Gold Coast Health Plan℠
A Public Entity

Quality Improvement and Health Equity Transformation Program 2023

www.goldcoasthealthplan.org

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I. BACKGROUND

Gold Coast Health Plan (GCHP) is an independent public entity created by county ordinance and authorized through Federal Legislation and the state Department of Health Care Services (DHCS) to provide health care services to Ventura County's Medi-Cal beneficiaries. The Ventura County Board of Supervisors approved implementation of a County Organized Health System (COHS) model, transitioning from fee-for-service Medi-Cal to managed care, on June 2, 2009. A year later, the board established the Ventura County Medi-Cal Managed Care Commission (VCMMCC) as an independent oversight entity, to govern and operate a single plan — Gold Coast Health Plan — to serve Ventura County's Medi-Cal population. The commission is comprised of locally elected officials, providers, hospitals, clinics, the county health care agency and consumer advocates.

II. MISSION, VISION, VALUES

Mission

The Quality Improvement and Health Equity Transformation (QIHET) Program is designed to support Gold Coast Health Plan's (GCHP) mission to improve the health of our members through the provision of high-quality care and services. Our member-first focus centers on the delivery of exceptional service to our beneficiaries by enhancing the quality of health care, providing greater access, and improving member choice.

In line with that goal, QIHET Program defines the processes for continuous quality improvement of clinical care and services, patient safety, and member experience, provided by GCHP and its contracted provider network, through its commitment to improving and sustaining its performance through the prioritization, design, implementation, monitoring, and analysis of performance improvement initiatives with a specific focus on health equity. Core values of the program include maintaining respect and diversity for members, providers, and employees.

Vision

Compassionate care, accessible to all, for a healthy community.

Values

The QIHET Program supports the organization's values of:

- **Integrity**: Achieving the highest quality of standards of professional and ethical behavior, with transparency in all business and community interactions.
- **Accountability:** Taking responsibility for our actions and being good stewards of our resources.
- **Collaboration:** Working together to empower our GCHP community to achieve our shared goals.
- **Trust:** Building relationships through honest communication and by following through on our commitments.
- **Respect:** Embracing diversity and treating people with compassion and dignity.

III. PURPOSE AND SCOPE

The purpose of the Gold Coast Health Plan (GCHP) Quality Improvement and Health Equity Transformation (QIHET) Program is to achieve high quality, equitable, and optimal clinical outcomes in all departmental programs in accordance with the state's mission to preserve and improve the health of all Californians. The QIHET Program provides the framework for GCHP to:

- Objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable health care and services.
- Identify and implement ongoing and innovative strategies to improve the quality, equity, appropriateness, and accessibility of member health care.
- Implement an ongoing evaluation process that lends itself to improving identified opportunities for under/over utilization of services.
- Facilitate organization wide integration of quality management and population health principles.
- Promote engagement in local community, statewide and national collaborations and initiatives aimed at improving quality and equity of care and services.

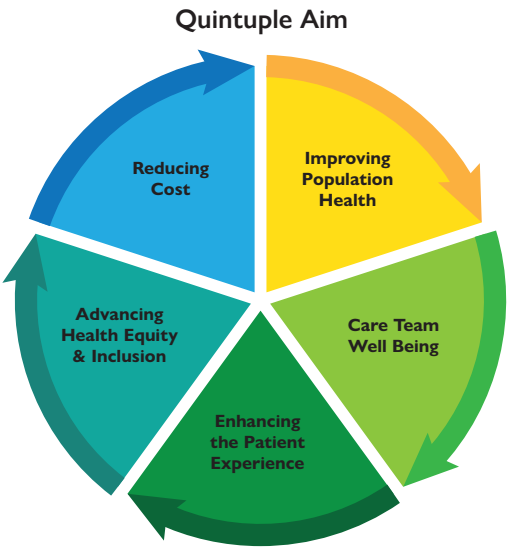
To accomplish this, GCHP's QIHET Program aligns its efforts with DHCS Comprehensive Quality Strategy as well as the goals set forth by the California Advancing and Innovating Medi-Cal (CalAIM) Initiative.

The Quality Strategy is anchored by three linked goals:

1. Improve the health of all Californians.
2. Enhance quality, including the patient care experience, in all DHCS programs.
3. Reduce the department's per-capita health program costs.

In conjunction with the Quintuple Aim, the eight priorities of the Quality Strategy are to:

1. Improve patient safety.
2. Deliver effective, efficient, and affordable care.
3. Engage persons and families in their health.
4. Enhance communication and coordination of care.
5. Advance prevention.
6. Foster healthy communities.
7. Eliminate health disparities.
8. Improve health outcomes



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The QI Program consists of the following elements:

A. QIHET Program Description including descriptions of key functional areas: The Population Health, Behavioral Health, Care Management, Utilization Management, and Pharmacy Programs.
B. Annual QIHET Program Evaluation.
C. Annual QIHET Program Work Plan.
D. Quality Improvement and Health Equity Activities.
E. QIHETP Committee Structure.
F. Policies and Procedures.

The QIHET Program will ensure that all medically necessary covered services are available in a culturally and linguistically appropriate manner and are accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups identified in Penal Code 422.56. The annual Population Needs Assessment (PNA) will serve to identify and evaluate member health needs and health disparities and implement targeted interventions.

