemic
4. Extent of further CY 2021 capitation rate adjustments

Questions?

AGENDA ITEM NO. 4

TO: Community Advisory Committee

FROM: Lupe Gonzalez, MPH, PhD, Director of Health Education, Cultural and Linguistic Services

DATE: October 28, 2020

SUBJECT: Population Needs Assessment (PNA) – Stakeholder Survey Findings

POWERPOINT PRESENTATION

ATTACHMENT:

Final October CAC Meeting Presentation_PNA Reporting Findings October2020
Final _DHCS_Gold Coast Health Plan_PNA_063020 pdf

RECOMMENDATION:

Receive and file the update

Gold Coast Health Plan[SM]
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Health Education, Cultural and Linguistic (HECL) Services

Community Advisory Committee 2020 Population Needs Assessment Report Findings

Wednesday, October 28, 2020

Lupe González, PhD, MPH
Director, Health Education/Cultural and Linguistic Services

Integrity

Accountability

Collaboration

Trust

Respect

AGENDA

- Overview of the 2020 Population Health Needs Assessment (PNA) Report
- Stakeholder Engagement – PNA Survey Findings
- Strategic Objectives
- Next Steps

PNA Overview

- Key requirements include the following items:
  - PNA Data Sources
    - Review reliable data sources
    - Claims and Encounter Data
    - Health Disparity Reports
    - Consumer Assessment of Healthcare Providers & Systems (CAHPS)
    - Ventura County Community Health Needs Assessment
  - PNA Findings and Action Plan
    - Collaborate with Quality Improvement Department
    - SMART Goals and Objectives
  - Stakeholder Engagement

Stakeholder Engagement Survey

- A total of 21 individuals completed the PNA Stakeholder Survey

- Survey Included the Following Key Sections:
    1. Member's health concerns/issues
    2. Cultural and linguistic needs
    3. Health conditions
    4. Member engagement
    5. Social Determinants of Health

Stakeholder Survey Key Findings

- Health Literacy – Important to address health insurance benefits, health coverage, and access to care.

- Communication Strategies – It was recommended to develop social media strategies in English and Spanish for members, as this can increase the awareness for improving member's health along with identifying the barriers that keeps members from participating.

- Social Networks – It was reported that GCHP members learn best on improving their health condition by seeking advice from: 1) family/friends and 2) doctor's offices/clinics.

Stakeholder Survey Key Findings

- GCHP members learn about their health by seeking health care advice and participating in community resources. However, there are many other social determinants of health factors that makes it difficult for members to manage their own health.

- Barriers to Health Care Services – Transportation to health care appointments, timely access to preventive care services, and lack of understanding of health care system and benefits.

- Access to Care – GCHP can improve member's health by providing timely access to PCPs, medication, developing user friendly information that is clear to the readers, and by providing ongoing media presentations (i.e., radio or media platforms).

Stakeholder Survey Key Findings

- Social Determinants of Health (SDOH) – Important to understand the factors that contribute health outcomes and build trust in the community.
- Build Trust in the Community – working with health promoters, friends/families, provider offices, health educators, and other community health workers.
- Cultural Diversity – Important to address cultural health beliefs, expand language assistance services including explain the difference between translating and interpreting services and delivery culturally and linguistically appropriate services to members.

Strategic Objectives

1. Identify members with a chronic health condition such as diabetes, hypertension, heart disease, or asthma to attend a health education class.

2. Increase asthma medication adherence among members between the ages of 5-64.

3. Chlamydia screening in women between the ages of 16-24 years of age.

Strategic Objectives (Continued)

4. Lead Screening in Children (LSC) - Childhood lead screening among children between 0-24 months.

5. Well-Child Visits in the First 15 Months of Life (W15) and Childhood Immunization Status Combo 10 (CIS-10) - Well child visits and immunization promotion among children between the ages of 0 to 24 months.

6. Health disparity and the impact of language, ethnicity, and cultural beliefs on managing diabetes (A1C) levels among Latinos.

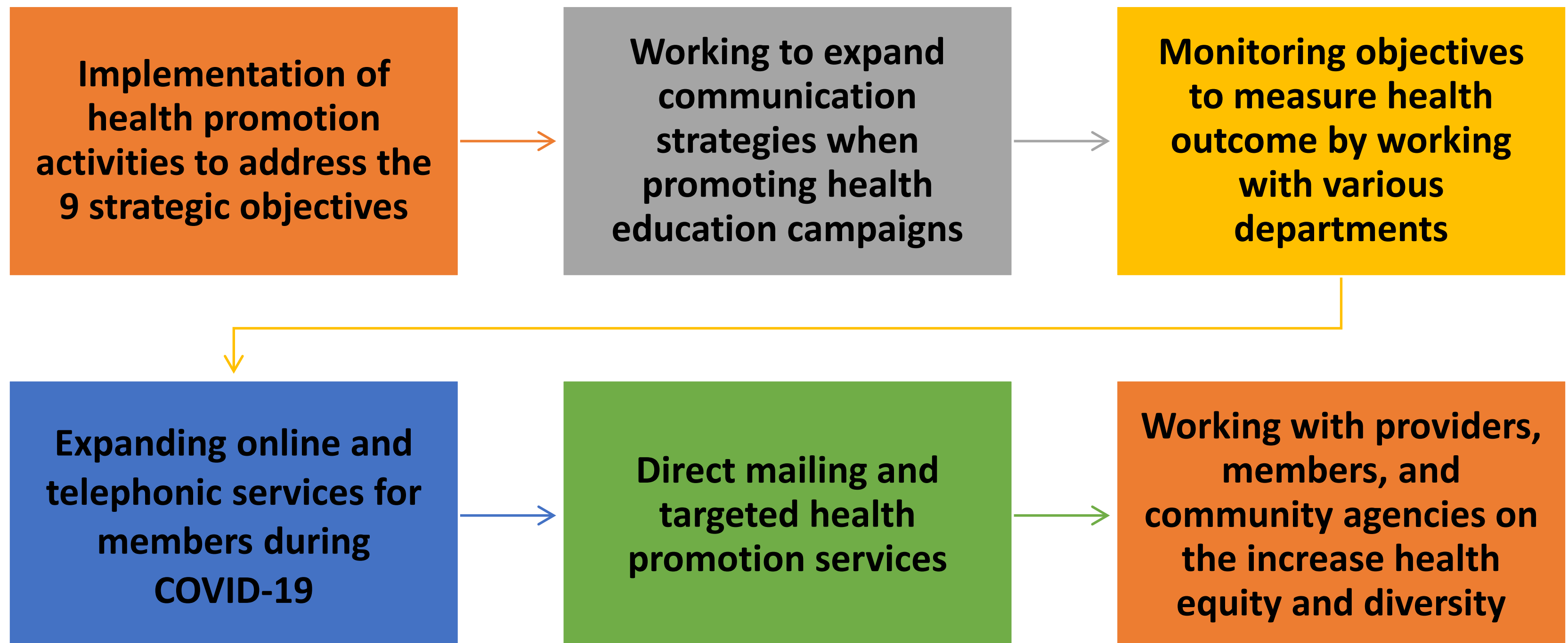
Strategic Objectives (Continued)

7. Language access services among providers and members, and the ability of providers to address the language, cultural beliefs, and health literacy of members.

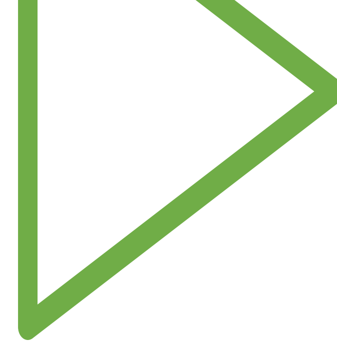
8. Childhood obesity and health promotion among children between the ages of 0-5 years of age.

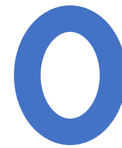
9. Increase awareness of access to care among members seeking routine medical services with primary care providers and specialist.

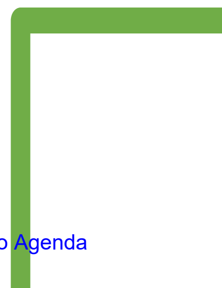
Next Steps



Questions?







Servicios de Educación para la Salud, Culturales y Lingüísticos (HECL)

Comité Asesor Comunitario Evaluación de las Necesidades de la Población de 2020 Resultados del Informe

Miércoles, 28 de octubre de 2020

Lupe González, PhD, MPH
Directora, Servicios de Educación para la Salud/Culturales y Lingüísticos

Integridad

Responsabilidad

Colaboración

Confianza

Respeto

AGENDA

- Repaso del Informe de Evaluación de Salud de la Población (PNA) de 2020
- Participación de las Partes Interesadas; Resultados de la Encuesta de la PNA
- Objetivos Estratégicos
- Próximos Pasos

Revisión de la PNA

- Los requisitos clave incluyen los puntos siguientes:
  - Fuentes de Datos de la PNA
    - Revisar fuentes de datos confiables
    - Datos sobre Reclamaciones y Encuentros
    - Informes de Disparidad en Salud
    - Evaluación de los Consumidores de Proveedores y Sistemas de Salud (CAHPS, por sus siglas en inglés)
    - Evaluación de Necesidades de Salud Comunitarias del Condado de Ventura
  - Resultados de la PNA y Plan de Acción
    - Colaborar con Departamento de Mejora de Calidad
    - Metas y Objetivos SMART
  - Participación de Partes Interesadas

Encuesta de Participación de Partes Interesadas

- Un total de 21 personas completaron la Encuesta para Partes Interesadas en la PNA

- La encuesta incluyó las siguientes secciones clave:
  1. Preocupaciones/problemas de salud de los miembros
  2. Necesidades culturales y lingüísticas
  3. Condiciones de Salud
  4. Participación de los Miembros
  5. Determinantes Sociales de la Salud

Resultados Clave de la Encuesta entre Partes Interesadas

- Alfabetización en Salud: Importante abordar beneficios de seguros de salud, cobertura médica y acceso a la atención.

- Estrategias de Comunicación: Se recomendó desarrollar estrategias en redes sociales en inglés y español para miembros, ya que esto puede incrementar la consciencia para mejorar la salud de los miembros, así como identificar las barreras que impiden participar a los miembros.

- Redes Sociales: Se reportó que los miembros de GCHP aprenden mejor sobre cómo mejorar su condición de salud pidiendo consejo a (1) familiares/amigos y (2) clínicas/consultorios médicos.

Resultados Clave de la Encuesta entre Partes Interesadas

- Los miembros de GCHP se informan sobre su salud buscando consejo sobre atención de salud y participando en recursos comunitarios. Sin embargo, hay muchos otros determinantes sociales de factores de salud que hacen difícil que los miembros gestionen su propia salud.

- Barreras para los Servicios de Salud: Transporte a citas de atención de salud, acceso oportuno a servicios de cuidados preventivos, y falta de entendimiento del sistema de salud y beneficios.

- Acceso a la Atención: GCHP puede mejorar la salud de sus miembros proporcionando acceso oportuno a proveedores de atención primaria, medicamentos, desarrollando información accesible para el usuario que sea clara para los lectores, y proporcionando presentaciones continuas en los medios (esto es, plataformas de radio o medios).

Resultados Clave de la Encuesta entre Partes Interesadas

- Determinantes Sociales de la Salud (SDOH, por sus siglas en inglés): Importante entender los factores que contribuyen a resultados de salud y a fomentar la confianza en la comunidad.

- Fomentar la Confianza en la Comunidad: Trabajar con promotores de salud, amigos/familias, oficinas de proveedores, educadores de salud y otros trabajadores de salud comunitaria.

- Diversidad Cultural: Importante abordar las creencias culturales sobre salud, ampliar los servicios de asistencia lingüística, incluyendo explicar la diferencia entre servicios de interpretación y traducción y proporcionar a los miembros servicios cultural y lingüísticamente apropiados.

Objetivos Estratégicos

1. Identificar a miembros con condiciones crónicas de salud, como diabetes, hipertensión, enfermedad cardiaca o asma, para que asistan a una clase de educación para la salud.

2. Incrementar el cumplimiento de la medicación contra el asma entre los miembros de edades entre 5-64 años.

3. Evaluación de clamidia en mujeres entre 16 y 24 años de edad.

Objetivos Estratégicos (Continúa)

4. Evaluación de Plomo en Niños (LSC, por sus siglas en inglés): Evaluación de plomo en la infancia entre niños de 0-24 meses.

5. Visitas de Bienestar Infantil en los Primeros 15 Meses de Vida (W15) y Combo 10 de Estado de Inmunización en la Infancia (CIS-10): Promoción de las visitas de bienestar infantil y de inmunización entre las edades de 0-24 meses.

6. Niveles de disparidad de salud e impacto de idioma, etnicidad y creencias culturales sobre el manejo de la diabetes (A1C) entre latinos.

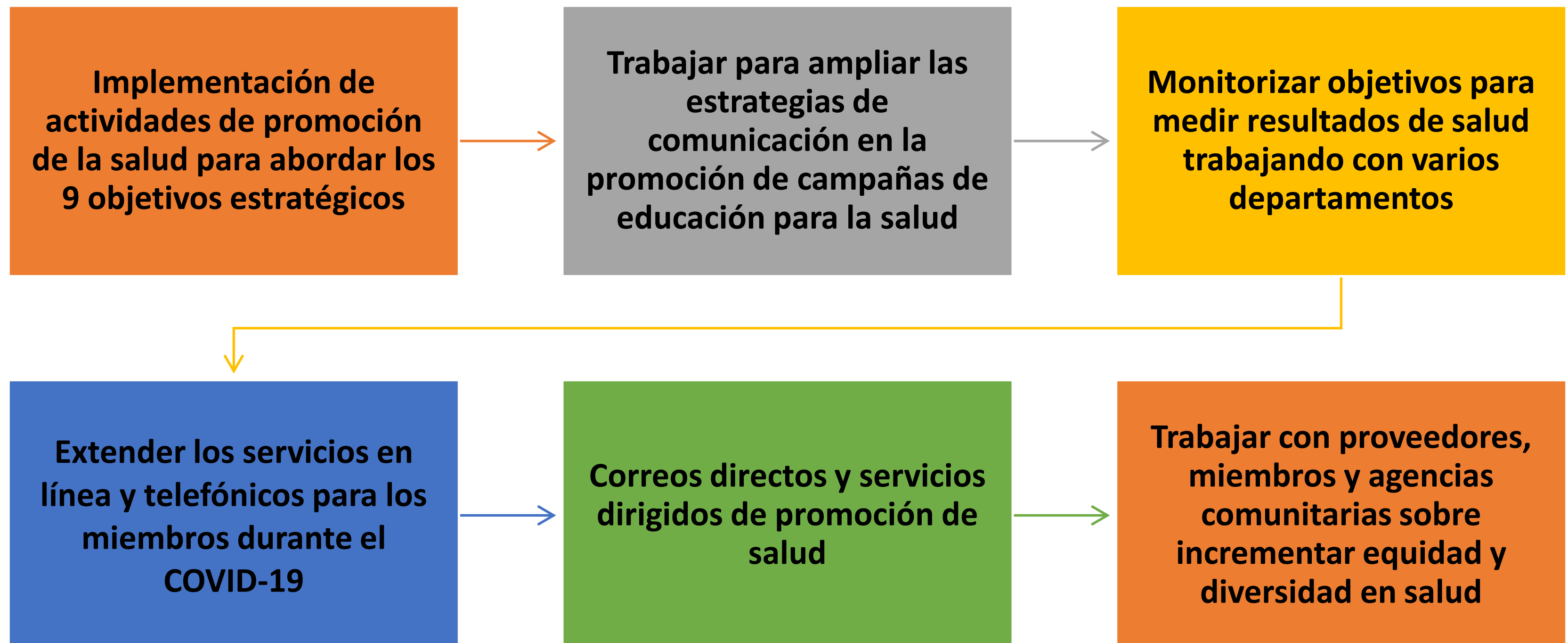
Objetivos Estratégicos (Continúa)

7. Servicios de acceso lingüístico entre proveedores y miembros, y la capacidad de los proveedores de abordar los idiomas, creencias culturales y alfabetización en salud de los miembros.

8. Obesidad infantil y promoción de salud entre niños de edades entre 0-5 años de edad.

9. Incrementar la consciencia de acceso a la atención entre miembros que buscan servicios médicos rutinarios con proveedores de atención primaria y especialistas.

Próximos Pasos



¿Preguntas?

Population Needs Assessment

Gold Coast Health Plan
June 2020

Responsible Health Education and/or Cultural and Linguistic Staff
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Introduction

Gold Coast Health Plan (GCHP) is an independent public entity and is governed by the Ventura County Medi-Cal Managed Care Commission serving Medi-Cal beneficiaries living in Ventura County. As of April 2020, GCHP has a membership of 189,145. Based on the Health Effectiveness Data and Information Set (HEDIS) continuous enrollment and eligibility criteria a total 165, 675 members were identified during the calendar year for 2019 for reporting quality and performance measure outcomes. The HEDIS criteria used to define the population include 11 months of consecutive enrollment in GCHP with full-scope Medi-Cal status.

GCHP was established in 2011 as a County Organized Health System (COHS) managed care model established by the Ventura County Board of Supervisors. GCHP is one of six COHS models throughout the state of California. GCHP operates under a contract by the California Department of Health Care Services (DHCS) to provide health services to Medi-Cal beneficiaries. GCHP operates by a governing body which is comprised of locally elected officials, providers, hospitals, clinics, the county healthcare agency, and consumer advocates.