The scope of the QI process encompasses the following:

1. Quality and safety of clinical care services including, but not limited to:
   - Preventive services for children and adults
   - Primary Care
   - Specialty care, including behavioral health services
   - Emergency services
   - Inpatient services
   - Ancillary services
   - Chronic disease management
   - Care Management
   - Population Health
   - Prenatal / perinatal care
   - Family planning services
   - Medication management
   - Coordination and Continuity of Care

2. Quality of nonclinical services including, but not limited to:
   - Accessibility
   - Availability
   - Member and Provider Satisfaction
   - Grievance and Appeal Process
   - Cultural and Linguistic Services
   - Network Adequacy
   - Health Equity

3. Patient safety initiatives including, but not limited to:
   - Facility site reviews / Medical record review / Physical Accessibility Review Surveys
   - Credentialing of practitioners / organizational providers
   - Peer review
   - Sentinel event monitoring
   - Potential Quality Issues (PQIs)
   - Provider Preventable Condition (PPC) monitoring
   - Health education
   - Utilization and risk management

4. A QI focus which represents:
   - All care settings
   - All types of services
   - All demographic groups

IV. AUTHORITY AND RESPONSIBILITY

The Ventura County Medi-Cal Managed Care Commission (VCMMCC), dba Gold Coast Health Plan (GCHP), will promote, support, and have ultimate accountability, authority, and responsibility for a comprehensive and integrated Quality Improvement and Health Equity Transformation (QIHET) Program. The VCMMCC, an independent oversight entity and governing body, is ultimately accountable for the quality and equity of care and services provided to members, but has delegated supervision, coordination, and operation of the program to the GCHP Chief Executive Officer (CEO) and Quality Improvement Department under the supervision of the Chief Medical Officer (CMO) and its Quality Improvement Committee (QIC). The CMO is responsible for the day-to-day oversight of the QIHET Program. The CMO, through the QIC, will guide and oversee all activities in place to continuously monitor health plan quality and equity initiatives.

The VCMMCC's role will be to approve the overall QIHET Program and QIHET Work Plan annually and will receive regular verbal and written updates to the QIHET Work Plan for review and comment / direction. Updates provided to the VCMMCC regarding the QIHET Program and Work Plan will include reviews of objectives and improvements made. The VCMMCC will receive operational information through regular reports from the CMO in conjunction with the operations of its various committees as described below.

To address the scope of the GCHP's QIHET Program goals and objectives, the structure consists of the Quality Improvement Committee (QIC) supported by six subcommittees that meet at least quarterly:

1. Medical Advisory Committee (MAC)
2. Utilization Management Committee (UMC)
3. Health Education and Cultural Linguistics Committee (HE/CL)
4. Credentials / Peer Review Committee (C/PRC)
5. Member Services Committee (MSC)
6. Grievance and Appeals Committee (G&A)

To further support community involvement and achieve the Plan's QI goals and objectives, the VCMMCC organized two committees, in addition to the QIC reporting directly to them. These include:

1. Provider Advisory Committee
2. Community Advisory Committee

Ventura County Medi-Cal Managed Care Commission (VCMMCC) Membership

GCHP is governed by the 11 member VCMMCC.Commission members are appointed for two- or four-year terms, and member terms are staggered. The VCMMCC is comprised of locally elected officials, providers, hospitals, clinics, the Ventura County Healthcare Agency, and consumer advocates.

Members of the VCMMCC are appointed by a majority vote of the Board of Supervisors.

V. QIHET PROGRAM GOALS AND OBJECTIVES

The overall goal of the Quality Improvement and Health Equity Transformation (QIHET) Program is to improve the quality, equity, and safety of clinical care and services provided to members through Gold Coast Health Plan's (GCHP) network of providers and its programs and services. Specific goals are established to support the purpose of the QIHET Program. All goals are reviewed annually and revised as needed. The Quality Improvement (QI) Program goals are primarily identified through:

- Ongoing activities to monitor care and service delivery.
- Issues identified by tracking and trending data over time.
- Issues / outcomes identified in the previous year's QIHET Program Evaluation.
- Monitoring of performance measures, e.g., Managed Care Accountability Set (MCAS).
- Accreditation standards, regulatory, and contractual requirements.

The QIHET Program goals include:

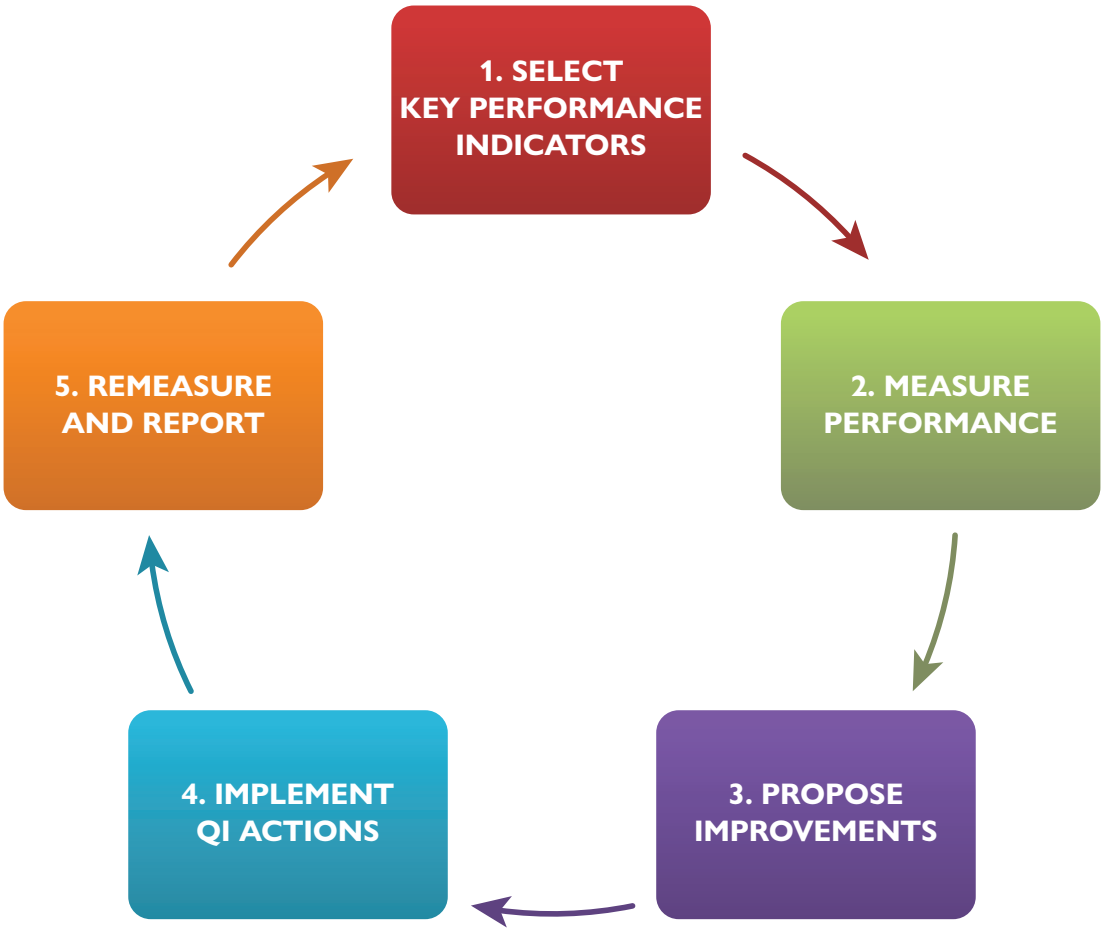
- Develop and maintain QIHET resources, structure, and processes that support the organization's commitment to equitable and quality health care for our members.
- Coordinate, monitor and report QIHET activities.
- Develop effective methods for measuring and reporting the outcomes of care and services provided to members.
- Identify opportunities and make improvements based on measurement, validation, and interpretation of data.
- Continuously improve the quality, appropriateness, availability, accessibility, coordination, and continuity of both physical and mental / behavioral health care services to members across the continuum of care.
- Provide culturally and linguistically appropriate services.
- Measure and enhance member satisfaction with the quality of care and services provided by our network providers.
- Maintain compliance with state and federal regulatory requirements.
- Ensure effective credentialing and re-credentialing processes for practitioners / providers that comply with state, federal and accreditation requirements.
- Ensure network adequacy and member access to primary and specialty care.
- Provide oversight of delegated entities to ensure compliance with GCHP standards as well as state and federal regulatory requirements.