Medi-Cal beneficiaries are assigned automatically to GCHP, including dual-eligible Medicare-Medicaid and Seniors and Persons with Disabilities (SPD). Other membership groups include children eligible for California Children's Services (CCS) as well as members living in skilled nursing facilities. GCHP has a robust provider network that consist of a total of 672 network providers, 194 Primary Care Providers (PCP) and 478 contracted Specialists.

The population needs assessment (PNA) is conducted to fulfill the contractual requirement of the Department of Health Care Services (DHCS), Medi-Cal Managed Care Plans Division. The goal of the PNA is to assess and improve the health status of individuals enrolled in Medi-Cal. The PNA will identify member health status and behaviors, cultural and linguistic needs, health disparities, and develop an action plan to address the barriers to care and gaps in services.

The Department of Health Education, Cultural and Linguistic Services is under the division of Population Health Management and Equity, which also includes the Department of Quality Improvement. The Chief Medical Officer oversees Population Health Management and Equity. The Health Education, Cultural and Linguistic Services (HECL) meets quarterly to review program services, policy and procedures, and work plan program objectives. The HECL Committee is comprised of representatives from health services, quality improvement, provider network operations, member services, and other departments with member facing contact. The PNA was prepared by the Department of Health Education, Cultural and Linguistic Services in collaboration with Quality Improvement, Decision Support Services (DSS), Provider Network Operations, Health Services Departments, and various representatives from the HECL Committee. The PNA

outlines findings from primary and secondary data analysis as well as information from key stakeholder interviews and survey responses. An external stakeholder meeting was held with members of the Community Advisory Committee (CAC) to review survey responses and identify key communication strategies to improve the health outcome among members enrolled in GCHP.

I. Population Needs Assessment Overview

The Population Needs Assessment (PNA) is conducted to fulfill the contractual obligation of Department of Health Care Services (DHCS), Medi-Cal Managed Care Division (MMCD), and concomitant All Policy Letter 19-011[1]. The goal of the PNA is to improve health outcomes and ensure GCHP is meeting the needs of its membership. The purpose of the PNA is to review primary and secondary quantitative and qualitative data to identify the health status, health education, cultural and linguistic needs, health disparities, gaps in services, and social determinants of health impacting members.

Findings of the PNA are intended to develop strategies for improving the health outcome of members by evaluating their health risk, identifying health needs, and setting priorities for program interventions.

Key data and reports collected for the preparation of the PNA includes:

- GHCP administrative data 2019, which includes claims, encounter, immunization registry, laboratory and pharmacy data.
- Healthcare Effectiveness Data and Information Set (HEDIS®) Results 2019
- CMS Adult and Child Core Measure Sets for Medicaid 2019
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2019 Survey Report
- DHCS Health Disparity 2016 Report
- Health Information Form/Member Evaluation Tool (HIF/MET) 2019

Additionally, various community needs assessment reports on health status, social determinants of health, socioeconomic data, and membership utilization data. The PNA report includes data on vulnerable populations and on the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community. In addition to quantitative data collection, the PNA gathered qualitative data from survey responses from GCHP's Community Advisory Committee (CAC) members by conducting stakeholder interviews and/or meetings with CAC members. GCHP employees who have direct member facing contact were also surveyed to identify health education, cultural and linguistic needs of members.

[1] Department of Healthcare Services (DHCS) All Plan Letter 19-011, 2019.

Utilizing multiple data sources including both quantitative and qualitative data findings, GCHP prepared the SMART (specific, measurable, achievable, realistic, time-bound) objectives for the 2020 PNA. The objectives identified were prioritized by reviewing multiple sources, such as performance measures that did not meet the DHCS mandated Minimum Performance Level (MPL), and those with the lowest rates, to establish the focused objectives for the program intervention strategy. Health disparity data reported by the GCHP Quality Improvement (QI) Department and DHCS was used to identify key health disparities for GCHP's population.

Health conditions prevalence showed diabetes, hypertension, heart disease, and asthma as the top health conditions among GCHP members. HEDIS data showed that asthma medication management, well-child visits, childhood immunizations, chlamydia screening in women and lead screening in children are top areas in need of improvement. Results from various health disparity reports showed poor health outcomes for Latino members diagnosed with diabetes living in the Santa Clara Valley, which includes Santa Paula, Fillmore, and Piru, and childhood obesity among Latino children living in Port Hueneme and the greater Oxnard area. The timely access to care and provider surveys indicated there is a need for language access among providers and members. Another area identified was members seeking routine medical services.

Utilizing multiple data sources to prepare SMART objectives, GCHP identified nine (9) SMART objectives and prepared an action plan with specific intervention strategies to address areas of improvement and to better address health outcomes. The areas of focus include the following:

1. Identify members with a chronic condition such as diabetes, hypertension, heart disease, or asthma to attend a health education class. The health navigators will promote member engagement and provide training to members adopting the evidenced-based Chronic Disease Self-Management Program.
2. Asthma Medication Ratio (AMR) - Asthma education and member engagement program for members between 5-64 years of age with a diagnosis of persistent asthma. The health education team will collaborate with various multi-disciplinary team members to identify potential members and will conduct an outreach campaign including educational phone calls and text messages.
3. Chlamydia Screening in Women - Chlamydia screening in women between the ages of 16-24 years of age. The health navigators will conduct member outreach calls, prepare health education flyer and member articles on prevention and the importance of timely screenings. In collaboration with QI Department, the health navigators will work to identify members to increase awareness.
4. Lead Screening in Children (LSC) - Childhood lead screening among children between 0-24 months. The Health Education Department will collaborate with

local organizations and educate medical clinics on best practices. In addition, Health Education Department will collaborate with QI Department to utilize Initial Health Assessments and medical record reviews to identify barriers and opportunities for improvement and implement a provider and member awareness campaign.

5. Well-Child Visits in the First 15 Months of Life (W15) and Childhood Immunization Status Combo 10 (CIS-10) - Well child visits and immunization promotion among children between the ages of 0 to 24 months.
6. Health disparity and the impact of language, ethnicity, and cultural beliefs on managing diabetes (A1C) levels among Latinos. Health Education Department will collaborate with QI and Health Services Departments to develop and implement a diabetes education among Hispanic/Latinos members living in the Santa Paula area.
7. Language access services among providers and members, and the ability of providers to address the language, cultural beliefs, and health literacy of members.
8. Childhood obesity and health promotion among children between the ages of 0-5 years of age.
9. Increase awareness of access to care among members seeking routine medical services with primary care providers and specialist.

The PNA replaced the DHCS required Group Needs Assessment (GNA) and will be conducted annually to assess the health care needs of GCHP members by providing high quality of care for all members. Findings of the PNA will be used to address the needs of beneficiaries and develop evidence-based culturally appropriate interventions to better server members.

II. Data Sources

Quantitative and qualitative data sources were used to assess the demographic profile, health status, and social determinants of health among GCHP's membership. The data collected for the preparation of the PNA include:

- Administrative Data 2018 & 2019 - GHCP Claims, Encounter, Immunization Registry, Laboratory and Pharmacy Data
- CMS Adult and Child Core Sets for Medicaid Results2019
- United States Census Bureau Data 2019
- Healthcare Effectiveness Data and Information Set (HEDIS®) Results 2019
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey 2019
- Department of Health Care Services (DHCS) Health Disparity Report 2016

- Health Risk Assessment – GCHP Health Information Form/Member Evaluation Tool (HIF/MET) Questionnaire 2019
- GCHP Health Services Utilization Management (UM) Report 2019
- Behavioral Health Utilization Data – 2019
    - Ventura County Behavioral Health Update 2019
    - Beacon Health Options Annual Report 2019
- DHCS Timely Access Care Survey 2019
- GCHP Provider Satisfaction Survey 2019
- GCHP Membership and Practitioner Report 2020
- County Health Ranking and Roadmaps 2019
- Ventura County Continuum of Care Alliance, Ending Homelessness in Ventura County 2019
- Community Health Implementation Strategy, Ventura County Community Health Needs Assessment Collaborative Report 2019
- Key Stakeholder Engagement Report 2020

Administrative Data 2019 – Claims, Encounter, and Pharmacy Data

Administrative data represents electronic information collected, processed, and stored in a data warehouse and maintained by GCHP's Information Technology and Decision Support Services (DSS) Departments. Typically, administrative data is an integrated data collection through the gathering of medical claims and member encounter data reported by health plan providers. Medical claims data consist of medical billing codes reported by providers. The collection and analysis of claim data is standard practice in the healthcare industry. Claim data consist of standard billing codes for service reimbursement. Claim data is used to report health plan member demographic data and health conditions. Claims data typically has a three-month lag and the need to use other data sets may be needed to assess the health care needs of members.

Immunization registry data is supplied to GCHP by the California Immunization Registry (CAIR). The GCHP Information Technology Department collects and stores the data which is used as a supplemental data source to claims/encounter data for reporting the outcomes of the HEDIS immunization measures.

Laboratory data is supplied to GCHP by contracted lab vendors. The GCHP Information Technology Department collects and stores the data which is used a supplemental data source to claims/encounter data for reporting the outcomes of lab utilization measures, such as Chlamydia Screening. Pharmacy data is collected and managed by GCHP DSS Department. Pharmacy claims data is based on specific reimbursement rates and prescription formulary. As with health care claims, pharmacy data also has a three-month lag.

GCHP utilizes member encounter data[2] as defined by the DHCS. Member encounter data consist of health information collected by the provider to

[2] DHCS Member Encounter Data APL

document the clinical encounter or visit. The encounter data is another form used to track health care quality and costs and to adjust provider capitation rates. GCHP DSS Department uses Milliman MedInsight software to calculate statistical analytical data reports.

Member data provided by the State was used to identify demographic data of membership by age, gender, race/ethnicity, and other demographic domains. Administrative and member data was used to assess the population's use of preventive services, chronic health conditions, and cultural and linguistic needs.

For the purpose of this report, membership was defined as members with full-scope Medi-Cal benefits who were enrolled continuously during the measure year with no more than a one-month gap in enrollment. The criteria used for defining membership eligibility follows the same protocol used by HEDIS, which is defined by the National Committee for Quality Assurance (NCQA) Elements derived from membership data to aid in the segmentation of the population are consist of medical billing codes reported by providers. The collection and analysis of claim data is standard practice in the healthcare industry. Claim data consist of standard billing codes for service reimbursement. Claim data is used to report health plan member demographic data and health conditions. Claims data typically has a three-month lag and the need to use other data sets may be needed to assess the health care needs of members.

Pharmacy data is collected and managed by GCHP DSS Department. Pharmacy claims data is based on specific reimbursement rates and prescription formulary. As with health care claims, pharmacy data also has a three-month lag.

GCHP utilizes member encounter data[3] as defined by the DHCS. Member encounter data consist of health information collected by the provider to document the clinical encounter or visit. The encounter data is another form used to submit a claim for reimbursement for service. GCHP DSS Department uses Milliman MedInsight software to calculate statistical analytical data reports.

Claims and encounter data was used to identify demographic data of membership by age, gender, race/ethnicity, and other demographic domains. It was also used to assess the population's use of preventive services, chronic health conditions, and cultural and linguistic needs.

For the purpose of this report, membership was defined as members enrolled in GCHP with 11 of 12 months eligibility. The criteria used for defining membership eligibility follows the same protocol used by HEDIS® which is defined by Health Services Advisory Group (HSAG), Inc. Elements derived from membership data to aid in the segmentation of the population are:

[3] DHCS Member Encounter Data APL

- Race/Ethnicity
- Age
- Gender
- Preferred Language
- Zip Code
- Medi-Cal Eligibility Aid Codes

The membership demographic data elements were pulled from the 2019 eligibility file to capture the most relevant and up-to-date demographic data for calendar year 2019. Claims data is also used to report on well-child visits and lead screening completed and other preventive care services.

CMS Adult and Child Core Sets 2019

The Centers for Medicare & Medicaid Services (CMS) prepares quality measures for health plans and other insurance groups to assess patient care in both inpatient and outpatient settings. The CMS Adult and Child Core Sets for Medicaid are standardized measures, which are developed and maintained by various measure stewards, and used by CMS to monitor the quality of care and health outcomes of adults and children enrolled in Medicaid[4].

United States Census Bureau Data 2019

The United States Census Bureau data was used to report the total population in California and Ventura County. The data was used to report the demographic profile of Ventura County including age, gender, ethnicity, income, education, and educational attainment.

Healthcare Effectiveness Data and Information Set (HEDIS®) 2019

The Health Care Effectiveness and Information Data Set (HEDIS) is a set of standardized performance measures maintained by the National Committee for Quality Assurance (NCQA) and used by managed care plans to assess health plan performance.

Managed Care Accountability Set (MCAS)

The Department of Health Care Services (DHCS) selects measures from the CMS Adult and Child Core Sets for Medicaid and HEDIS to develop the Managed Care Accountability Set (MCAS), a list of measure that all Medi-Cal Managed Care Plans are required to report annually.[4] For the 2020 measurement

[4] CMS, Method Brief, November 2019. https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/methods-brief.pdf

year, the MCAS list consists of 36 measures (14 hybrid and 22 administrative) that addresses the following domains of care:

- Primary Care Access and Preventive Care
- Maternal and Perinatal Health
- Care of Acute and Chronic Conditions
- Behavioral Health

Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2019

The CAHPS survey, is a comprehensive survey tool for assessing consumer's experiences with their health plans and provides a rating score across national and state providers and plans. The CAHPS survey was administered by Health Services Advisory Group (HSAG), Inc., for the Department of Health Care Services (DHCS) and Medi-Cal managed care health plans. Questions in the CAHPS survey addressed areas such as getting needed care, getting care quickly, how well doctors communicate, customer services, and shared decision making[5].

The 2016 CAHPS survey report and the 2019 CAHPS data report was used to review findings from adult beneficiaries and parents or caregivers of child beneficiaries enrolled in a Managed Care Plan (MCP). The CAHPS survey is a national survey of beneficiaries enrolled in an MCP, which assesses members access to care and services over the prior six months of enrollment. The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and will aid in improving overall beneficiary satisfaction[6].

Department of Health Care Services Health Disparity Report 2016

To access and improve health disparities among individuals enrolled in a Medi-Cal managed care plan, the Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG) to conduct a health disparities study using the External Accountability Set (EAS) performance indicators reported by 23 full-scope Medi-Cal managed care health plans for reporting year 2017 with data derived from calendar year 2016. DHCS released the performance indicators for reporting year 2019 with data derived from calendar year 2018. The report includes data from full-scope Medi-Cal beneficiaries and does not include data for fee-for-services beneficiaries. The goal of the health disparity report is to assess and improve the health of all

[5] SPH Analytics, Gold Coast Health Plan, Group Needs Assessment (GNA) Report 2016.
[6] 2916 CAHSPS Medicaid Managed Care Survey Summary Report. DHCS, January 2018.

Californians, enhance quality of care, and reduce the per capita health care program costs[7].

Health Risk Assessment – GCHP Health Information Form/ Member Evaluation Tool (HIF/MET) Questionnaire 2019

The Department of Health Care Services issued an All-Plan Letter, 14-005, for Medi-Cal Managed Care Plan to use an approved standardized health risk questionnaire to stratify risk factors among Seniors, Persons with Disabilities, and all newly enrolled Medi-Cal members. The HIF/MET questionnaire consists of 10 questions including self-reported chronic health conditions. The purpose of the HIF/MET questionnaire is to identify risk factors by using a risk stratification or algorithm to analyze member specific health conditions, identify members that are high risk, and prepare an individual care plan[8]. The HIF/MET questionnaire is issued in multiple languages and available on the DHCS website.

The HIF/MET survey is mailed to newly enrolled members and asked to complete and return the survey in a self-addressed envelope. GCHP prepares quarterly reports on HIF/MET surveys returned and processed. Annual reports are also gathered and reported to the GCHP Utilization Management Committee. In addition to the HIF/MET survey, GCHP Care Management (CM) Department gathers information on social determinants of health and assist members with identifying resources and social support agencies to address the needs of members.

GCHP Health Services Utilization Management (UM) Report 2019

GCHP Health Services Department maintains a utilization management report of inpatient, emergency room visits, care management services, transportation, and other related services. The report is prepared quarterly and reported to GCHP Quality Improvement Committee.

Behavioral Health Utilization Data 2019

Data related to behavioral health utilization is derived by the 2019 Annual Beacon Health Options' report and from the 2019 Ventura County Behavioral Health Department Report. GCHP contracts with Beacon Health Options to provide mild to moderate services. The behavioral health utilization report includes data on adult and children by various demographic elements including age, preferred language, and race/ethnicity.

[7] DHCS Health Disparity Report. California Department of Healthcare Services, May 2016 and 2019. Available at http://www.dhcs.ca.gov.
[8] DHCS Health Information Tool/Member Evaluation Form (HIF/MET), All Plan Letter (APL-14005). California Department of Health Care Services, June 2014.

DHCS Timely Access Care Survey 2019 and GCHP Provider Satisfaction Survey 2019

The DHCS, Medi-Cal Managed Department, coordinates with Health Services Advisory Group (HSAG) Inc., and the State's External Quality Review Organization (EQRO), to prepare and conduct a timely access survey among providers contracted with Medi-Cal Managed Care Health Plans[9]. The timely access assessment evaluates access to primary care physicians, core specialty, facility services, as well as compliance with Medi-Cal Plans' network adequacy, timely access requirements, and standards.

The Provider Satisfaction Survey combined with the Timely Access Care Survey was administered to providers in the winter of 2019. SPH Analytics conducted a Provider Satisfaction Survey on behalf of GCHP. The survey identified provider perspectives on six multiple organizational areas including the following: finance, utilization management/quality management, network/coordination of care, pharmacy, call center, and provider relations. The survey meets the contractual obligations pertaining to the DHCS access to care regulatory compliance standards. SPH Analytics also conducted the Provider Satisfaction Survey in 2013, 2015, and 2017.

GCHP Membership and Practitioner Report 2020

GCHP Provider Network Operations Department prepares annual reports on the total number of practitioners by members. Data reported on membership and practitioners is gathered through the Medi-Cal membership website and the total number of providers contracted with GCHP. The data is used to assess the ratio of providers to members, geographic distribution of providers, language breakdown among providers and members, and other related data.

County Health Rankings and Roadmaps 2019

The Robert Wood Johnson Foundation prepares a County Health Rankings and Roadmaps Report. The county health ranking is based on health and social indicators for each county and compared to other counties throughout California and the nation. The report summarizes overall health outcomes of each county, as well as other factors that contribute to the overall health of individuals[10].

Ventura County Continuum of Care (COC) Alliance Report 2019

The Ventura County Continuum of Care (COC) Alliance maintains reports on the homeless population in Ventura County. The homeless count for Ventura County

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[9] 2017-18 Access Assessment Final Report, DHCS and HSAG.
[10] Remington, P.L., Catlin, B.B. & Gennuso, K.P. The County Health Rankings: rationale and methods. *Population Health Metrics* **13,** 11 (2015). https://doi.org/10.1186/s12963-015-0044-2.

is calculated on an annual point-in-time count. According to the 2019 Ventura Continuum of Care Alliance, Ending Homelessness in Ventura County report, there are 1,669 adults and children who were homeless during the point-in-time count, which accounts a 28.5% increase from the previous year[11]. The majority of homeless live in the Oxnard and Ventura area of the county, and account for nearly two-thirds or 66% of homeless population.

Community Health Implementation Strategy, Ventura County Community Health Needs Assessment Collaborative Report 2019

The Ventura County Community Health Improvement Collaborative (VCCHIC) is a non-profit organization to improve population health outcomes in Ventura County[12]. The Ventura County Collaborative partnered with Conduent Healthy Communities Institute (HCI) to conduct the Community Health Needs Assessment (CHNA)[13]. The goal of the CHNA is to improve the quality of care by increasing care coordination among health systems and community organizations. The 2019 data report identifies social determinants of health impacting residents of Ventura County.

Social determinants of health are economic and social conditions that influence health outcomes including education, housing, poverty, social status, social networks, and physical environment. According to Centers for Disease Control and Prevention (CDC), conditions in the places where people live, learn, work, and play affect a wide range of health risk and outcomes[14]. These conditions are known as social determinants of health (SDOH). Studies have found that poverty limits access to healthy foods and safe neighborhoods, and level of education can be a predictor of better health. Researchers suggest that understanding what is known about SDOH, is an important factor in developing programs that will improve individual and population health.

Key Stakeholder Engagement Report 2020

A qualitative survey and focus groups interviews were used to gather data for the key stakeholder engagement report. GCHP identified two groups to conduct key stakeholder interviews including representatives from the GCHP Community Advisory Committee (CAC) and an internal survey with GCHP employees with direct contact with members and the community.

[11] Ventura County Continuum of Care Alliance, Ending Homelessness in Ventura County, April 2019, www.venturacoc.org/facts-figures.
[12] Ventura County Community Health Needs Assessment Collaborative, Community Health Implementation Strategy, November 2019.
[13] Kaiser Foundation Hospital Board of Director's Community Health Committee, Community Health Needs Assessment, September 2019.
[14] CDC, Social Determinants of Health (SDOH), https://www.cdc.gov/socialdeterminants/index.htm

Community Advisory Committee (CAC) Survey 2020

CAC membership consist of 10 members who represent various constituencies served by GCHP. These include beneficiaries with chronic medical conditions, County Health Care Agency, County Human Services Agency, foster children, Medi-Cal beneficiaries, seniors, persons with disabilities, and persons with special needs. An electronic qualitative survey in English and Spanish was mailed to CAC members. The survey had a total of 26 questions and was divided into five sections: 1) member's health concerns/issues; 2) cultural and linguistic needs; 3) health conditions; 4) member engagement; and 5) oral and behavioral health.

A focus group was conducted via teleconference through a special meeting with the GCHP CAC members. Of the 10 CAC members, a total of 9 CAC members participated in the special CAC meeting. Dr. Lupe González, PhD, MPH, Director of Health Education, Cultural and Linguistic Services, provided a presentation to the CAC members, provided an overview of the PNA, and held an open forum discussion related to the stakeholder survey.

Internal Survey 2020 – GCHP Employees with Direct Member Contact

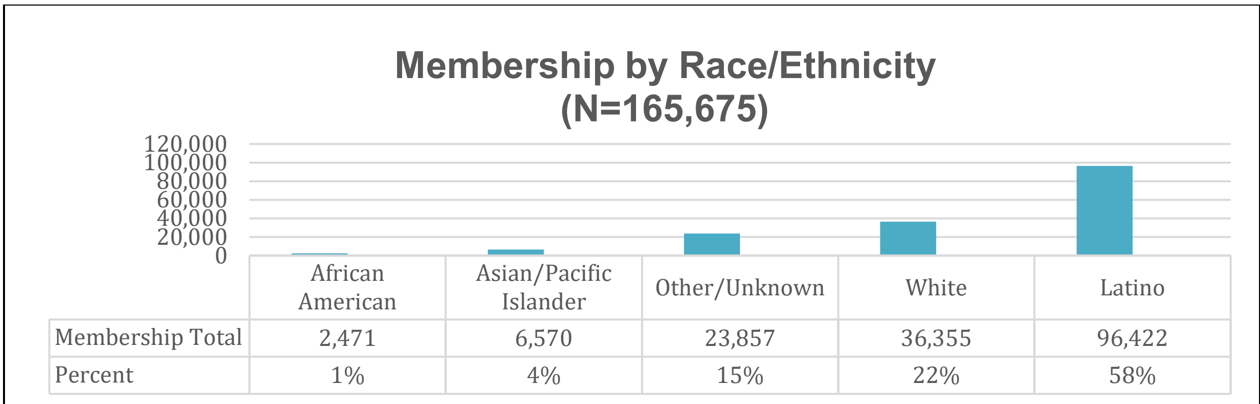
A qualitative survey was prepared for internal key stakeholders who have direct contact to GCHP members and the community. The internal survey had a total of 43 questions. The questions consisted of a variety of topics including member concerns, health education, cultural linguistics, specific health conditions, social issues, behavior health, oral health, and member engagement. The internal survey was aligned with similar questions as the CAC survey and included questions related to GCHP staff experiences in working with members.

III. Key Data Assessment Findings

Membership Profile

According to GCHP's DSS Department analysis the total membership, using the HEDIS methodology, consists of 165,675. Figure 1 shows racial and ethnic distribution of members enrolled in GCHP. In 2019, the majority of members enrolled in GCHP is comprised of Latinos (58%), while White beneficiaries account for 22% of membership. The Asian/Pacific Islanders members account for 4%, and African American represents 1%. The category of unknown/other represents 15% of the population, with 11% as other and 4% unknown. Comparison between 2018 and 2019 membership by race/ethnicity shows a slight increase of 1% among the Latinos, while other ethnicity groups remain constant.

Figure 1: GCHP Membership by Race/Ethnicity (2019)



	African American	Asian/Pacific Islander	Other/Unknown	White	Latino
Membership Total	2,471	6,570	23,857	36,355	96,422
Percent	1%	4%	15%	22%	58%

Figure 2 represents the age breakdown of GCHP members by percent. Slightly over half of the all members (55.82%) are over 18 years of age, and 44.18% are less than 17 years of age. Roughly 25% of the membership was between 21 – 44 years of age. Females represent over half (53.47%) of the membership, and 16% are seniors (See Appendix for Membership Demographic Summary Tables). Figure 3 shows the majority of members reside in the Oxnard and Port Hueneme areas.

Figure 2: Age Breakdown by Percent GCHP (2019)

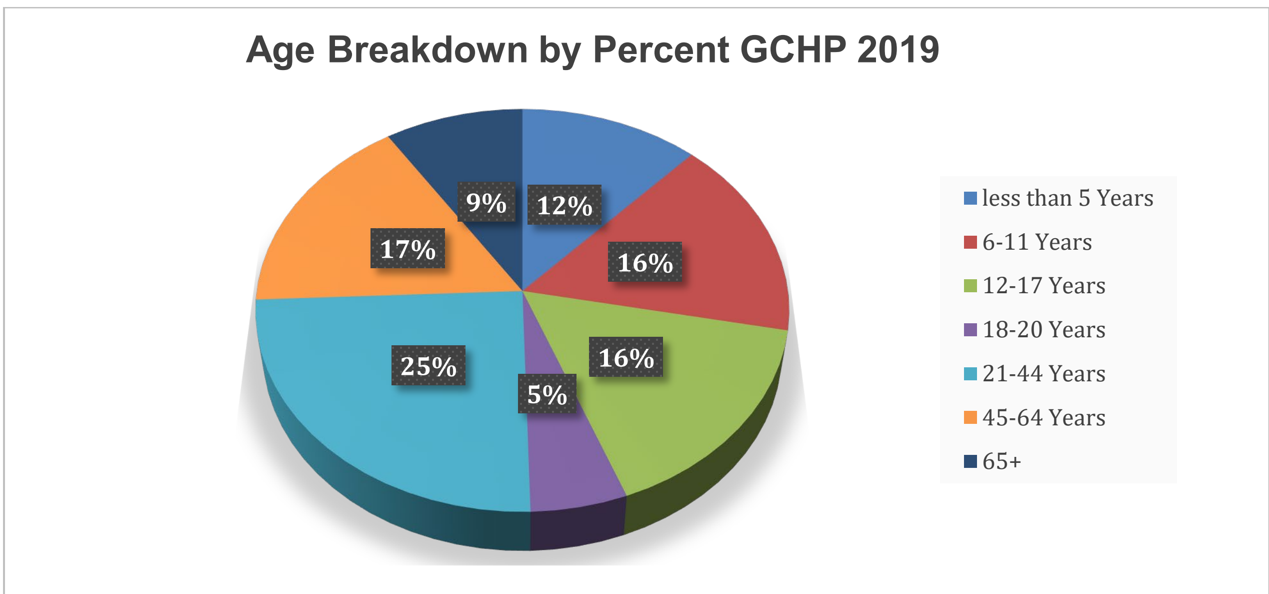
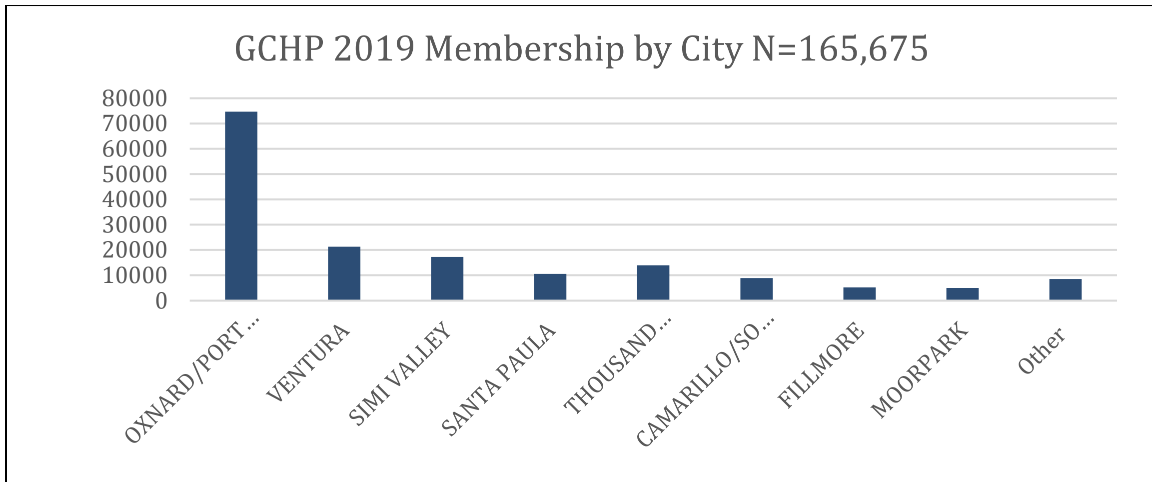


Figure 3: GCHP 2019 Membership by City



County Specific Demographics

Ventura County is a coastal community with large agricultural fields with a population of 850,967 (July 2018) and is the 26th largest county in the state of California[15]. The race/ethnic breakdown for the population shows 45% are White, 43.3% of the population is Latino, 7.9% Asian, 2.4% African American, and all others comprise 1.4%[16]. Table 1 shows the percentage race/ethnic breakdown of individuals enrolled in Medi-Cal as compared with the total population for Ventura County. Overall, Hispanic/Latinos enrolled in GCHP are overrepresented by 15% of the general population in Ventura County.

Table 1: Ventura County Population and GCHP Membership Comparison

Race/Ethnicity	Ventura County Total Population: 850, 967	GCHP Total Membership: 165,675
White	45%	22%
Hispanic/Latino	43.3%	58%
Asian/Pacific Islanders	7.90%	4%
African American	2.40%	1%
Other	1.40%	15%

Approximately 23% of the population is under the age of 18 and 16% of the population is over the age of 65. The educational attainment level for Ventura

[15] United States Census Bureau, 2018.
[16] Community Health Implementation Strategy, Ventura County CHNA Collaborative Report, April 2019.

County varies with roughly 19% graduating with a diploma or equivalent degree, 32% with some college and/or associates of arts degree, 32% received either a baccalaureate/higher education degree, and 16% do not report the level of education received.

According to the United States Census Bureau, 2018, the median household income is approximately $84,000, poverty rate is 9.6%, and the employment rate is 61.3%. The average age is 38 years, and 50.8% of the population is female. English continues to be the primary language (61.6%) spoken at home among residents and approximately 38.4% of the population speak another language other than English at home. Spanish is the second leading primary language (30.2%) spoken at home. According to the Human Services Agency for Ventura County, the total number of people who enrolled or received Medi-Cal in Ventura County in 2019 was 209,947[17]. Among county residents, 42,012 have veteran status. The percent of households with a computer is 90.9%, and those with a broadband internet subscription is 85.1%[18].

Language and Health Literacy

GCHP has one threshold language (Spanish) as defined by the Department of Health Care Services. Membership preferred languages varies, with 26 different languages reported (See Appendix for Membership Demographic Table). Most members have chosen English and Spanish as their preferred language, with 60% identifying English as their preferred language and 37% preferred Spanish. All other languages had a percentage of less than 1%. Although 58% of the members enrolled in GCHP report Hispanic/Latino as their race/ethnic background, only 37% identified Spanish as their primary language. Figure 4 highlights preferred language by membership. Members self-identify preferred language including sign language. GCHP monitors members who self-identify sign language through the Medi-Cal enrollment file.

Figure 4: Membership by Preferred Language (2019)

[17] Ventura County Human Service Agency, 2019, VCHSA website.
[18] Ventura County Continuum of Care Alliance, Ending Homelessness in Ventura County, April 2019, www.venturacoc.org/facts-figures.