The Program Objectives include the following:

- To integrate the QIHET Program with other key operational functions of GCHP.
- To conduct an annual evaluation of the QIHET Program.
- To establish and conduct an annual review of quality, equity, and performance improvement projects (PIPs) related to significant aspects of clinical and non-clinical services.
- To identify opportunities for improvement through analysis of utilization patterns and through information collected from quality and performance metrics including the DHCS Managed Care Accountability Set (MCAS), the National Committee of Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), the Centers for Medicare and Medicaid (CMS) Core Measures for Medicaid, as well as other measure stewards.
- To encourage feedback from members and providers regarding delivery of care and services and to use the feedback to evaluate and improve the manner by which care and services are delivered.

VI. QI PROGRAM METHODOLOGY

Gold Coast Health Plan (GCHP) utilizes the Plan-Do-Study-Act (PDSA) Cycle methodology, which is an improvement process tool used by the Institute for Health Care Improvement's (IHI) Model for Improvement and adopted by the state Department of Health Care Services (DHCS) as the standardized process for testing the effectiveness of interventions aimed at improving the quality of care and services. PDSA cycles focus on identifying and measuring improvement opportunities by utilizing small-scale studies to test the effectiveness of interventions that can be modified or expanded to achieve continuous improvement.



The Quality Improvement and Health Equity Transformation (QIHET) Program is based on the latest available research in the area of quality improvement and health equity. At a minimum, it includes a method of monitoring, analysis, evaluation, and improvement in delivering high-quality, equitable care and service. The QIHET Program involves tracking and trending of quality indicators to ensure measures are reported, outcomes are analyzed, and goals are achieved. Contractual standards, evidence-based practice guidelines, and other nationally recognized sources (CAHPS®, HEDIS®, CMS Core Set for Medicaid) may be utilized to identify performance / metric indicators, standards, and benchmarks. Indicators are objective, measurable, and based on current knowledge and clinical experience (as applicable).

The indicators may reflect the following parameters of quality:

- Structure, process, or outcome of care.
- Administrative and care systems within healthcare services to include:
  - Acute and chronic condition management including care management and population health activities.
  - Utilization and risk management.
  - Credentialing.
  - Member experience / satisfaction.
  - Care and provider experience.
  - Member grievances and appeals.
  - Practitioner accessibility and availability.
  - Plan accessibility.
  - Member safety.
  - Preventive care.
  - Behavioral / mental health.
  - Health disparities and inequities.
  - Social determinants of health.

MCAS / HEDIS® / CMS Core Set for Medicaid measures and CAHPS® amongst other quality metric results are integrated in the QIHET Program and may be adopted as performance indicators for clinical improvement. The CAHPS® survey is utilized as one of the tools for assessing member satisfaction.

Quality initiatives and performance improvement interventions are developed and implemented as indicated by data analysis and/or medical record reviews. Initiatives are reassessed on a quarterly and/or annual basis to evaluate intervention effectiveness and compare performance.

VII. HEALTH EQUITY, INCLUSION, DIVERSITY, and NON-DISCRIMINATION

Health Equity

Gold Coast Health Plan (GCHP) is committed to equity, inclusion, and diversity to maintain high-quality and affordable health care. Therefore, GCHP's Quality Improvement and Health Equity Transformation (QIHET) Program will continue to focus on improving health equity in order to develop programs and interventions using the foundational architecture of health equity and quality improvement theory which drive system transformation and innovation. GCHP's 2023 QIHET Program includes a focus on whole-person care through partnerships with members, providers, community-based organizations, schools, public health agencies, outside counties, and other health care systems. Specifically, focusing on improving access to services and developing community support strategies for at-risk populations and those populations experiencing health disparities with an emphasis on children's preventive care, maternal health outcomes, and behavioral health.

Inclusion, Diversity, and Non-Discrimination

GCHP assigns members to primary care providers (PCPs) and follows state and federal civil right laws. GCHP does not unlawfully discriminate, exclude members or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. All contracted providers are expected to render services to members they have accepted assignment for or have agreed to accept referrals and shall comply with the state and federal civil rights laws. Providers shall not refuse services to any member based on the criteria above. GCHP follows up on all grievances alleging discrimination and takes appropriate action.