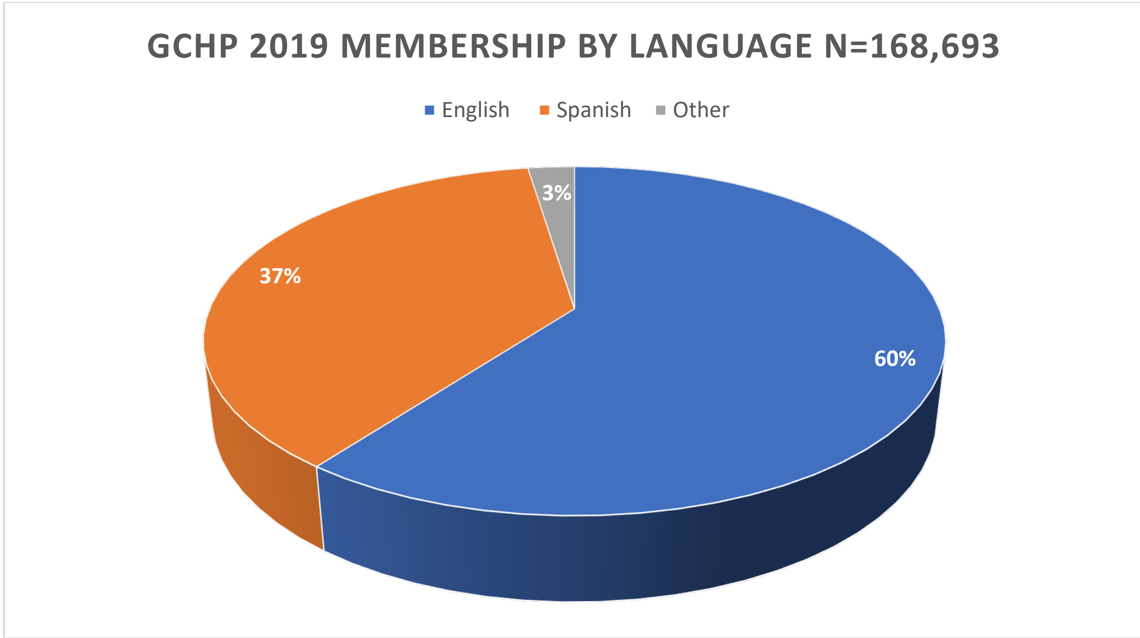
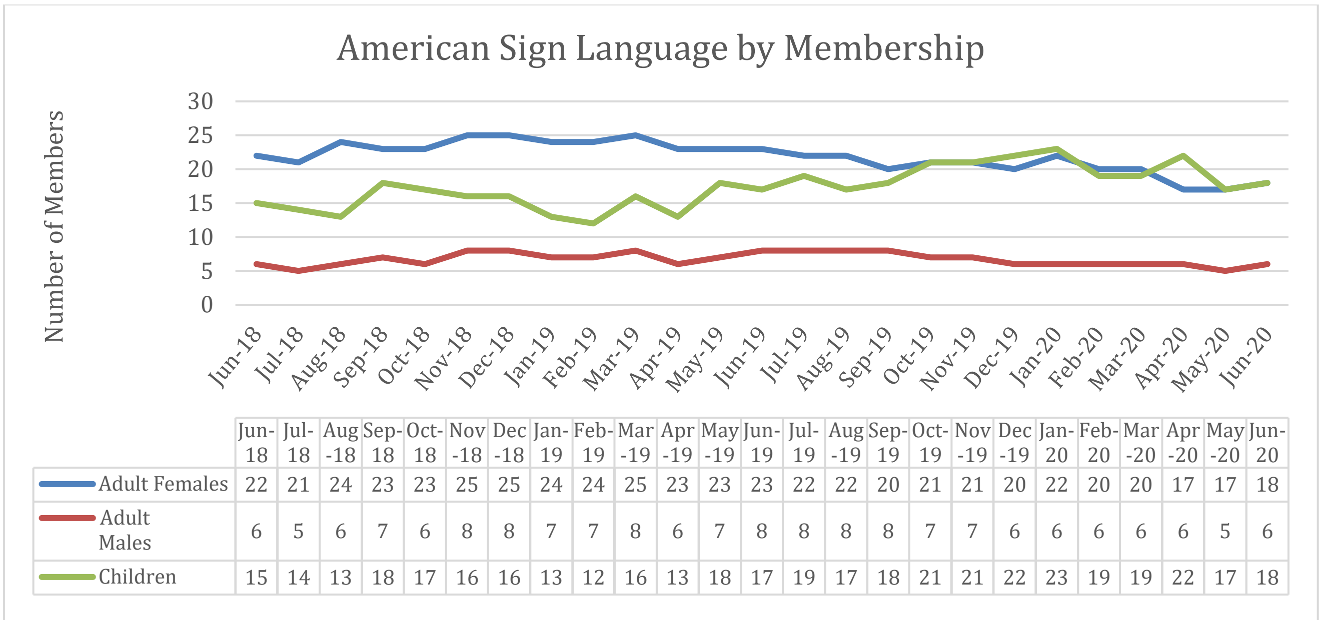


Figure 5 shows members who self-report sign language as their primary language from 2018 through 2020. On the average there are more adults than children who report American Sign Language as their primary language.

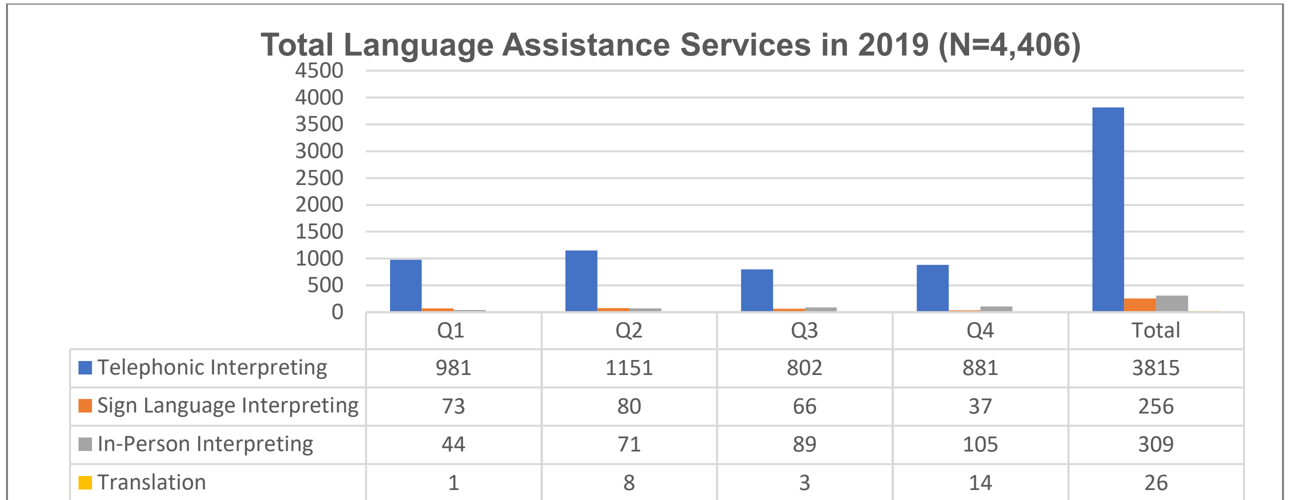
Figure 5: 2018-2020 American Sign Language by Membership



	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Adult Females	22	21	24	23	23	25	25	24	24	25	23	23	23	22	22	20	21	21	20	22	20	20	17	17	18
Adult Males	6	5	6	7	6	8	8	7	7	8	6	7	8	8	8	8	7	7	6	6	6	6	6	5	6
Children	15	14	13	18	17	16	16	13	12	16	13	18	17	19	17	18	21	21	22	23	19	19	22	17	18

Figure 6 highlights the total utilization of language assistance services for 2019. The utilization of language assistance services in 2019 was 4,406, with 3,815 (87%) services rendered for telephonic interpreting services, 309 (7%) referrals processed for in-person interpreting services, and 256 (6%) referrals were processed for sign language interpreting services. Additionally, a total of 26 member-direct translation requests were processed in 2019.

Figure 6: Language Assistance Services in 2019



	Q1	Q2	Q3	Q4	Total
Telephonic Interpreting	981	1151	802	881	3815
Sign Language Interpreting	73	80	66	37	256
In-Person Interpreting	44	71	89	105	309
Translation	1	8	3	14	26

Seniors and Persons with Disabilities (SPD)

As of April 2020, GCHP membership includes approximately 29,000 members who are seniors and persons with disability. This represents 15% of the total membership in Ventura County. SPD members complete a health risk assessment and work closely with nurse care managers and the Health Education Department.

LGBTQ+ Community

GCHP does not have health plan level demographic data on individuals who identify with sexual orientation/gender identity; often individuals collectively identify as Lesbian, Gay, Bisexual, Transgender, Questioning/Queer (LGBTQ+).

A network provider specializing in providing health care services to the LGBTQ+ community started collecting data within their own electronic health record system. According to their clinic data, a total 250 individuals who self-report as LGBTQ+ where treated in 2019. Data reported is a combination of members who self-report sexual orientation and claims data. Of the 250 patients reported, roughly 80% are enrolled in GCHP.

Homeless

In general, the homeless population in Ventura County has increased from 2018 to 2019. Ventura County homeless population rose by 4.4% for the third year in a row[19]. Data collected through membership aid codes identified a total of 1,735 members who were homeless in 2018 and 2,495 in 2019, for a total of 44% increase.

Health Status and Disease Prevalence

Chronic Health Conditions

The California Department of Public Health (CDPH) identifies chronic disease and injury as the leading causes of death, disability, and diminished quality of life in California (CHPH 2019). Chronic diseases make-up 80 percent of health care expenditures in California. Chronic disease impacts some populations more than others and can lead to health inequities, especially for the poor and underserved populations. According to the CDPH, Chronic Disease Control Branch (CDCB), many individuals who reside in California have multiple chronic conditions, which may place them at greater risk for other chronic conditions, limits their ability to be physically active, which can lead to an early death[20]. Thirty-seven (37%) percent of Californians live with at least one chronic condition[21]. High blood pressure control has been identified by the CDCB as a top priority focus for the department.

Similarly, low-income individuals enrolled in GCHP experience multiple chronic health conditions. GCHP DSS Department identified several chronic health conditions including diabetes, hypertension, asthma, heart failure, stroke, and cancer as the top chronic health conditions impacting GCHP members. Data from community needs assessments shows similar findings for adults, while childhood obesity is the leading cause of chronic health conditions in children.

Diabetes

Diabetes continues to be a lead health condition among members enrolled in GCHP. Across the nation the number of adults diagnosed with diabetes has tripled in the last 20 years. According to the CDC, there are approximately 30 million adults with diabetes. Diabetes is the number one cause of kidney failure, lower limb amputations, and adult blindness.

As of April 2019, GCHP data shows 20,199 adults with pre-diabetes/diabetes, with 53% being Latino and 47% as white. The majority (42%) of members

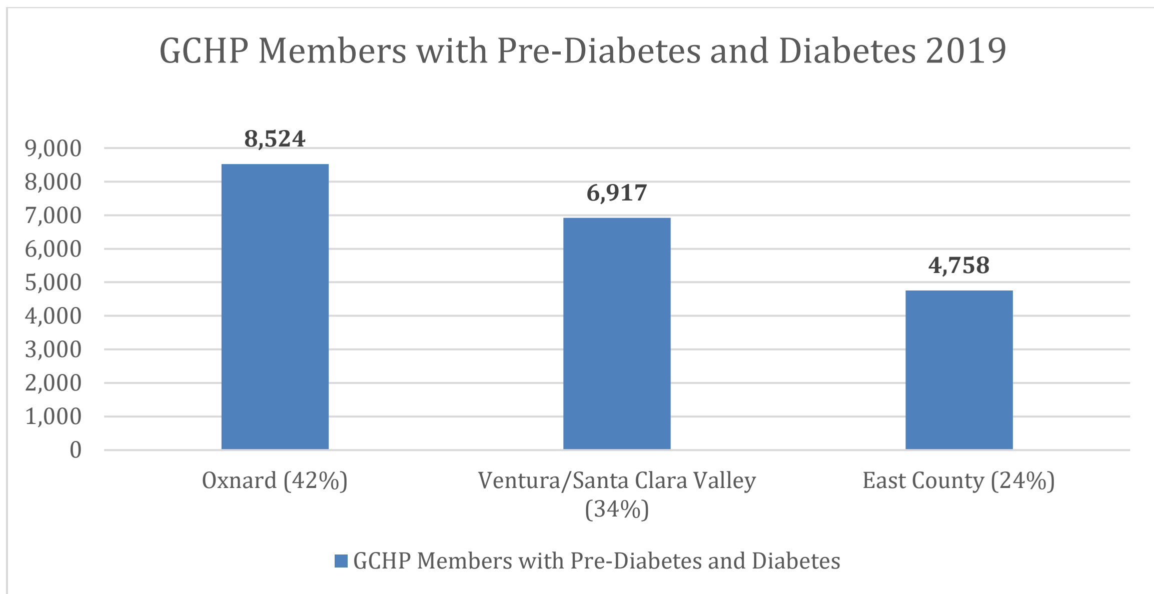
[19] Ventura County CHNAC 2019, Community Needs Assessment.
[20] California Department of Public Health (CDPH), Chronic Disease Control Branch (CDCB), website, www.chdp.ca.gov.
[21] California Department of Public Health (CDPH), website, www.chdp.ca.gov.

diagnosed with pre-diabetes/diabetes live in the greater Oxnard area, which includes the city of Port Hueneme and Oxnard, 34% live in Ventura/Santa Clara Valley area, and 24% reside in eastern part of the county (Simi Valley, Thousand Oaks, and Moorpark).

According to the DHCS Health Disparity Report (2016) the rate of screening for comprehensive diabetes care (HbA1c testing) in Latinos is higher than other race/ethnic groups[22]. Data from the GCHP HEDIS 2019 report shows that diabetes is slightly above the minimum performance level for this indicator.

However, advance analysis of the diabetes measure (HbA1c) shows that most of the members who live in the Ventura/Santa Clara Valley, especially in the City of Santa Paula, have a higher percentage (34%) of pre-diabetes/diabetes as compared to the total number beneficiaries enrolled in GCHP who live in Santa Paula (13%). Figure 7 shows the breakdown of members diagnosed with prediabetes/diabetes by city/region in Ventura County. Health disparity data shows that Latinos enrolled in GCHP and live in Ventura/Santa Paula are more likely to be diagnosed with prediabetes/diabetes. Figure 3 shows 22% members live in Ventura/Santa Paula area, however, Figure 7 shows 34% of the cases diagnosed with pre-diabetes/diabetes.

Figure 7: GCHP Members with Pre-Diabetes and Diabetes (2019)



[22] DHCS Health Disparity Report 2016

Hypertension

Hypertension is a leading cause of heart disease, stroke and other health conditions[23]. According to the CDC, 1 in 3 adults in the United States have high blood pressure. Studies have found that there are many risk factors that contribute to hypertension including smoking, obesity, alcohol, and genetics[24]. GCHP identified hypertension as the second leading chronic health condition among members enrolled in GCHP. The Health Risk Assessment, Health Information Form/Member Evaluation Tool (HIF/MET) data showed a total of 469 members referred to the Department of Health Education for additional follow-up, with 57% self-reporting co-morbidities of diabetes and hypertension.

Upon further review of the data prepared by GCHP DSS Department, heart failure and stroke represent approximately 1.28% of the members diagnosed with a heart condition.

Asthma

According to the Centers for Disease Control and Prevention (CDC), 1 in 14 people are diagnosed with asthma. Approximately 24 million individuals in the United States have asthma and 5.2 million are affected by asthma in California. The California Department of Public Health, California Breathing (2015-2016) Data Tool, states the lifetime prevalence rate for the state is 17% and 14.9% for individuals over 18 years of age in Ventura County. For measurement year 2016-2018, the age-adjusted hospitalization rate due to asthma in Ventura County is 2.5 per 100,000[25], with children between the ages of 0-9 with the highest rate.

Cancer

According to the Ventura County's Community Health Needs Assessment 2019, cancer is the leading cause of premature death for males and females based upon Age-Adjusted rate per 1000,000 population per year from 2015-2017[26]. Although cancer is one of the leading diagnoses among members, data shows that a small percentage of members (.17%) have cancer.

Childhood Obesity

Various community health needs assessments conducted in Ventura County found that childhood obesity continues to be an area of improvement. In 2010 study by the UCLA Center for Health Policy Research on childhood obesity compared obesity rates across different counties. Within Ventura County, the

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[23] Center for Disease Control (CDC) Prevention, website 2020.
[24] DHCS Health Disparity Medi-Cal Population 2013
[25] Health Matters in Ventura County, Website.
[26] Ventura County's Community Health Needs Assessment 2019.

city of Port Hueneme had the highest percentage (52.9%) of all cities in the county, followed by Oxnard at 47.9% and 47.9% for Santa Paula. Overall percentage of childhood obesity in Ventura County was 35.9%, while the percentage of childhood obesity for the state was 38.0%[27].

Results of the Community Advisory Committee (CAC) focus group found that childhood obesity continues to be a problem within the Latino community. Promoting health eating and physical activity is important to maintain health and wellness. Discussion along CAC members found that GCHP can partner with school districts and First 5 programs to promote health lifestyle classes among children and parents. One advocate promoted the interest of working with policy makers and statewide Women, Infant and Children (WIC) offices to promote healthy eating and avoid sugary drinks through the WIC voucher program.

Lead Poisoning

In January 2020, the California State Auditor released its audit of DHCS and CDPH's respective responsibilities related to lead testing and lead poisoning prevention. Specific to testing, the audit found that DHCS did not ensure children received tests at the appropriate age. From fiscal years 2009–10 through 2017–18, more than 1.4 million one- and two-year old children did not receive any of the required tests, and another 740,000 children missed one of the two tests. Many of these children live in areas of the State with high occurrences of elevated lead levels, making the missed tests even more troubling. Recommendations from DHCS include implementation of a blood lead test performance measure for managed care plans, conducting outreach to families targeting those whose children have not utilized preventive services, and incorporating new requirements in the managed care plan contracts requiring plans to regularly identify and contact children who have not had the appropriate testing. The National Committee for Quality Assurance (NCQA) Lead Screening in Children (LSC) HEDIS measure evaluates the percentage of children two (2) years of age who had one or more capillary or venous blood test for lead poisoning by their second birthday.

Lead screenings were found to be underutilized by GCHP members. Blood lead testing are done as part of the Well Child Physical or as requested by Primary Care Physicians. Lead is harmful to children and can damage a child's brain and nervous system. Lead poisoning is especially dangerous for children under the age of six because they are rapidly growing and developing bodies absorb more lead. Lead exposure can cause permanent learning and behavioral problems that make it difficult for children to succeed in school. A blood lead test is the only way to know if a child has lead poisoning. Most children with lead poisoning do not look or act sick. Children at highest risk for lead exposure are those in

[27] UCLA Center for Health Policy Research, Ventura County Fact Sheet, Childhood Obesity, June 2012.

government assisted health programs and those who live or spend time in older housing. Old housing may have deteriorating or disturbed lead-based paint, and/or lead-contaminated soil and dust. Children at risk of lead exposure should be tested at both one and two years of age. Additionally, children three to six years old who are at risk and were not tested at ages one and two years old, should have a blood lead test. Parents can talk to their child's doctor about getting tested for lead.