To ensure that members have equitable access to covered services delivered in a manner that meet their needs, GCHP conducts the following activities:

- Review of member complaints and grievances.
- Provision of language assistance services to assist providers to provide culturally and linguistically appropriate medical care to Limited English Proficient members.
- Conducting a Population Needs Assessment as defined by DHCS.
- Provision of Cultural Competency Training for both providers and GCHP staff.
- Conducting surveys of members to determine if culture and language needs are met by providers.
- Provision of a Seniors and Persons with Disabilities (SPD) Cultural Sensitivity Training for providers and staff.
- Assessment of provider linguistic capabilities.
- Assessment of GCHP staff language capabilities.
- Conduct readability and suitability of member informing materials set by DHCS regulations.

VIII. PROGRAM ORGANIZATION, OVERSIGHT, RESOURCES, AND EVALUATION

Chief Medical Officer

The Chief Executive Officer (CEO) has appointed the Chief Medical Officer (CMO) as the designated physician to support the Quality Improvement and Health Equity Transformation (QIHET) Program by providing day to day oversight and management of quality improvement activities and has overall responsibility for the clinical direction of GCHP's QIHET Program. Further description of the QIHET Program's multidisciplinary resources and responsibilities are included in Attachment 1. 2023 QIHETP Resources.

QIHET Program Evaluation

A written evaluation of the QIHET Program is completed annually. This annual report includes a comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement and health equity program, including but not limited to the results of performance measures, health equity, outcomes / findings from Performance Improvement Projects (PIPs), consumer and provider satisfaction surveys, and the quality review of services rendered. The analysis includes a review and revision of the QIHET Program Description, evaluation of the prior year's QIHET Work Plan, and the development of the current year's QIHET Work Plan to ensure ongoing performance improvement.

The evaluation is reviewed and approved by the QIC and VCMMCC and includes the following:

- A description of completed and ongoing QIHETP activities that address quality and safety of both physical and mental / behavioral health care provided to GCHP members, including trended measures and an analysis of barriers to success.
- A description of completed and ongoing QIHETP activities that address service quality and the experience of care for GCHP members, including trended measures and an analysis of barriers to success.
- Analysis and evaluation of the overall effectiveness of the QIHET Program (QI committee structure, QI program resources, practitioner participation and leadership involvement), including progress toward influencing network-wide clinical practices, population health needs, health disparities, and addressing the cultural and linguistic needs of GCHP members.
- Recommendation for restructure or changes to the QI Program for the subsequent year to improve effectiveness.

IX. ANNUAL WORK PLAN

The annual Quality Improvement and Health Equity Transformation (QIHET) Work Plan serves as the roadmap for the QIHET Program and outlines measurable, organizational, and multidisciplinary objectives, activities and interventions focused on improving key performance indicators (KPI). The goal is to identify the GCHP's approach to improving and sustaining performance through the prioritization, design, implementation, monitoring, and analysis of performance improvement and health equity initiatives.

The QIHET Work Plan is developed largely from recommendations from the annual QIHET Program Evaluation. Areas of significant focus include partially resolved and unresolved activities from the previous year, and newly identified focus areas for the coming year. The focus areas include clinical and non-clinical care and service improvement activities that have the greatest potential impact on the quality of care and services, and patient safety. The QIHET Work Plan also reflects the contractual requirements of GCHP.

At a minimum, the QIHET Work Plan includes a clear description of the monitoring and improvement activities and objectives, the specific timeframe and responsible parties for conducting the activities, and monitoring of previously identified issues. Activities and outcomes are compared to predetermined goals / benchmarks and/or target improvement metrics.

Additional improvement activities identified during the year or other changes made to the QIHET Work Plan are presented to the QIC and VCMMCC for approval on an ongoing basis. The QIC oversees the prioritization and implementation of clinical and non-clinical QIHET Work Plan initiatives. The QIHET Work Plan is assessed and updated at a minimum, semi-annually, and is included as part of the Annual QIHET Program Evaluation.

GCHP views the QIHET Work Plan as a living document that reflects ongoing progress on QIHET activities and a tool to focus improvement efforts throughout the year and evaluate progress against the objectives. This continuous quality improvement effort will help GCHP achieve its mission to improve the health and well-being of the people of Ventura County by providing access to high quality and equitable medical services.

Quality Improvement activities that measure and monitor access to care include the following:

- Access and Availability Studies
- Initial Health Assessment monitoring
- GeoAccess Studies
- Network Adequacy

Quality Improvement activities that measure and monitor provider and member satisfaction include the following:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Member Grievance Reviews
- Provider Satisfaction Surveys
- Focus Groups

Quality Improvement activities that evaluate preventive care, behavioral healthcare, care of chronic conditions, as well as coordination, collaboration and patient safety include the following:

- MCAS / HEDIS® / CMS Core Set for Medicaid including race / ethnicity stratification of specific measures
- Coordination of Care Studies
- Facility Site Reviews
- Potential Quality Issue Investigation

Quality Improvement activities that evaluate GCHP's ability to serve a culturally and linguistically diverse membership may include but is not limited to the following:

- Annual provider language study
- Annual cultural and linguistic study
- Ongoing monitoring of interpreter service and use
- Ongoing monitoring of grievances
- Focus groups to determine how to meet needs of diverse members
- Population Needs Assessment

Quality Improvement activities that evaluate GCHP's quality of care include the following:

- Credentialing and Recredentialing activities
- Peer Review Activities
- Delegation Oversight

Communication and Feedback

Ongoing education and communication regarding quality improvement and health equity initiatives is accomplished internally and externally through committees, staff meetings, mailings, website content and announcements. Providers are educated regarding quality improvement and health equity initiatives via on-site quality visits, quality improvement focused trainings and webinars, provider update memos / e-blasts, Provider Operations Bulletin (POB) articles, and the GCHP website. Reporting of specific MCAS / HEDIS® / CMS Core Set for Medicaid measure performance is communicated to providers via an annual report card and monthly progress reports of current and projected rates including care gap reports of members who need specific clinical services. This reporting is also provided to GCHP's Population Health and Behavioral Health Teams for internal development of program initiatives.

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X. PROGRAM RESOURCES DEDICATED TO QUALITY IMPROVEMENT AND HEALTH EQUITY

Quality Improvement and Health Equity Transformation (QIHET) Program Resources - Multidisciplinary Staff

Resources for the Quality Improvement and Health Equity Transformation (QIHET) Program come from various department staff in addition to the leadership roles described in the Program Oversight section of this document.

Support for improvement initiatives related to population health, behavioral health, care management, utilization / risk management, and other clinical process improvement and outcome measures are provided by Health Services Department, Population Health Department, Information Technology Department, and Quality Improvement (QI) Department staff.

Quality initiatives related to service including member satisfaction and those related to complaints and appeals are supported by Member Services Department and Grievance and Appeals Department staff.

Quality initiatives related to provider network and provider communication is supported by Provider Network Operations Department staff.

Credentialing and peer review functions are supported by QI Department staff.

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The QI Department staff assists the Senior QI Director in assessing data for improvement opportunities. They work with other departments to assist in planning and implementing activities that will improve care or service.

Responsibilities of multidisciplinary staff include but are not limited to the following:

- Assist in creating the annual QIHET Program Description.
- Assist in coordination of MCAS / HEDIS® / CMS Core Set for Medicaid data collection, reporting and analysis of results.
- Work with other departments to gather information for the annual QIHETP Evaluation.
- Collaborate in developing activities for the annual QIHETP Work Plan.
- Identify areas for improvement and assist in implementing quality improvement and health equity initiatives.
- Assist the Senior QI Director in achieving the goals of the QIHET Program.

Further description of the QIHET Program's multidisciplinary resources and responsibilities are included in Attachment 1. 2023 QIHETP Resources.

QIHET Program Resources - Program and Tools

GCHP has dedicated resources to the acquisition of programs and tools that promote high quality and equitable services for our members. These include, but are not limited to:

- Online Member Administration Support: provider directories, health plan benefit summaries, drug formularies and claim forms,
- Online Provider Resources: eligibility and benefit look-up, claims submittal, formulary information, forms,
- Online Member Education and Engagement Resources: members are offered access to comprehensive clinical information in the Health Library on the GCHP website,
- Online Data for performance metrics: providers have access to Inovalon's INDICES® dashboards that offer visualization and customization capabilities that enable measurement of performance against benchmarks and identification of gaps in care.

QIHET Program Resources - Sources of Data

GCHP utilizes tools and resources that provide standards, benchmarks, guidelines, best practices, and measurement and evaluation methodologies to assist in guiding our improvement strategies. These resources include:

- *National initiatives and measurement sets* such as Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Healthcare Effectiveness Data and Information Set (HEDIS®), Centers for Medicare and Medicaid (CMS) Core Set for Medicaid, Quality Compass
- *Government issued laws, regulations and guidance* including those from DHCS, CMS, the U.S. Preventive Services Taskforce (USPSTF), and National Institutes of Health (NIH)

- *Healthcare Quality Improvement Organizations* such as the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), and the Agency for Healthcare Research and Quality (AHRQ), Health Services Advisory Group (HSAG)
- *The Guide to Community Preventive Services (The Community Guide)*; a collection of evidence-based findings of the Community Preventive Services Task Force established by the U.S. Department of Health and Human Services (DHHS)

QIHET Program Resources – Data, Information and Analytics Support

GCHP's QIHET Program monitors and evaluates performance and information from many different sources throughout the organization including, but not limited to:

- Enrollment and demographic data, including race, ethnicity, and language preference data is collected to monitor health care quality and for identifying and reducing health disparities among our patient population.
- Claims data (utilization by diagnosis / procedure, provider, treatment/medications, site of care, etc.) to ensure members are receiving appropriate care and to mitigate gaps through sharing of this data with other organization business units (e.g., Population Health and Behavioral Health).
- Population health / Care management reports to assess support of members with complex or chronic medical and behavioral health conditions, and to evaluate coordination of care across the continuum.
- Grievance and appeal data, including type of grievances, trends, and root cause analysis.
- Ongoing tracking and trending of quality of care and serious reportable event (SRE) data to identify patient safety issues and assess provider qualifications.
- Member and provider survey data to assess satisfaction with services and operations.
- Credentialing process data to measure timeliness of application processing and quality of network providers.
- Network adequacy / accessibility measurement data to assess provider availability and accessibility
- MCAS / HEDIS® / CMS Core Set for Medicaid data to assess the effectiveness of clinical care and services

QIHET Program Resources - HEDIS® Certified Software

GCHP's QIHET Program utilizes the HEDIS® Certified Software vendor, Inovalon, to calculate all Managed Care Accountability Set (MCAS) and HEDIS® quality measure rates to ensure accurate calculations. The Inovalon HEDIS® engine is used to calculate monthly prospective rates as well as the rates for the annual MCAS / HEDIS® audit. The data used to calculate measure rates is produced monthly by GCHP's IT Population Health Enablement Department's Sr. IT Business Analyst. The engine ingests the following data sources to calculate measure rates:

- Enrollment and demographic data, including race, ethnicity, and language preference data
- Claims data
- Encounter data
- Laboratory data
- Immunization registry data

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- Health Information Exchange data
- Medical Record data
- DHCS Supplemental data
- Medi-Cal Rx pharmacy data

The calculated measure rates are used to monitor quality metric performance and identify opportunities for quality improvement intervention focus areas.

XI. QUALITY COMMITTEES AND SUBCOMMITTEES

Gold Coast Health Plan's (GCHP) Quality Committees and Subcommittee Structure consists of six subcommittees each reporting up to the Quality Improvement Committee (QIC). The QIC then reports directly to the Ventura County Medi-Cal Managed Care Commission (VCMMCC) as the overseeing body for quality within GCHP. In addition to the QIC, the VCMCC oversees the Provider Advisory Committee (PAC) and Committee Advisory Committee (CAC). The PAC and CAC both function to support quality improvement and health equity activities by encouraging community participation in QI activities, however each reports directly to the VCMMCC.