Healthcare Effectiveness Data and Information Set (HEDIS) Results 2019 and 2019 Gap Analysis

To assess health plan performance and identify focused areas for improvement, the Quality Improvement (QI Department completed an annual QI work plan analysis by evaluating the results of the 2019 reporting year MCAS rates and evaluating the health plan's alignment and performance with other healthcare initiatives promoted by DHCS. Data sources used to report rates and evaluate outcomes included administrative data (claims, encounter, pharmacy), supplemental data (immunization registry, lab, EMR feeds), medical record reviews and initial health assessment audits. The GCHP Quality Improvement Department completed an annual gap analysis and identified the following focus areas: tobacco cessation, initial health assessment utilization, adverse childhood experience screenings, lead screening in children, asthma medication ratio, adolescent well care, cervical cancer screenings, chlamydia screenings in women, childhood immunization status – combo 10, developmental screenings in the first three years of life, well-child visits in the first 15 months of life, and well-child visits in the 3rd to 6th years.

Table 2 below shows the 2019 Measure Year (MY) rates for the chlamydia screening in women (CHL) by the total rate and age groups. The rates show that the 16-20 age group:

- Significantly lower rates compared to the 21-24 age group represent a larger portion of the CHL population
- Lower compliance with completing the CHL screening.

Table 2: 2019 Chlamydia Screening in Women Rates

Measure	Sub Measure	Denominator	Numerator	2019 MY Rates
Chlamydia Screening in Women	Total Rate	5318	2979	56.02%
	Age 21 to 24	2380	1544	64.87%
	Age 16 to 20	2938	1435	48.84%

Of the 12 areas identified with a gap in care, health education and quality improvement identified four (4) priority focus areas for inclusion in the 2020

action plan and objectives due to low performance. For the purpose of this report and preparing an action plan, the well-child visits and childhood immunization were combined into one objective. Below are four (4) areas of improvement:

- well-child visits and childhood immunizations,
- chlamydia screenings in women,
- asthma medication ratio,
- lead screenings in children

Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2019 Survey

CAHPS survey results highlight national and statewide comparisons among Medi-Cal managed care health plans statewide. A total of nine (9) domains were assessed including: 1) Rating of Health Plan, 2) Rating of all Health Care, 3) Rating of Personal Doctor, 4) Rating of Specialist Seen Most Often, 5) Getting Needed Care, 6) Getting Care Quickly, 7) How Well Doctor's Communicate, 8) Customer Services, and 9) Decision Making. Medi-Cal beneficiaries were asked to rate their Medi-Cal managed health plan on all domains from a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." On a national comparison scale, GCHP beneficiaries who responded to the CAHPS survey rated GCHP two (2) stars, which reflects at or above the 25th and below the 50th percentiles for adult and child health care services. However, GCHP received one star which indicates being below the 25th percentile in the following areas: Getting Needed Care, Getting Care Quickly, and Customer service [28].

The tables below identify secondary data health indicators reported in CAHPS. Table 3 and 4 summarize the finding of the 2016 and 2019 CAHPS survey for adults and child measures. Overall, GCHP scored well in adult measures and only two (2) areas were identified as needed improvement: 1) rating of specialist seen most often and 2) shared decision making. For the child measures, the rates were positive, however, still relatively low in two (2) areas including: 1) rating of all health care and 2) how well doctors communicate. Although both measures in the child survey showed a positive increase, the overall rate was low.

[28] SPH Analytics 2016

Table 3: Adult CAHPS Survey 2016 and 2019 Comparison[29]

Measure	2016	2019	2016-2019 Rate Change
Rating of Health Plan	55.6%	56.3%	**0.7%**
Rating of All Health Care	50.4%	57.1%	**6.7%**
Rating of Personal Doctor	70.2%	70.3%	**0.1%**
Rating of Specialist Seen Most Often	65.8%	59.5%	**-6.3%**
Getting Needed Care	78.9%	79.4%	**0.5%**
Getting Care Quickly	75.9%	80.6%	**4.7%**
How Well Doctors Communicate	91.3%	92.5%	**1.2%**
Customer Service	85.1%	86.1%	**1.0%**
Shared Decision Making	83.0%	80.6%	**-2.4%**

[29] GCHP 2013, 2016 and 2019, Quality Improvement CAHPS Summary Report, June 2020.

Table 4: Child CAHPS Survey 2016 and 2019 Comparison

Measure	2016	2019	2016-2019 Rate Change
Rating of Health Plan	66.1%	69.8%	3.7%
Rating of All Health Care	59.5%	68.4%	8.9%
Rating of Personal Doctor	76.4%	79.2%	2.8%
Rating of Specialist Seen Most Often	71.9%	77.1%	5.2%
Getting Needed Care	75.2%	83.8%	8.6%
Getting Care Quickly	76.9%	85.1%	8.2%
How Well Doctors Communicate	89.8%	92.7%	2.9%
Customer Service	82.4%	87.8%	5.4%
Shared Decision Making	67.5%	77.3%	9.8%

Provider Network Operations at GCHP will be working with providers to increase the overall rating of health care among adults and children, as well as working to increase the number specialist (pediatricians).

Shared decision making was an area identified as an opportunity for improvement in the CAHPS 2019 survey report. GCHP Health Education Department acknowledges the importance of individuals being part of the health care decision process. Studies have defined shared decision making in health care as health literacy. Health literacy is the degree to which individuals have the capacity to engage and understand basic health information[30]. An objective related to increasing awareness and knowledge about shared decision making and/or health literacy is outlined in the action plan section.

[30] Sentell, L., et al., Considering Health Literacy, Health Decision Making and Health Communication in Social Networks of Vulnerable New Mothers in Hawaii: A Pilot Feasibility Study. Int. J. Environ. Res. Public Health (March 2020).

 Return to Agenda

Access to Care

The purpose of the timely access to care survey was to determine if provider offices were adhering to contractual obligations pertaining to the DHCS Timely Access Standards. In 2019, SPH Analytics conducted a Provider Satisfaction and Timely Access Surveys on behalf of GCHP. The survey identified provider perspectives on six (6) multi-organizational areas including finance, utilization management/quality management, network/coordination of care, pharmacy, call center, and provider relations. SPH Analytics has been working with GCHP for over seven (7) years and conducted the Provider Satisfaction Survey in 2013, 2015, and 2017. In 2019, there was significant increase in satisfaction rates in all measured areas. Overall satisfaction for GCHP in 2019 was 70.2% versus 33.6% in 2015. In comparison to other health plans GCHP rates for 2019 were higher than other health plans surveyed by SPH Analytics[31].

The timely access survey was conducted in 2019 for the months of September and October. A total of 672 providers (194 PCPs and 478 Specialist) were surveyed. The PCP scores for the following questions increased in 2019: office wait times, patient call back time, and preventative/well-child exam. The overall compliance rate for urgent care decreased significantly among PCP. The Specialist scores for the following questions increased in 2019: urgent care overall, wait time, and patient call back time. However, the rate for routine care initial visit decreased.

Table 5 shows the different compliance rates for GCHP PCPs and Specialist in 2019. The survey also assessed the following areas: urgent care, non-urgent care, office wait time, patient call back time, physical/well-woman exams (PCP only), preventive/well-child exams (PCP only), and initial routine care visits (Specialist only).

Table 5: Compliance Rates Primary Care Physicians and Specialist Providers 2019

Compliance Measure	Compliance Rate of PCP	Compliance Rate of Specialist
Urgent Care	70.2%	60.9%
Non-Urgent Appointment	89.5%	90.7%
Office Wait time	86.2%	96.1%
Patient Call Back Time	62.7%	75.3%
Physical/Well-Woman Exam	83.1%	
Preventive/Well-Child Exam	91.7%	
Routine Care Initial Visit		70.0%

[31] GCHP Time Access Survey, SPH Analytics Inc., 2019 Provider Satisfaction Survey Report.

A total of 92.3% of Specialist offices' recordings were compliant per Gold Coast Health Plan access to care standards. PCP offices had a higher rate of compliance (93.2%) in comparison to Specialist offices. However, the option to listen to the after-hours recording in Spanish decreased (62.5%). Figure 8 shows the comparison of emergency instructions provided and instruction available in Spanish between PCPs and Specialist.

Figure 8: Access to Care Standard – Reached a Recording/Auto-Attendant Instructions 2019

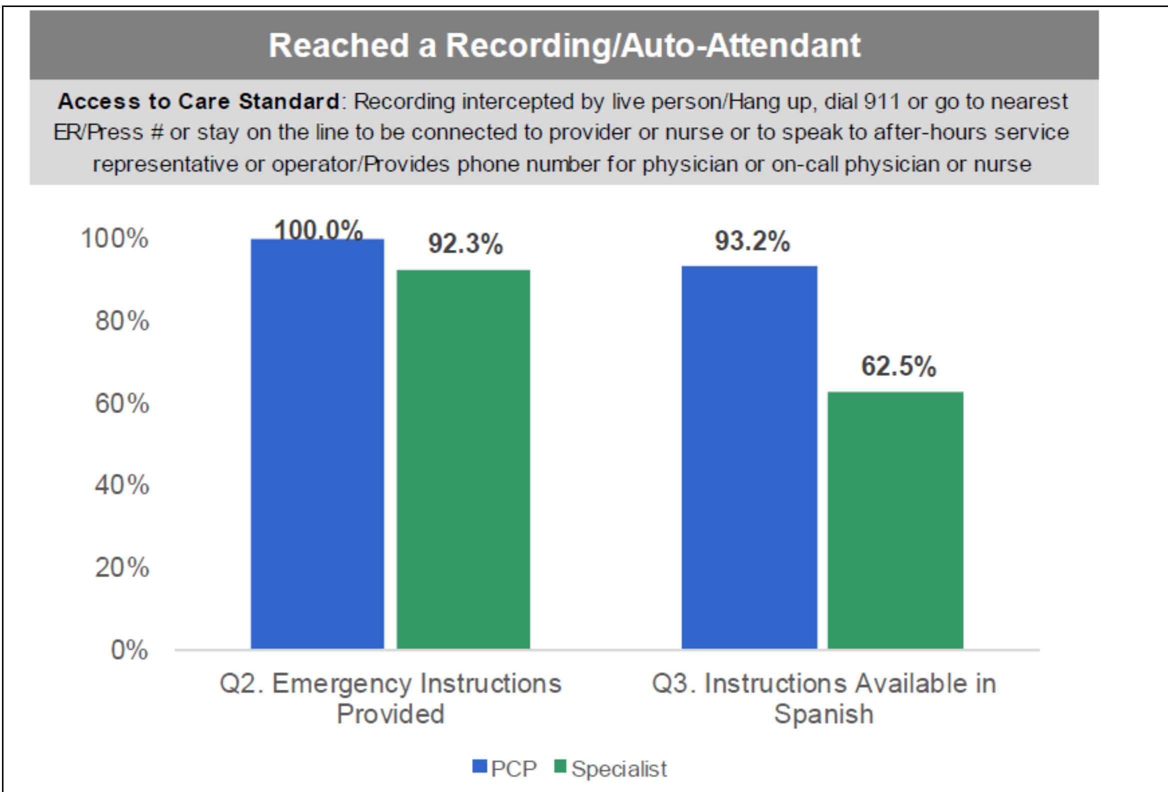
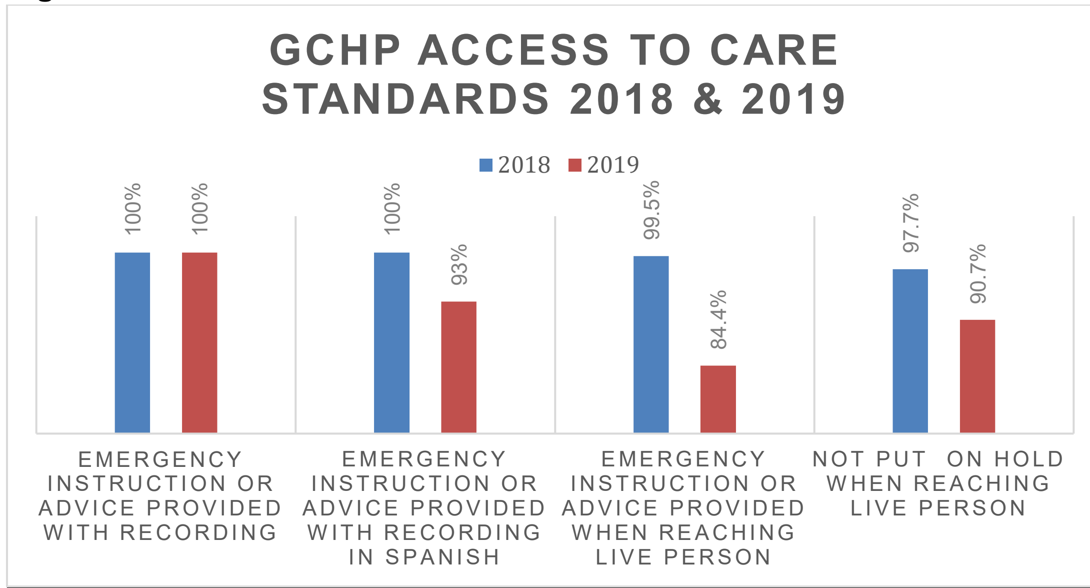


Figure 9 shows the compliance rate for emergency instructions and advice provided including instructions provided in Spanish when reaching a recording, auto attendant, or live person. The access to care standard includes recording intercepted by live person/hang up, dial 911, go to emergency room/press #, stay on the line to connect to provider/nurse, speak to after-hours service representative, operator provides number for physician or nurse, and not being put on hold. The was a 7% decrease for providing instruction or advise when reaching a live person, an approximation of 7% decrease of providing instruction in Spanish, and a 15% decrease of not being put on hold from 2018 to 2019.

Figure 9: GCHP Access to Care Standards 2018 and 2019



The Health Education, Cultural and Linguistics Department in collaboration with Provider Network Operations met to prioritize areas to address in the PNA SMART objectives. Referring to the data from the 2019 Provider Satisfaction Survey and Timely Access Survey, the areas of focus were prioritized based on what needed improvement and what areas the Plan would be able to address. The items from the Provider Satisfaction Survey are under the contractual agreement of DHCS and were not considered as an area that could be changed. For the Timely Access Survey, all areas were found to have some opportunity for improvement, thus identifying provider education and training to access to care standard as one of the PNA SMART objectives.

Results of the CAHPS, Timely Access Survey, and Provider Satisfaction Survey identified areas of opportunity of improvement. The Health Education Department has identified shared decision making as a strategic objective from the CAHPS report and to increase awareness of importance of Spanish language auto recordings during after-hours form the time access report. The activities will include provider outreach, collaborative between various department within GCHP in promoting health education and language assistance services, participation in Provider Joint Operation Meetings, submit articles on language assistance in various GCHP publications, and increase provider cultural competency trainings.

In addition to the findings listed above, GCHP issued a Request for Proposal for language assistance services. With the implementation and transition period of the new language assistance service vendor contract, GCHP will have

opportunity to provide provider training and education for timely access services and promote language assistance services.

Figure 10 show the breakdown of the eight (8) hospitals in the region. GCHP has 227 Primary Care Physicians caring for their adult membership and 198 Primary Care Physicians for their child membership. There is a total of 2,198 specialists under GCHP, with 1,144 dedicated to care for adults and 1,054 for caring for children[32].