Committee minutes are recorded at each meeting and reflect key discussion points, recommended policy decisions, analysis and evaluation of Quality Improvement and Health Equity Transformation (QIHET) activities, needed actions, planned activities, responsible person, and follow up. Minutes record the practitioner and health plan staff attendance and participation. Minutes will be produced within a reasonable timeframe, at a minimum, within one month or by the date of the next meeting. Minutes are reviewed and approved by the originating committee and are signed and dated within the same reasonable timeframe. Committee meeting minutes shall be submitted to DHCS quarterly, or as requested.

The responsibilities, scope, membership, and objectives of the QIC, as well as the subcommittees reporting to the QIC, are as follows:

Quality Improvement Committee (QIC)

The QIC is the principal organizational unit that has been delegated authority to monitor, evaluate and report to the VCMMCC by the VCMMCC on all component elements of the GCHP QIHET Program. The QIC shall have a minimum of eight voting members and be chaired by the GCHP Chief Medical Officer (CMO) and facilitated by the Senior QI Director. Membership will consist of the chairs of the six QI Subcommittees and at least one Commissioner and at least one practicing physician in the community. The QIC shall meet at least quarterly. Ad hoc committees, however, will meet on an as needed basis. The QIC will critically examine and make recommendations on all quality and equity functions of GCHP described in this program and by state and federal regulatory authorities as appropriate.

It is the responsibility of the QIC and its subcommittees to assure that QIHET activities encompass the entire range of services provided and include all demographic groups, care settings, and types of service. The committee reviews recommendations from the GCHP quality subcommittees and makes recommendations on their implementation. The Ventura County Medi-Cal Managed Care Commission (VCMMCC) is updated quarterly or as frequently to demonstrate follow-up on all findings and required action by the Chair of the QIC or designee via a report which may include QIC minutes, information packet, performance dashboards, or other communication mechanism. All of the GCHP's committees / subcommittees are required to maintain confidentiality and avoid conflict of interest.

An annual QIHET Report is submitted to the VCMMCC addressing:

A. Quality improvement and health equity activities, such as:
   i. Utilization Reports
   ii. Review of the quality of services rendered
   iii. MCAS / HEDIS® / CMS Core Set for Medicaid results
   iv. Quality Improvement Projects and initiatives (status and/or results)
   v. Health Equity Projects and initiatives (status and/or results)
   vi. Satisfaction Survey Results
   vii. Collaborative initiatives both internally and externally (status and/or results)
B. Success in improving patient care and outcomes, health equity, and provider performance.
C. Opportunities for improvement.
D. Overall effectiveness of quality monitoring and review activities or specific areas that require remedial action as indicated in the annual report issued by the state's EQRO.
E. Effectiveness in performing quality management functions and achieving goals and objectives through quality monitoring programs will be measured and reported.
F. Presentation of the QIHET Work Plan including recommendations for revision identified as a result of the review.

QIC Objectives:

- Ensure communication processes are in place to adequately track work plan and QIHET activities and enable horizontal and lateral communication as well as closing the loop when issues are resolved.

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- Ensure QIC members can have a candid discussion about barriers to achieving quality goals and objectives, and to facilitate the removal of such barriers.

QIC Responsibilities:

- Oversees the annual review, analysis, and evaluation of goals set forth by the QIHET Program as well as GCHP's QI policies and procedures.
- Makes recommendations for implementation of interventions or corrective actions based on results of quality improvement and health equity activities.
- Facilitates data-driven indicator reviews and development for monitoring key quality management activities, including but not limited to: MCAS / HEDIS®, Access / Availability, Performance Improvement Projects, Service / Clinical Quality measures, UM/CM metrics, Population Health metrics, Behavioral Health metrics, Credentialing performance, and Delegation Oversight.
- Reviews reports from GCHP committees and departments, including quarterly dashboards, key activities and action plans including subcommittee updates, and reports regarding monitoring of health plan functions and activities.

QIC Membership:

- Chief Medical Officer (Chair)
- Medical Director – currently vacant
- Senior Director of Quality Improvement
- Senior Director of Health Education and Cultural Linguistics
- Senior Director of Network Operations
- Clinical Programs Pharmacist
- Chief Compliance Officer
- Senior Director of Compliance
- Senior Director of Care Management
- Senior Director of Utilization Management
- Director, Behavioral Health & Social Programs
- Chief Executive Officer
- Executive Director of Population Health & Equity
- Executive Director of Operations
- Senior Manager of Operations
- Manager, Member Services
- External Practitioner Representatives
- Commissioner
- Carelon (formerly Beacon Health Options) Regional Chief Medical Officer Behavioral Health

QIC Reporting Structure:

The QIC reports to the VCMMCC. The Chair of the QIC ensures that quarterly reports are submitted to the VCMMCC.

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Meeting Frequency:

The QIC meets at a minimum quarterly.

Medical Advisory Committee (MAC)

The purpose of the MAC is to provide feedback and advice to the health plan on any aspect of health plan policy or operations affecting network providers or members. Through MAC, GCHP seeks input/guidance to foster discussion of matters including, but not limited to the following:

- The delivery of medical care to GCHP's membership.
- Issues of concern to the physician community.
- Quality of care concerns.
- GCHP clinical programs to ensure optimal effectiveness for members and providers.
- Local medical care practices that may affect health plan operations.

Scope:

The committee scope may include, but is not limited to, the following data / activities / processes:

- Clinical Practice and Preventive Healthcare Guidelines (CPGs / PHGs)
- Provider Grievance Process
- Provider Satisfaction
- Provider Access / Availability Standards
- Provider Contracting
- Provider Materials / Communications
- Clinical Programs and Service Delivery
- Utilization Management
- Pharmacy
- Quality Improvement (including clinical studies, MCAS / HEDIS® / CMS Core Set Medicaid / CAHPS® survey outcomes)

Feedback from the MAC is relayed to the QIC as well as other QI committees and/or departments where data may be relevant to process improvements. Practitioner feedback may be utilized in a variety of ways, including but not limited to: providing subject matter expertise, help improve outcomes, assess / revise policies and procedures, and/or modify program offerings.

Membership:

Membership is comprised of six to 10 fully credentialed and actively participating physicians representing the contracted provider community for GCHP's programs. The Chief Medical Officer (CMO) will serve as Chair and will ensure that the membership has adequate specialty representation. Efforts are made to rotate membership every two years; however, in order to ensure continuity of committee activity, membership may be extended.

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Meeting Frequency:

The committee meets at a minimum on a quarterly basis.

Member Services Committee (MSC)

The MSC oversees those processes that assist members in navigating GCHP's system. This committee provides oversight of service indicators, analyzes results, and suggests the implementation of actions to correct or improve service levels. Through monitoring of appropriate indicators, the MSC will identify areas of opportunity to improve processes and implement interventions.

MSC Objectives:

- Ensure GCHP members understand their health care system and know how to obtain care and services when they need them.
- Ensure GCHP members will have their concerns resolved quickly and effectively and have the right to voice complaints or concerns without fear of discrimination.
- Ensure GCHP members can trust that the confidentiality of their information will be respected and maintained.
- Have access to appropriate language interpreter services at no charge when receiving medical care.
- Ensure GCHP members can reach the Member Services Department quickly and be confident in the information they receive.
- Utilize the CAHPS® survey to identify service indicators for improvement.
- Ensure GCHP's Member Rights and Responsibilities are distributed and available to members and providers.
- Ensure that GCHP's member materials are developed in a culturally appropriate format.
- Interface with other GCHP committees to improve service delivery to members.

MSC Membership:

- Manager of Member Services (Chair)
- Executive Director of Operations
- Senior Director of Network Operations or designee
- Executive Director of Strategy and External Affairs
- Senior Manager of Operations (Grievance and Appeals) or designee
- Senior Director of Quality Improvement or designee
- Senior Director of Care Management or designee
- Chief Medical Officer
- Senior Director of Health Education and Cultural Linguistics or designee
- Director of Communications
- Senior Director of Compliance or designee

Meeting Frequency:

The MSC meets quarterly at a minimum.

Grievance and Appeals Committee (G&A)

The Grievance and Appeal (G&A) Committee monitors expressions of dissatisfaction from members and providers. Information gathered is used to improve the delivery of service and care to Gold Coast Health Plan (GCHP) members.

G&A Committee Objectives:

- Review and respond to all member and provider grievances timely.
- Review issues for patterns which may require process changes.
- Review all grievances and appeals that may affect the quality of care delivered to members.
- Ensure all GCHP departments are educated on the appropriate process for communicating member and provider grievances and/or appeals to the correct area for resolution.
- Ensure that issues needing intervention are reviewed and routed to the appropriate area for discussion and intervention.

G&A Committee Membership:

- Senior Manager of Operations (Chair)
- Senior Grievance and Appeals Specialist
- Chief Medical Officer or designee
- Executive Director of Operations
- Senior Director of Network Operations or designee
- Manager of Member Services or designee
- Senior Director of Quality Improvement or designee
- Senior Director of Care Management
- Senior Director of Utilization Management
- Senior Director of Compliance or designee
- Senior Director of Health Education and Cultural Linguistics or designee
- Clinical Programs Pharmacist or designee

Meeting Frequency:

The committee meets quarterly.

Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) oversees the implementation of the UM Program and promotes the optimal utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Committee is multi-disciplinary and monitors continuity and coordination of care as well as under- and over-utilization. The committee is

charged with reviewing and approving clinical policies, clinical initiatives, and programs before implementation. It is responsible for annually providing input on GCHP's clinical strategies, such as clinical guidelines, utilization management criteria, population health / care management protocols, and the implementation of new medical technologies. The UMC is a subcommittee of the QIC, and reports to the QIC quarterly.

UMC Responsibilities:

Responsibilities include but are not limited to the following:

- Annual review and approval of the UM and Population Health / Care Management Program documents.
- Review and approval of program documents addressing the needs of special populations. This includes, but may not be limited to, Children with Special Health Care Needs (CSHCN) and Seniors and Persons with Disabilities (SPD).
- Suggest and collaborate with other departments to address areas of patient safety. This may include, but is not limited to, medication safety and child safety.
- Annual adoption of preventive health criteria and medical care guidelines with guidance on how to disseminate criteria and ensure proper education of appropriate staff.
- Review of the timeliness, accuracy, and consistency of the application of medical policy as it is applied to medical necessity reviews.
- Review utilization and case management monitors to identify opportunities for improvement.
- Review data from Member Satisfaction Surveys to identify areas for improvement.
- Ensure policies are in place to review, approve and disseminate UM criteria and medical policies used in review when requested.
- Review, at least annually, the Interrater Reliability (IRR) test results of UM staff involved in decision making (RN's and MD's) and take appropriate actions for staff that fall below acceptable performance.
- Interface with other GCHP committees for trends, patterns, corrective actions, and outcomes of reviews.

Membership:

- Chief Medical Officer (Chair)
- Medical Director – currently vacant
- Senior Director of Care Management
- Senior Director of Utilization Management
- Managers of Care Management
- Managers of Utilization Management
- Clinical Programs Pharmacist
- Physician Reviewers
- Compliance Designee
- Senior Director of Quality Improvement
- Carelon (formerly Beacon Health Options) Regional Chief Medical Officer Behavioral Health

Meeting Frequency:

The UMC meets quarterly at a minimum.