Figure 10: Network Providers by Region

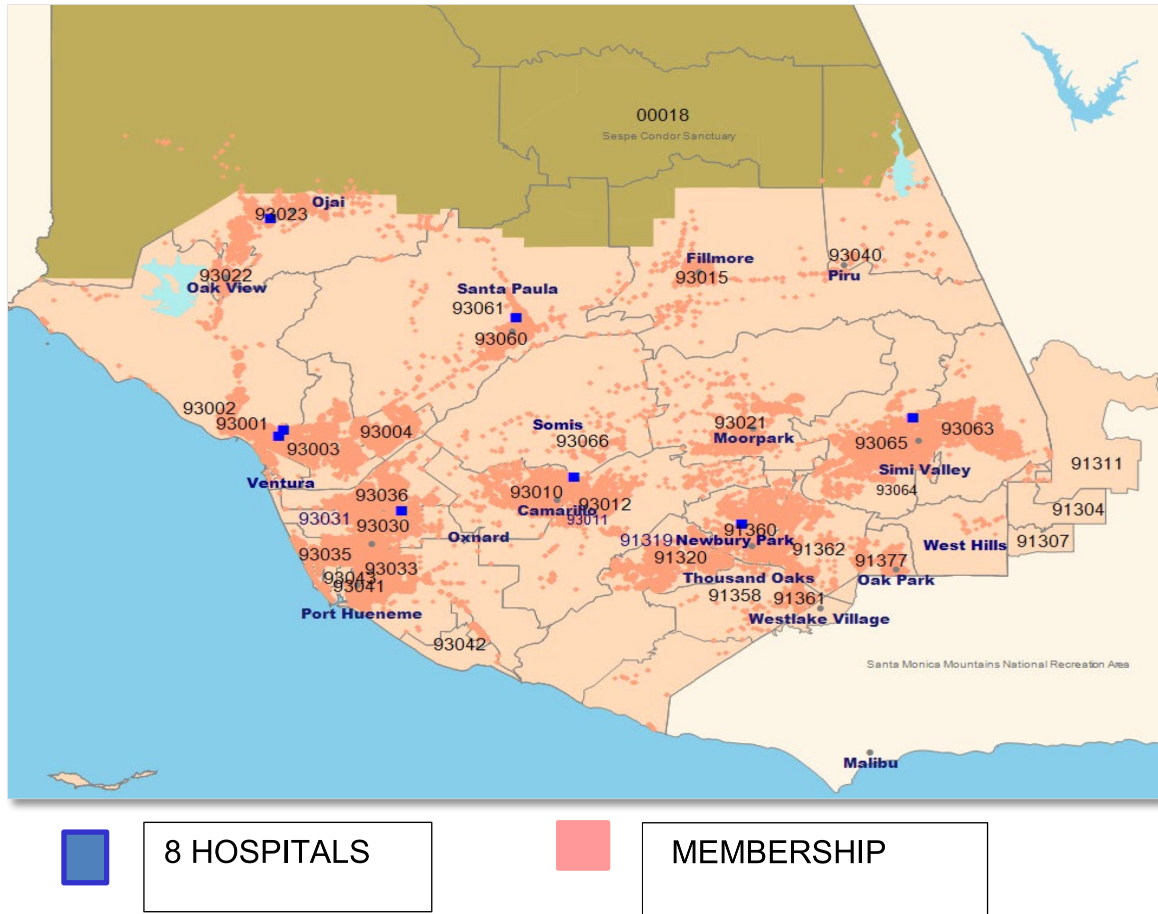
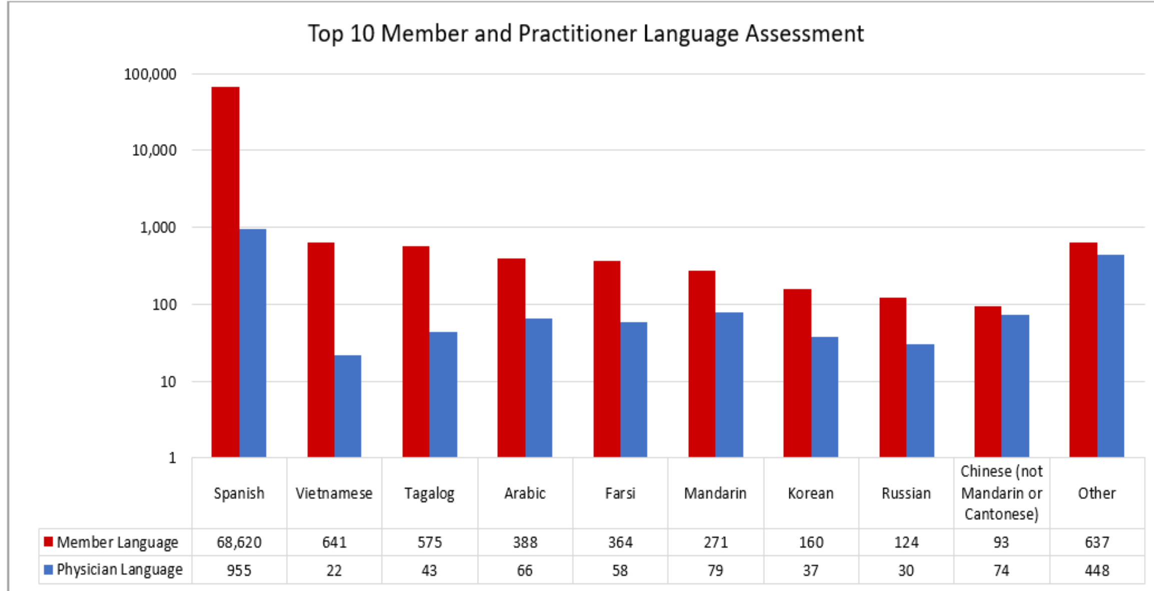


Figure 11 shows the top 10 languages spoken by GCHP members in comparison with providers who speak the same language.

[32] GCHP Membership and Practitioner Report 2020

Figure 11: Top 10 GCHP Member Language Compared to Language Spoken by Practitioner



Department of Health Care Services managed care health plan (MCP) specific health disparities 2016 data

To assess and improve health disparities, the California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG) to conduct a health disparities study using the external accountability set (EAS) performance indicators reported by the 23 full-scope Medi-Cal managed care health plans (MCPs) for reporting year 2017 with data derived from calendar year 2016. This report does not include data for fee-for-service (FFS) beneficiaries in Medi-Cal. EAS indicators reflect clinical quality, timeliness, and access to care provided by MCPs to their beneficiaries; and each MCP is required to report audited EAS results to DHCS annually. The goal of the Health Disparities Report is to improve health care for Medi-Cal beneficiaries by evaluating the health care disparities affecting beneficiaries enrolled in Medi-Cal MCPs [33].

The findings present the racial/ethnic health disparities results for each EAS indicator, where applicable, organized by domain (Preventive Screening and Children's Health, Preventive Screening and Women's Health, Care for Chronic Conditions, and Appropriate Treatment and Utilization). DHCS requested that HSAG evaluate EAS measure indicator data collected for reporting year 2017 at the statewide level, which evaluated performance during calendar year 2016, also known as Healthcare Effectiveness and Information Data Set (HEDIS®) measurement year 2016. Several EAS measures consist of more than one

[33] DHCS Health Disparity Report, 2016.

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indicator; therefore, this report will refer to EAS indicators rather than measures. Although HSAG stratified all EAS indicators by race/ethnicity, primary language, age, and gender, HSAG only identified health disparities based on statistical analysis for the racial/ethnic stratification (Health Disparity Report, 2016).

Health disparities were identified when indicator rates for racial/ethnic groups were better than or worse than the rates for the white group (i.e., the reference group). If a racial/ethnic group's indicator rate was similar to the white group, then no health disparity was identified. The health disparity in which all groups were below the performance level was children and adolescents' access to primary care practitioners- 12 to 19 years. The Hispanic or Latino group only had one other health disparity for having better rates in immunizations for adolescents -Combination 2 indicator. The Asian group had 3 other health disparities in Children and Adolescents' access to primary care practitioners for 25 months to 6 Years and 7 to 11 years being below the minimum performance level and having a better rate than the white group in immunization for adolescents- Combination 2 indicator. The white group had 6 other disparities including 3 in children and adolescents' access to primary care practitioners (12 to 24 months, 25 months to 6 years, and 7 to 11 years), childhood immunizations status- combination 3, breast cancer screenings, and annual monitoring for the patients on persistent medications- ACE Inhibitors or ARBs being below the minimum performance level (Health Disparity Report, 2016).

The three groups with the most health disparities include Native Hawaiian or Other Pacific Islander with the highest number of health disparities, followed by Black or African American, and American Indian or Alaska Native. The Native Hawaiian or Other Pacific Islander group had 11 other health disparities including 3 in children and adolescents' access to primary care practitioners (12 to 24 months, 25 months to 6 years, and 7 to 11 years), childhood immunization status- combination 3, breast cancer screenings, cervical cancer screenings, postpartum care rates, asthma medication ratio rates, and 4 comprehensive diabetes care (eye exam, HbA1c control, HbA1c poor control, HbA1c testing rates). The Black or African American group had 9 other disparities including 3 in children and adolescents' access to primary care practitioners (12 to 24 months, 25 months to 6 years, and 7 to 11 years), childhood immunization status- combination 3, postpartum care rates, annual monitoring of persistent medications (diuretics), 2 in comprehensive diabetes care (HbA1c poor control, HbA1c testing rates), and all causes of readmission rates. The American Indian or Alaska Native group had 7 other disparities including 3 in children and adolescents' access to primary care practitioners (12 to 24 months, 25 months to 6 years, and 7 to 11 years), childhood immunization status- combination 3,

breast cancer screenings, postpartum care, and annual monitoring for patients on persistent medications (ACE inhibitors or ARBs[34]).

In conclusion the racial/ethnic group with the highest number of health disparities was the Native Hawaiian or Pacific Islander. The health disparities with the most discrepancies with multiple racial/ethnic groups were children and adolescents' access to primary care practitioners (12 to 24 months, 25 months to 6 years, 7 to 11 years, 12 to 19 years), and childhood immunization status- combination 3. There were measures were there were no rates for racial/ethnic groups being below the minimum performance level which include: counseling for nutrition, counseling for physical activity, well-child visits in the third, fourth, fifth, and sixth years of life, timeliness of prenatal care, comprehensive diabetes care (blood pressure control, medical attention for nephropathy, and controlling blood pressure rates), avoidance of antibiotic treatment in adults with acute bronchitis, and use of imaging studies for low back pain (Health Disparity Report, 2016).

Health Education, Cultural & Linguistics, and Quality Improvement Gap Analysis

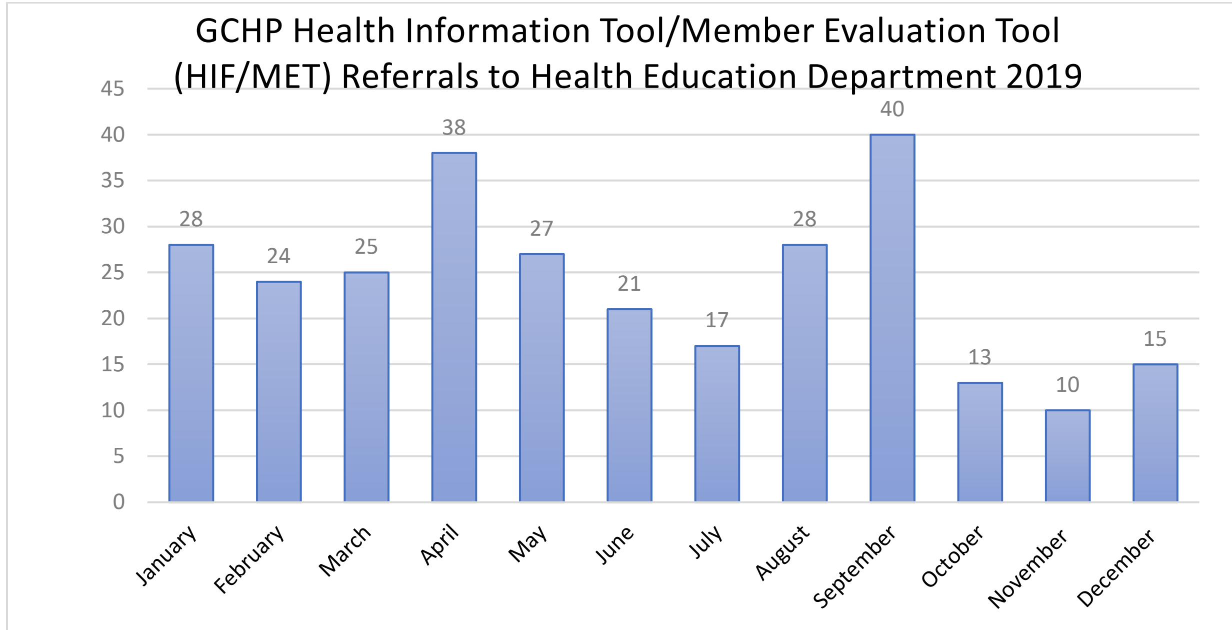
Gold Coast Health Plan offers free health education services to help members achieve a healthy lifestyle. Health education services are designed to ensure that all members have access to health education programs, health promotion materials and classes. The GCHP Health Education, Cultural and Linguistic Services Department can offer information about physical, nutrition, social, behavioral, pregnancy, parenting and many other health education topics. Dr. Lupe Gonzalez, Ph.D., M.P.H., Director of Health Education, Cultural and Linguistic Services oversees the department. The department's staff includes one cultural and linguistic specialist, one senior health navigator, and three health navigators. Health Navigators are trained using the community health worker model and are bilingual/bicultural. Health Navigators help members with scheduling health education classes and act as advocates, provide support and education to empower members and families to become self-reliant in managing the disease process and accessing care. The Health Navigators are advocates for GCHP by providing exceptional service and first call resolution.

Health Education, Cultural and Linguistic Services collaborates with GCHP with providers, and many departments within GCHP; however, many of the cases referred to the department come from the Care Management (CM) Department. Figure 12 shows the total number of members referred to the department through the Health Information Form (HIF)/Member Evaluation Tool (MET) questionnaire. Members who self-report a chronic condition are referred to the Health

[34] DHCS Health Disparity Report, 2016.

Education, Cultural and Linguistic Services Department for assistance with health education services.

Figure 12: HIF/MET Referrals to Health Education Department 2019



Cultural and Linguistic Services

GCHP Health Education, Cultural and Linguistics Department provides language assistance services to members with limited English proficiency. According to the GCHP Cultural and Linguistics Report, in 2019 GCHP provided a total of 4,372 interpreting services, with 87% of interpreting provided by phone, 7% was provided in-person for spoken language, and 6% for American Sign Language interpretation. The top 5 languages requested for telephonic interpreting are Spanish, Vietnamese, Arabic, Mandarin, and Farsi. The Cultural and Linguistics Department also offers materials to providers to assist with interpreting and translation services.

Conclusion

Both quantitative and qualitative data findings were used to prepare the PNA SMART objectives. The objectives identified were prioritized utilizing multiple data sources. GCHP identified 9 key findings and prepared an action plan with specific intervention strategies to address areas of improvement and to better address health outcomes that impact members. The areas of focus include the following:

- Diabetes, hypertension, heart disease, and asthma education
- Asthma education and member engagement program for members between 5 – 64 years of age with a diagnosis of persistent asthma.
- Chlamydia screening in women between the ages of 16-24 years of age.
- Childhood lead screening among children between 0-24 months.
- Well child visits and immunization promotion among children between the ages of 0 to 12 months.
- Health disparity and the impact of language, ethnicity, and cultural beliefs on managing diabetes (A1C) levels among Latinos.
- Language access services among providers and members, and the ability of providers to address the language, cultural beliefs, and health literacy of members.
- Childhood obesity and health promotion among children between the ages of 0-5 years of age.
- Access to care among members seeking routine medical services with primary care providers and specialists.

IV. Action Plan

Objective 1: By December 31, 2020, increase awareness from 0% to 3% among members diagnosed with diabetes, hypertension, heart disease and asthma about the Chronic Disease Self-Management Program (CDSMP). **Measure:** Chronic Health Conditions – Diabetes, Hypertension or Asthma **Data Source:** 2020 Claims, Encounter, Medical Records, Health Information Form/Member Evaluation Tool
Strategies
1. Train health navigators in CDSMP, an evidence-based program to promote member engagement and self-help coping tools. Training will consist of in-person group setting, telehealth, and online training tools.
2. Obtain a Business Agreement with the Camarillo Health Care District to facilitate CDSMP to GCHP members.
3. Identify potential participants using administrative data generated by the DSS, QI Departments, HIF/METs, and self-identified members.
4. Develop member engagement outreach call script in English and Spanish.
5. Conduct CDSMP classes, telehealth, or online program for members.
6. Evaluate program using preapproved tools from the CDSMP and summary findings of the program.

Objective 2: By December 31, 2020, increase the percentage from 50.09% to 52.09% by 2.0%) of members, 5-64 years of age with a diagnosis of persistent asthma, who had a ≥ 0.50 ratio of controller medications to total asthma medications during the measurement year. Age Groups: • 5 – 11 • 12-18 • 19-50 • 51-64 • Total 5 - 64 **Measure:** Asthma Medication Ratio (AMR) **Data Source:** Claims, Encounter, Pharmacy
Strategies
1. Train health education team on the California Breathe, Breathe Easy Program, Asthma Education Program.
2. Collaborate with QI, CM, and DSS Departments to identify potential members who are non-compliant with asthma medication adherence.
3. Conduct asthma outreach campaign including educational interactive voice response (IVR) calls and text messages.
4. Based on identified individuals diagnosed with asthma, use the Breathe Easy Program educate members and to conduct follow - up education (i.e. online resources and telehealth).
5. Work with QI and PNO to provide Provider Education via the POB, Provider memos, etc.
6. Evaluate the health promotion program and prepare summary report.

Objective 3: By December 31, 2020, increase percentage of CHL screening from 56.02% to 58.0% among women, 16-24 years of age, who were identified as sexually active and/or who had at least one chlamydia screening during the measurement year to meet or exceed the DHCS MPL (50th percentile). **Measure:** Chlamydia Screening in Women (CHL). **Data Source:** Claims, Encounter, Lab
Strategies
1. Train health navigators to conduct member outreach calls.
2. Prepare a health education flyer on the prevention CHL and the importance of screening.
3. Create and implement a provider and member health education campaign.
4. Prepare article for the member newsletter, “Winning Health” on the prevention of STIs.
5. Collaborate with QI on identifying members for the health education campaign.
6. Evaluate the health education campaign and work with QI to review measures.

Objective 4: By December 31, 2020, increase the percentage of children who had one or more capillary or venous lead blood test for lead poisoning by their 2nd birthday by 2%. **Measure:** Lead Screening in Children (LSC) **Data Source:** Claims, Encounter Data, Lab
Strategies
1. Explore partnerships with Help Me Grow/First 5 and CHDP to educate clinics on best practices. Prepare articles of the importance of lead screening in various member and provider publications.
2. Collaborate with QI to utilize Initial Health Assessments and medical record reviews to identify barriers and opportunities for improvement.
3. Create and implement provider and member awareness campaigns.
4. Collaborate with QI to evaluate improved data capture with single source lab provider (Quest Diagnostics).
5. Evaluate the lead screening program and prepare summary report.

Objective 5: By December 31, 2020, implement a health education campaign to promote well child visits and immunizations (Combo 10) among children (0-24 months). **Measures:** Well-Child Visits in the First 15 Months of Life (W15) and Childhood Immunization Status Combo 10 (CIS-10) **Data Source:** Claims, Encounter, CAIR Immunization Registry, Medical Records
Strategies
1. Collaborate with QI Department to provide clinics/providers with the annual 2019 MY MCAS rate reports.
2. Collaborate with QI to identify clinic to conduct member education campaign.
3. Explore partnerships with VCPH/VCOE/community agencies to educate clinics on reporting and/or best practices.
4. Collaborate with QI to conduct gap closure campaign for members identified as missing well-child visits before first 15 months and immunizations before their 2nd birthday. Identify health education materials to be used in the campaign.
5. Create and implement provider and member education campaigns.
6. Prepare articles on the importance of well-child visits and immunizations in various member and provider publications.
7. Evaluate the program and prepare a summary report.

Objective 6: By December 31, 2020, implement a diabetes education program for Latinos living in the Ventura/Santa Paula area and decrease the percentage from 34% to 30% of members diagnosed with diagnosed with diabetes. **Measure:** None **Data Source:** Health Disparity, Administrative Data (Claims, Encounter, and Pharmacy) and DSS Health Status Data
Strategies
1. Collaborate with QI and Health Services Departments to develop and implement a diabetes education among Latinos members living in the Santa Paula area.
2. Identify members using the health status data reports prepared by the DSS Department at GCHP.
3. Explore partnerships with Ventura County Public Health and Ventura County Medical Center (VCMC) and other network providers to identify potential members.
4. Conduct health education classes, telehealth, or online program for members identified for the program.
5. Create and implement provider and member education campaigns.
6. Prepare articles on the importance of diabetes care and treatment.
7. Evaluate the program and prepare a summary report.

Objective 7: By December 31, 2020, implement an awareness campaign of language access services among providers and members. Increase the percentage by 3% of providers ability to address health literacy for shared decision making and improve communication. **Measure:** None **Data Source:** CAHPS, Timely Access Survey, Provider Satisfaction Survey, and CAC Survey, Claims and Encounter Data.
Strategies
1. Collaborate with QI and Provider Network Operations Department to share CAHPS, Timely Access Survey and Provider Satisfaction survey results.
2. Prepared education campaign to promote language assistance services and cultural competency trainings.
3. Explore partnerships with network providers to promote cultural competency trainings to providers.
4. Prepare a health literacy program to promote member and provider communication on shared decision making.
5. Implement provider and member cultural competency and health literacy education campaigns.
6. Prepare articles on the importance of member engagement and shared decision practices in various member and provider publications.
7. Evaluate the program and prepare a summary report.

Objective 8: By December 31, 2020, implement a childhood obesity and health education campaign on reducing sugary drinks among children living in the Port Hueneme and Oxnard areas. **Measure:** None **Data Source:** Claims, Encounter, Medical Records
Strategies
1. Collaborate with QI and Health Services Departments to identity potential clinics and members who may participate in the program.
2. Train staff on the public health campaign ReThink your Drink, and to develop health articles in the member newsletter to on healthy eating and staying active.
3. Explore partnerships with, WIC, CHDP, VCPH, VCOE and non-profit community agencies to educate children on reducing the intake of sugary drinks.
4. Create and implement provider and member education campaigns.
5. Create member incentive program using promotional materials.
6. Prepare articles on the importance of health lifestyle and reducing sugary drinks in member and provider publications.
7. Evaluate the program and prepare a summary report.

<table>
<tr><td>Objective 9: By December 31, 2020, increase awareness of access to care among members seeking routine medical services with primary care providers and specialists.
Measure: None
Data Source: Provider Satisfaction and Timely Access Surveys</td></tr>
<tr><td>Strategies</td></tr>
<tr><td>1. Collaborate with Provider Network Operations to create and implement provider access to care campaign.</td></tr>
<tr><td>2. Create and implement access to care and standard to care trainings for providers.</td></tr>
<tr><td>3. Prepare articles on the importance of standards to care for members and provider publications.</td></tr>
<tr><td>4. Evaluate the program and prepare a summary report.</td></tr>
</table>

V. Stakeholder Engagement

GCHP conducted external and internal stakeholder surveys and interviews. GCHP administered a qualitative survey among members of the Community Advisory Committee (CAC) and followed-up with a telephone conference interview with CAC members. A special meeting, also known as a focus group, was held with GCHP CAC members.

Community Advisory Committee (CAC) Focus Group and Survey

The purpose of the CAC is to advocate for the health and wellbeing of members and provide input on the health education, cultural and linguistic services available to members. There are 10 voting members who represent various constituencies served by GCHP. These include beneficiaries with chronic medical conditions, County Health Care Agency, County Human Services Agency, foster children, Medi-Cal beneficiaries, seniors, persons with disabilities, and persons with special needs. The Health Care Agency and the Human Services Agency are standing seats, except for those positions, each of the appointed members serves a two-year term; however, committee members may reapply for additional terms as there are no term limits. The committee meets once every quarter and reports to the governing board known as the Ventura County Medi-Cal Managed Care Commission.

The purpose of the survey was to elicit responses from CAC members on the health and wellbeing of members. The CAC survey included 26 questions, with five (5) key sections including: 1) member's health concerns/issues; 2) cultural and linguistic needs; 3) health conditions; 4) member engagement; and 5) oral and behavioral health. Five or 60% of CAC members completed and returned the survey. Dr. González, PhD, MPH, Director of Health Education, Cultural and Linguistic Services provided a presentation to the CAC members and gave an

overview of the PNA. An open forum was held to discuss items related to the stakeholder survey.

Key findings of the CAC survey responses identified important health concerns or issues for GCHP members including health care coverage, access to care, and social determinants of health. Below is a summary of the key findings identified by the CAC members:

- Health Care Services - Important to address health concerns or issues for GCHP members including health care coverage, access to care, and social determinants of health.
- GCHP members learn about their health by seeking health care advice and participating in community resources. However, there are many other social determinants of health factors that makes it difficult for members to manage their own health.
- Communication - It was reported that GCHP members learn best on improving their health condition by:1) family/friends, 2) doctor's offices/clinics, 3) media, and 4) Internet/website access. It was recommended to develop social media in English and Spanish for members, as this can increase the awareness for improving member's health along with identifying the barriers that keeps members from participating. Other suggestions included working in collaboration with community-based organizations, local radio, and television programs.
- Access to Care - GCHP can improve member's health by providing timely access to PCPs, medication, developing user friendly information that is clear to the readers, and by providing ongoing media presentations (i.e., radio or media platforms).
- Social Determinants of Health (SDOH): Identifying SDOH that prevent members from seeking health care services; building trust is important and work with member by quickly resolving issues that arise. Develop outreach campaigns for members that support their structures by working with affordable housing units, transportation, health services and provide application assistance.

Internal Survey - GCHP Department Representatives with Direct Member Contact

GCHP surveyed key department representatives with member direct contact. Survey questions were drafted using various questionnaires used by a Medi-Cal Managed Care Health Plans, Partnership Health Plan, and health education questions from the 2016 Group Needs Assessment (GNA) survey[35]. A survey was emailed to 26 GCHP employees with direct member contact. A total of 16 surveys were completed, for a total response rate of 61.5%. The survey consisted of 43 questions focusing on health education, cultural and linguistic

[35] DHCS 2016 Group Needs Assessment (GNA) Questionnaire. www.dhcs.ca.gov.

needs, access to care, method of communication of health care services, and barriers to health care services. A review of the findings included the following items:

- Social Determinants of Health (SDOH) as was identified as a key factor in members seeking care. Employees identified food insecurity, transportation, and literacy/education are key factors for seeking health care.
- Communication – majority of respondents indicated that communicating with members is a concern. The lack of internet services, cost of internet, and cell phone usage is limited. Communicating through these means is challenging. The best method of communicate with members is through direct mail followed by telephone.
- Access to Care – there are concerns about access to care and behavioral health providers. Respondents shared that members expressed fear of seeking behavioral health services and stigma associated with mental health in community.
- Cultural Beliefs – GCHP employees believe that cultural factors are important in the delivery of health care. Increase awareness of language access services and health beliefs.

Educating Health Care Providers and Allied Health Care Personnel

Findings of the PNA and key informative surveys will be shared with CAC members, the Commission (the governing body of GCHP), providers, allied health care personnel, members, and community-based agencies. GCHP will work with various internal and external agencies to share the PNA findings and work collaboratively to improve the health and wellbeing of members. Findings of the PNA will also by published in the Provider Operations Bulletin, community report, and GCHP website.

The PNA results will be shared with key stakeholders and below is a summary of key meetings:

- GCHP Monthly Commission Meeting
- GCHP Quarterly CAC Meeting
- GCHP Executive Leadership Meeting
- GCHP Health Education, Cultural and Linguistic Quarterly Meeting
- GCHP Quality Improvement Committee
- GCHP Medical Advisory Committee
- GCHP UM Committee
- GCHP and CHDP Collaborative Meeting
- Ventura County Office of Education (VCOE) Health Services Meeting
- Ventura County Community Collaborative Meeting
- GCHP Provider Advisory Committee Meeting
- Community Outreach Partnership Meetings

Appendix A: Member Demographics

A. Plan's Members by Race/Ethnicity

Race/Ethnicity	Member Numbers (2018)	% of Total Membership (2018)	Member Numbers (2019)	% of Total Membership (2019)	% of Membership in 2019 (minus) % of Membership in 2018
American Indian/Alaskan Native	401	0%	390	0%	0.00%
Asian/Pacific Islander	6,763	4%	6,570	4%	-0.04%
Black/African American	2,483	1%	2,471	1%	0.02%
Hispanic/Latino	99,218	59%	96,422	58%	-0.62%
Caucasian/White	37,077	22%	36,355	22%	-0.04%
Other	15,515	9%	16,413	10%	0.71%
Not Available/Unknown	7,236	4%	7,054	4%	-0.03%
Totals	**168,693**	**100%**	**165,675**	**100%**	N/A

B. Plan's Members by Preferred Language

Preferred Language	Member Numbers (2018)	% of Total Membership (2018)	Member Numbers (2019)	% of Total Membership (2019)	% of Membership in 2019 (minus) % of Membership in 2018
American Sign Language (ASL)	38	0.02%	38	0.02%	0.00%
Arabic	380	0.23%	383	0.23%	0.01%
Armenian	58	0.03%	64	0.04%	0.00%
Cambodian	41	0.02%	47	0.03%	0.00%
Cantonese	75	0.04%	77	0.05%	0.00%
Farsi	318	0.19%	354	0.21%	0.03%
English	101,685	60.28%	100,102	60.42%	0.14%
Hebrew	4	0.00%	3	0.00%	0.00%
Hmong	3	0.00%	3	0.00%	0.00%
Ilocano	12	0.01%	11	0.01%	0.00%
Italian	9	0.01%	9	0.01%	0.00%
Japanese	26	0.02%	22	0.01%	0.00%
Korean	166	0.10%	143	0.09%	-0.01%
Lao	3	0.00%	1	0.00%	0.00%
Mandarin	263	0.16%	277	0.17%	0.01%
Other Chinese Language	84	0.05%	79	0.05%	0.00%
Other Non-English	224	0.13%	249	0.15%	0.02%
Other Sign Language	3	0.00%	3	0.00%	0.00%
Polish	1	0.00%	2	0.00%	0.00%
Portugese	3	0.00%	5	0.00%	0.00%
Russian	110	0.07%	118	0.07%	0.01%
Samoan	11	0.01%	6	0.00%	0.00%
Spanish	62,918	37.30%	61,471	37.10%	-0.19%
Tagalog	540	0.32%	526	0.32%	0.00%
Thai	13	0.01%	15	0.01%	0.00%
Turkish	4	0.00%	4	0.00%	0.00%
Vietnamese	607	0.36%	620	0.37%	0.01%
No Valid Data Reported	1,045	0.62%	1,031	0.62%	0.00%
No response, client declined to state	47	0.03%	10	0.01%	-0.02%
NULL	2	0.00%	2	0.00%	0.00%
Total	**168,693**	**100%**	**165,675**	**100%**	N/A

C. Plan's Members by Age

Age (Years)	Member Numbers (2018)	% of Total Membership (2018)	Member Numbers (2019)	% of Total Membership (2019)	% of Membership in 2019 (minus) % of Membership in 2018
< 1	296	0.18%	278	0.17%	-0.01%
1 - 5	20,493	12.15%	19,503	11.77%	-0.38%
6 - 11	28,108	16.66%	26,785	16.17%	-0.50%
12 - 17	26,413	15.66%	26,632	16.07%	0.42%
18 - 20	8,969	5.32%	8,910	5.38%	0.06%
21 - 44	41,605	24.66%	41,020	24.76%	0.10%
45 - 64	27,890	16.53%	27,306	16.48%	-0.05%
65 +	14,919	8.84%	15,241	9.20%	0.36%
Totals	**168,693**	**100%**	**165,675**	**100%**	N/A

D. Plan's Members by Sex

Sex	Member Numbers (2018)	% of Total Membership (2018)	Member Numbers (2019)	% of Total Membership (2019)	% of Membership in 2019 (minus) % of Membership in 2018
Male	78,587	46.59%	77,082	46.53%	-0.06%
Female	90,106	53.41%	88,593	53.47%	0.06%
Unknown	**0**	**0.00%**	**0**	**0.00%**	0.00%
Totals	**168,693**	**100%**	**165,675**	**100%**	N/A

E. Plan's Members by SPD and Dual Category

Aid Category	**Aid Category Calculated Description**		**Aid Category**	**Aid Category Calculated Description**	
Aid Category	Member Numbers (2018)	% of Total Membership (2018)	Member Numbers (2019)	% of Total Membership (2019)	% of Membership in 2019 (minus) % of Membership in 2018
SPD	**26,591**	**15.76%**	**26,575**	**16.04%**	**0.28%**
Dual	**18,792**	**11.14%**	**18,921**	**11.42%**	**0.28%**
SPD Non-Dual	**8,551**	**5.07%**	**8,394**	**5.07%**	**0.00%**

F. Plan's Members by Homeless Condition based on Diagnosis Code

	Homeless Calculated Description			**Homeless Calculated Description**	
Homeless	Member Numbers (2018)	% of Total Membership (2018)	Member Numbers (2019)	% of Total Membership (2019)	% of Membership in 2019 (minus) % of Membership in 2018
Total	**1,735**	**1.03%**	**2,495**	**1.51%**	**0.48%**

Appendix B: Stakeholder Surveys

Dear Consumer Advisory Committee Members:

As a Consumer Advisory Committee (CAC) member, we would like to hear from you regarding your thoughts on health priorities in the community, delivering health education services and ensuring members receive language assistance services.

The Department of Health Care Services (DHCS) requires Managed Care Plans (MCPs) to conduct a Population Needs Assessment (PNA). The PNA will be conducted annually as directed by the DHCS. Your responses will help Gold Coast Health Plan (GCHP) ensure that services are culturally and linguistically appropriate for members.

The goal of the Population Needs Assessment (PNA) is to improve health outcomes for members and ensure that MCPs are meeting the needs of all their Medi-Cal members by:

- Identifying member health needs and health disparities;
- Evaluating health education, cultural and linguistic (C&L) needs, and quality improvement (QI) activities and available resources to address identified concerns;
- Implementing targeted strategies for health education, C&L, and QI programs and services.

GCHP would like to get your feedback on our current Health Education, Cultural and Linguistic (HECL) services, quality improvement services and access to primary care providers. Please complete the questionnaire and email your responses to Maddie Gutierrez, Clerk to the Commission at **mgutierrez@goldchp.org** no later than **Wednesday, May 20, 2020**.

Population Needs Assessment, Stakeholder Questionnaire

1. What do you think are the important health concerns or issues for individuals you serve that are GCHP members?

   ____
   ____

2. We are interested in learning what members are doing to manage their health condition. Please list what members are doing to manage their health.

   ____
   ____

3. What can GCHP do to support our members in improving their health?

   ____
   ____

4. Do GCHP members in the community know about the health education services provided by GCHP's Health Education Department?

   a. If yes, please list the services.

      ____
      ____

   b. If no, what can GCHP do to increase awareness? Please list ideas:

      ____
      ____

5. How do GCHP members learn about improving their health conditions? Please rank the following with 1 being the highest and 6 being the lowest:

   ☐ GCHP website

   ☐ Internet

   ☐ Doctor's offices/clinics

   ☐ Media

   ☐ Family/friends

   ☐ Other (please explain): ______________________________

6. How can GCHP deliver health education services to the community you serve? Please rank the following with 1 being the highest and 5 being the lowest:

   - [ ] GCHP website
   - [ ] Internet
   - [ ] Doctor's offices/clinics
   - [ ] Media
   - [ ] Family/friends
   - [ ] Other (please explain):

   ___

7. How can primary care providers better address and provide health education services to their members/patients?

   ___

   ___

The following questions will help us identify ways to better address the cultural and linguistic needs of GCHP members.

8. How does your organization address the cultural and health beliefs of the members you serve?

   ___

   ___

9. Are language assistance services like translation and interpretation important to you and the community you serve?

   a. *If Yes*, what makes this is a priority?

   ___

   ___

   b. *If No*, why is this not a priority?

   ___

   ___

   c.

10. How does your organization currently help low-income and/or underserved community members?

____

____

    a. How does your organization address the cultural health beliefs of members?

    ____

    ____

    b. How does your organization address the health and cultural beliefs of indigenous groups such as Mixteco/Zapoteco, etc.?

    ____

    ____

11. Tell us what you believe to be the best method to effectively communicate with our members about language assistance services and other GCHP services?

____

____

12. How can Plan providers assist our members in delivering culturally and linguistically appropriate services?

____

____

13. Do you have any general comments or suggestions related to language assistance services or cultural health belief?

____

____

The following questions are specific to members with specific health conditions and how to address strategies to promote certain health screenings.

14. Chronic conditions
    a. What are some interventions that will help to reduce chronic conditions such as diabetes, hypertension, etc., among GCHP members?

    ____

    ____

b. What are the barriers to members seeking diabetes treatment/care?

____

____

c. Other comments:

____

____

15. Asthma

a. What are some interventions that can assist GCHP members with asthma medication adherence? Include intervention strategies for adults and children.

____

____

b. Other comments:

____

____

16. Members with special needs

a. How can GCHP better assist our members with special needs?

____

____

b. What other resources can help our members with special needs and those that provide care to these members?

____

____

c. Other comments:

____

____

17. Developmental and Health Screenings

a. How can GCHP promote developmental and health screenings either through parents or providers?

____

____

18. Foster Care
    a. How can GCHP improve the services provided to members and caregivers under foster care?

19. Homelessness
    a. What is the best method of reaching the homeless population?

    b. What barriers other than housing do you believe impacts the health of the homeless population?

    c. Other comments:

The following questions are regarding GCHP's member engagement:

20. Do you have any suggestions on how to promote member engagement?

21. What are some suggestions to engage members in managing their health needs?

22. How satisfied are you with your experience when referring members to GCHP? Check one:

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Neutral
- ☐ Unsatisfied
- ☐ Very unsatisfied

The following questions relate to oral and behavioral health:

23. How can GCHP promote oral/dental health services to the members you serve?

____

____

24. What do you believe are some barriers for members in getting routine dental care?

____

____

25. How can GCHP promote behavioral health to the members you serve?

____

____

26. What do you believe are some of the barriers for members seeking behavioral health services? Please be specific to adults and children services.

____

____

Thank you for taking the time to complete the survey, your responses will help us develop intervention strategies that will meet the cultural and linguistic needs of our members.

2020 Population Needs Assessment Survey
Internal Stakeholder Engagement

1.What department do you work for?

2.What is your job title?

3.What is your role in working with GCHP members?

4.What are the important health concerns or issues members have expressed to you?

5.Please list what you believe works best for our members in managing their health?

6.How can GCHP support our members in improving their health?

7.What are the three (3) top barriers for GCHP members when getting the services they need?

8.Do you believe GCHP members are aware of the health education services provided by GCHP's Health Education Department, yes or no? If no, please explain.

5.Please list what you believe works best for our members in managing their health?

6.How can GCHP support our members in improving their health?

7.What are the three (3) top barriers for GCHP members when getting the services they need?

8.Do you believe GCHP members are aware of the health education services provided by GCHP's Health Education Department, yes or no? If no, please explain.

9.How do GCHP members learn about improving their health conditions? Please rank the following with 1 being the highest and 6 being the lowest. (Please drag or move arrows on the right side of each option until you reach the desired location/ranking.)

GCHP website
Internet
Doctors' offices/clinics
Media
Family/friends
Other (please explain in question #10)

10.What is the other method GCHP members are using to learn about their health conditions?

11.How can primary care providers better address and provide health education services to GCHP members?

12.How can Health Education collaborate with your department to better serve our members?

13.In general, do you have any comments or suggestions related to health education services?

14.Do you believe GCHP employees know about cultural and linguistic services, yes or no? If no, please provide suggestions on how to promote cultural linguistic services to other GCHP employees and members.

15.Tell us what you believe to be the best method to effectively communicate with our members about language assistance services.

16.How can GCHP providers assist our members in delivering culturally and linguistically appropriate services?

17.In general, do you have any comments or suggestions related to language assistance services or cultural health beliefs?

Return to Agenda

18.What are some interventions that will help to reduce chronic conditions such as diabetes, hypertension, etc. among GCHP members?

19.What are the barriers to members seeking diabetes treatment/care?

20.Do you have other comments related to chronic conditions?

21.What are some interventions that can assist GCHP members with asthma medication adherence? Include intervention strategies for adult and children.

22.Do you have other comments related to asthma?

23.How can we collaborate with other organizations to promote healthy eating?

24.Do you have comments or concerns related to obesity?

25.How can GCHP better assist our members with special needs?

26.What other resources can help our members with special needs and those that provide care to these members?

27.Do you have other comments related to members with special needs?

28.How can GCHP promote developmental and health screenings either through parents or providers?

29.How can GCHP improve the services provided to members and caregivers under foster care?

26.What other resources can help our members with special needs and those that provide care to these members?

27.Do you have other comments related to members with special needs?

28.How can GCHP promote developmental and health screenings either through parents or providers?
29.How can GCHP improve the services provided to members and caregivers under foster care?

30.What is the best method of reaching the homeless population?

31.What barriers other than housing, do you believe impacts the health of our homeless population?

32.Do you have other comments related to the homeless population?

33.In your opinion, what are the top five (5) social determinants of health that impact our members?

34.Do you believe GCHP is reaching out to members who have substance use disorder, yes or no? If no, what are some suggestions to outreach to those members?

35.How can GCHP promote behavior health to our members?

36.What do you believe are some of the barriers for members seeking behavior health, both for adult and children services?

37.When working with members, are they asking about Medi-Cal Dental or dental services?

38.How can GCHP promote oral/dental health services to our members?

39.What do you believe are the barriers for our members in getting routine dental care?

40.In general, what is the best method to communicate with our members?
Please rank the following with 1 being the highest and 6 being the lowest.
(Please drag or move arrows on the right side of each option until you reach the desired location/ranking.)

Direct mail
Telephone
E-Mail
Text message
In-person
Other (please explain in question #41)

41.What is the other method to communicate with our members?

42.What are some of the challenges in communicating with our members via cell phone and text messaging?

43.What are some of the challenges members experience when using the Internet?

AGENDA ITEM NO. 5

TO: Community Advisory Committee

FROM: Anne Freese, Pharm.D., Director of Pharmacy

DATE: October 28, 2020

SUBJECT: Medi-Cal Rx Update

VERBAL PRESENTATION

RECOMMENDATION:

Receive and file the update.

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

Medi-Cal Rx Update

Annie Freese, Pharm.D.
Director of Pharmacy

Agenda

- Member Communication
- Transition Benefit
- Medi-Cal Rx Website

Communication Schedule: Members

Date	Topic	Responsibility
October 2020 (delivered)	90-Day Notice Letter	DHCS
November 2020	60-Day Notice Letter	DHCS
November-December 2020	Outreach Campaign	GCHP
December 2020	30-Day Notice Letter	GCHP
January 2021	New ID Cards	GCHP

Other Member Outreach

Item	Targeted Date(s)	Description
Building Community Newsletter	Oct. 14th	Community newsletter sent to community partners providing high level details on Medi-Cal Rx
Member Newsletter*	Oct. 15-19th	Member newsletter with front page article discussing Medi-Cal Rx
Newspaper Ads*	Nov. 4th -22nd Dec. 2nd -27th	Ad in local print media providing high level details regarding Medi-Cal Rx
Radio Ads/Radio Air Time*	Nov. 6th – 22nd Dec. 1st – 27th	Ads and air time (GCHP employee interview) on local radio stations providing high level details regarding Medi-Cal Rx
GCHP Press Release	Dec. 15th	Press release discussing high level details on Medi-Cal Rx

Transition Benefit

DHCS Transition Policy Principals:

- 180 day transition period
- Claim and PA history provided to Medi-Cal Rx PBM
- For existing prescriptions that did not require a PA under the MCP (GCHP), but will under Medi-Cal RX, grandfathering will be offered:
  - Match based upon prescription number, **not** the drug and limited to 1 year from the date the prescription was written
- For existing prescriptions that did require a PA under the MCP (GCHP), and will also need a PA under Medi-Cal RX, grandfathering will be offered:
  - Match based upon PA authorization dates and date prescription was written, **not** the drug and limited to 1 year from the date the prescription was written
- For new prescriptions regardless of need for a prior authorization, grandfathering will not apply.

Medi-Cal Rx Web Portal:

https://medi-calrx.dhcs.ca.gov/home/

Information Available:

- Program Overview and FAQs
- Training and Communication Schedules
- Details regarding Transition Policy

Member Portal Details Coming Soon

Medi-Cal Rx: Questions

- For questions and/or comments regarding Medi-Cal Rx, DHCS invites stakeholders to submit those via email to rxcarveout@dhcs.ca.gov

- For questions and/or comments for GCHP regarding pharmacy benefits, please reach out to Annie Freese at afreese@goldchp.org

AGENDA ITEM NO. 6

TO: Community Advisory Committee

FROM: Marlen Torres, Executive Director of Strategy and External Affairs

DATE: October 28, 2020

SUBJECT: Community Relations Update

POWERPOINT PRESENTATION

ATTACHMENT:

Community Relations, October 28, 2020 -PPT Presentation

Gold Coast Health Plan[SM]
A Public Entity

Community Relations Update

Wednesday, October 28, 2020

Marlen Torres, Executive Director of Strategy and External Affairs

Integrity

Accountability

Collaboration

Trust

Respect

Overview of FY 2019-2020

- The Community Relations team participated in over 30 coalition/community meetings, held a booth at 59 events, engaged over 6,000 community members (over 2,000 of them were GCHP members).
- The team coordinated the sponsorship program, over $50,000 sponsorships were awarded to community-based organizations.
- Participated in 30 networking/coalition meetings and joined “Backpack Medicine” to provide resources and information to the most vulnerable population.

Sponsorships

Aggregate Report:

Sponsorships	
Sponsorships Awarded	35
Total Amount Awarded	$46,370 / $51,370*

Sponsorships

Detailed report by community/impact:

Sponsorship Type	Number of Sponsorships	Total Amount Awarded	Cities Targeted
Non-Profit Fundraising Events	22	$23,620	Ventura County
COVID-19 Response	7	$20,500	Ventura County
Health Walks	3	$2,250	Ventura, Oxnard
Diversity Sponsored Events	3	$5,000	Oxnard Camarillo Ventura

Community Engagement

- The community relations team participated in 89 enjoyable community events and collaborative meetings.

- The events ranged from resource fairs, festivals, college expositions, conferences, summits, and back to school nights.

- For the first time, GCHP participated in three Oxnard traditions, the annual Salsa Festival, the Christmas Parade and Fiestas Patrias.

Community Engagement

Aggregate Report:

Community Engagement Information	
Participated Events	59
GCHP members engaged	2,283
Community members engaged	6,826
Distributed GCHP Materials	Member Services Brochure, Transportation Business Card, Member Orientation Flyer
Networking/Coalition Meetings	30

By Geography:

Cities	Total Events
Oxnard	46
El Rio	2
Santa Paula	3
Ventura	3
Camarillo	4
Moorpark	1

Community Engagement

By focus area:

Focus Area	Total Events Attended	Members	Total Participants	Cities Targeted
Homeless Events *Backpack Medicine	4	84	107	Oxnard, Ventura
School Events (K-12)	22	901	2,231	Oxnard, Santa Paula, Camarillo, Ventura, El Rio
Community College Events	4	73	278	Oxnard, Ventura, Camarillo
General Conferences	10	313	888	Oxnard, Ventura, Camarillo, Moorpark
Festivals/Holiday Events	9	615	2,224	Oxnard
General Community Health and Resources Events	6	154	472	Oxnard, Santa Paula, El Rio
Agriculture Worker Events	4	143	626	Oxnard, Santa Paula

Sponsorships FY 2020-2021

- Entering the new fiscal year, GCHP has awarded over $18,000 in sponsorships this quarter.
- The sponsorship program this year, will focus on addressing member/ community with determinants of health.
- The sponsorship program is assisting important community-based organizations with funding to continue with essential programs for members and community.
- Through the sponsorship program, community-based organizations can also submit letters of support.

Sponsorships

Name of Organization	Description	Amount
Diversity Collective Ventura County	The '2020 Ventura County Virtual Pride" will raise funds to sustain the Diversity Collective programs and services. These services include free anonymous HIV & AIDS testing, peer-support groups, cultural competency training, and Rainbow Umbrella Youth Group.	$1,000
Boys & Girls Club of Santa Clara Valley	The donation and all funds raised from our Golf Classic will benefit the club programs and all members, including operational costs. Over 1,650 youth and community members utilize the Club.	$250
Ventura County Pregnancy Center	The "Earn While You Learn" is a program designed to benefit pregnant women, mothers & fathers of infants up to age 2 with educational classes on prenatal, parenting, life skills, relationships, & finance classes.	$1,000
Community Memorial Health System (CHMS)	CHMS is working on a quality improvement project with their OB care team that seeks to improve patient health and safety among the current pandemic, and into the future. The project aims to add value to the traditional prenatal model of care by replacing a handful of in-office visits with virtual at home Telehealth visits, supplemented with remote monitoring equipment (fetal Doppler, BP cuff and scale).	$5,000
Boys & Girls Club of Greater Conejo Valley (BGCGCV)	BGCGCV is looking to provide scholarships for vulnerable youth and families that provide youth full-day access to in person academic.	$2,000

Community Engagement 2020-2021

The Community Relations team continues to participate in collaborative meetings, community town hall meetings, and trainings in virtual platforms. Through these avenues, the team can gage what are the community/ member needs. Below you can find more information about the community relations team efforts:

Name of Meeting	Date	Description
Oxnard Police Department Outreach Coordinators meeting (recurring monthly meeting)	August 5,2020 September 2,2020 October 7,2020	The Oxnard Police Department host this collaborative meeting. Community partners share resources, promote outreach events, and bring presenters to educate participants. The goal is to bring community awareness and resources to Ventura County residents.
Circle of Care (recurring monthly meeting)	August 5,2020 September 2, 2020	One Step A La Vez hosts this meeting on a monthly basis to engage community leaders, share resources, network, and promote community events. The goal of this collaborative meeting is to better serve the Santa Clara Valley.
Tele Town Hall: Conversation with Secretary of State Alex Padilla, Senator Hannah-Beth Jackson Assemblymember Monique Limon Congressman Salud Carbajal	August 12, 2020	California representatives discussed the importance of participating in the 2020 Census and the important impact the Census brings to public services. Additionally, the group answered questions from the public regarding voting.
Building Community Safety Training (three-week training one day a week for 2 hours)	September 16,2020 September 23,2020 September 30,2020	The Urban Peace Institute in collaboration with the City and the Oxnard Police Department hosted a three-week training for community workers. The training educated participants on how to conduct outreach and communicate with individuals that live in communities with a heavy gang presence.
Multi-Unit Smoke -Free Task Force	September 17, 2020	The task force is responsible of engaging the community to create a smoke free environment in multi-unit housing for the City of Oxnard.
Ventura County Action on Smoking Collation	September 24,2020	A collation formed by community partners to share resources, ideas on ways to help prevent and reduce smoking in Ventura County.

Building Community

- The community newsletter was launched in August and sent to community partners, elected officials, providers and GCHP committee members.
- Through the Building Community Newsletter, the team will be able to connect virtually with the community by sharing important information.
- For more information contact: CommunityRelations@goldchp.org

www.goldcoasthealthplan.org

Gold Coast Health Plan
A Public Entity

Building Community
Advocating for Members & Engaging the Community

Compassionate Care, Accessible to All, for a Healthy Community.

Dear Partners,

Welcome to Gold Coast Health Plan's new bimonthly newsletter, Building Community. We are excited to share with you the important work we are doing to ensure that our members have access to high-quality care and are connected to the resources they need, particularly now during the pandemic.

In these unprecedented times, the work we are all doing to serve our community's most vulnerable residents is critical to their well being. The community needs its safety net now more than ever and we are working with our partners to share information and resources so that we can reach as many people as possible.

When I joined GCHP as interim CEO in November, I never could have anticipated the stress that GCHP, our health care system, community, and state would be faced with. The pandemic has had a significant effect on the state budget. While Medi-Cal benefits have remained largely intact, the funding GCHP receives from the state is being reduced retroactively.

It is against that backdrop that GCHP's governing board, the Ventura County Medi-Cal Managed Care Commission, extended my contract to remain as CEO. I am grateful for and humbled by the commission's continued trust to lead the organization and provide stability during these turbulent times.

I believe wholeheartedly in the important work we are doing to serve our members and in the plans that we have put in place to get us through this pandemic and the ensuing economic crisis. I look forward to continuing to work with our community partners to keep our community healthy.

Sincerely,

Margaret Tatar
Chief Executive Officer

Meet the Leadership

AGENDA ITEM NO. 7

TO: Community Advisory Committee

FROM: Marlen Torres, Executive Director, Strategy and External Affairs
Luis Aguilar, Member Services Manager

DATE: October 28, 2020

SUBJECT: CAC New Member Applications Update

VERBAL PRESENTATION

AGENDA ITEM NO. 8

TO: Community Advisory Committee

FROM: Steve Peiser, Senior Director Network Management
Vicki Wrighster, Contracting Manager

DATE: October 28, 2020

SUBJECT: Provider Communication Plan

PowerPoint with Verbal Presentation

ATTACHMENTS:

Provider Communication Plan

Gold Coast Health Plan

Community Advisory Committee Meeting

Provider Communication Plan
October 28, 2020

Steve Peiser, Sr. Director Network Management
Vicki Wrighster, Contracting Manager

Integrity
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Provider Communication

- Provider Resource Guide
  - Single document to address the changes that will occur as a result of the system migration
  - Provider Portal
    - New user account numbers and sign-ons
    - Claims Adjudication and Claims Submission
- Provider Update Meetings
  - Virtual meetings will be held beginning in late October through November
- Creation of a Provider ETP information webpage on the GCHP website
  - Provider Portal
  - Provider Resource Guide
  - Schedule of Provider Trainings
  - Additional resources as necessary
- Provider Operations Bulletin
  - October 2020
  - November 2020
- Dedicated email address to answer provider questions