Health Education, Cultural and Linguistics (HE/CL) Committee

The purpose of the HE/CL Committee is to assess the health education, cultural and language needs of the Plan's population. The HE/CL Committee will be responsible to ensure materials of all types are available in languages other than English to appropriately accommodate members with Limited English Proficiency (LEP) skills. The HE/CL Committee will review data to assist GCHP staff and providers to better understand unique characteristics of the varied population. The HE/CL Committee will assist in developing cultural competency and sensitivity training and ensure that those that serve GCHP's population are appropriately trained.

HE/CL Committee Responsibilities:

- Ensure members have access to appropriate health education materials.
- Ensure providers have access to health education services and materials, including alternative formats.
- Ensure providers and GCHP staff deliver culturally and linguistically (C&L) appropriate health care services to GCHP's diverse membership.
- Ensure Providers and staff receive training on cultural competency, language assistance, Seniors and Persons with Disabilities (SPD) and/or diversity training.
- Ensure that all members, regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, or language capabilities have equitable access to quality health care.
- Ensure that GCHP implements cultural and linguistic requirements set forth by the state Department of Health Care Services (DHCS).
- Ensure the Population Needs Assessment (PNA) is completed to determine a baseline for serving education and cultural / language needs as well as to develop interventions to address identified unmet population needs.
- Collaborate and work with GCHP's Health Services Department, Quality Improvement Department, Provider Network Operations Department, and other departments to ensure health education and cultural and linguistic services needs are addressed.
- Ensure opportunities are available to educate members on the disease process, preventive care, behavioral health, GCHP processes and all other areas essential to good member health.
- Assist providers in educating GCHP members and promote positive health outcomes.
- Ensure that all written information materials comply with the readability and suitability requirements set forth by the DHCS. The member informing materials shall be at a sixth grade or lower reading level and be consistent with the GCHP's membership needs.
- Educate GCHP staff on specific cultural barriers that might hinder the delivery of optimal health care.

Membership:

- Senior Director of Health Education and Cultural Linguistic Services (Chair)
- Chief Medical Officer or designee
- Executive Director of Population Health & Equity
- Representative from Department of Care Management
- Representative from the Department of Communications
- Representative from the Member Services Department
- Representative from Provider Network Operations
- Representative from the Quality Improvement Department
- Representative from Community Relations
- Representative from Grievance and Appeals Department
- Cultural and Linguistic Specialist
- Senior Health Navigator / Health Navigators

Meeting Frequency:

The committee meets quarterly, at a minimum.

Credentials / Peer Review Committee (C/PRC)

The Credentials / Peer Review Committee provides guidance and peer input into GCHP's credentialing and practitioner peer review process.

The C/PRC fulfills the credentialing and peer review functions as follows:

C/PRC Committee Responsibilities:

The C/PRC reviews and evaluates the qualifications of each practitioner / provider applying to become a contracted Network Practitioner / Organizational Provider or seeking recredentialing as a contracted Network Practitioner/Organizational Provider. The C/PRC has authority to:

- Review and ratify Type I Credentialing and Recredentialing practitioner/provider list. Type I files will be presented to the C/PRC on a list of Type 1 files as one group for approval.
- Receive, review, and act on Type II practitioners / providers applying for Credentialing or Recredentialing.
- Review the quality of care findings resulting from GCHP's credentialing and quality monitoring and improvement activities.
- Act as the final decision maker in regard to the initial and subsequent credentialing of practitioners / providers based on clinical competency and/or professional conduct.
- Review member and provider clinical complaints, grievances, and issues involving clinical quality of care concerns and determine corrective action when necessary.
- Review the credentialing and recredentialing policies and procedures annually.
- Establish, implement, and make recommendations regarding policies and procedures.

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Membership:

The C/PRC is a peer-review body that includes the CMO and participating practitioners who span a range of specialties, including primary care (i.e., family practice, internal medicine, pediatrics, general medicine, geriatrics, etc.) and specialty care. It consists of seven to nine voting members who serve two-year terms which may be renewed (there are no term limits). Members are nominated by the CMO and approved by the VCMMCC.

To assure due process in the performance of peer review investigations, the CMO shall appoint other physician consultants, as necessary, to obtain relevant clinical expertise and representation by an appropriate mix of physician types and specialties.

Meeting Frequency:

The committee meets quarterly.

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XII. QIHET PROGRAM KEY FUNCTIONAL AREAS

Population Health Management

GCHP's Population Health Management (PHM) Program ensures that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, which ultimately leads to longer, healthier, and happier lives, improved outcomes, and health equity. Specifically, the PHM Program:

- Builds trust with and meaningfully engages members.
- Gathers, shares, and assesses timely and accurate data to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes. This data is provided by or through collaboration with the QI Department.
- Addresses upstream drivers of health through integration with public health and social services.
- Supports all members in staying healthy through development of PHM interventions guided by QI identified focus areas. This is accomplished through the provision of gaps reporting and identification of target populations by QI. Gaps reporting and identification of target populations is completed utilizing GCHP's Healthcare Effectiveness Data and Information Set (HEDIS®) certified software engine as well as through QI analyses.
- Provides care management services for members at higher risk of poor outcomes.
- Provides transitional care services (TCS) for members transferring from one setting or level of care to another.
- Reduces health disparities.
- Identifies and mitigates Social Drivers of Health (SDOH).

GCHP is currently in the building phase for its PHM Program and will continue to improve the depth and breadth of services available to our members as we learn more about their needs and characteristics through a data-driven, quality improvement approach.

The PHM Program functions under the direction of the Executive Director of Population Health and Equity with clinical quality improvement guidance provided by the CMO.

For additional information regarding the PHM Program and Strategy, see Attachment 2. GCHP PHM Strategy 2023.

Care Management

The Care Management team uses a population health framework that incorporates an interdisciplinary structure utilizing data from across the healthcare continuum. This structure aligns with GCHP's efforts to achieve positive health outcomes for defined populations in alignment with the DHCS Comprehensive Quality Strategy as well as the goals set forth by the CalAIM initiative.

Care Management accepts referrals from a variety of sources such as:

- Medical and/or behavioral claims/encounters
- Utilization Management
- HIF/MET
- Health Risk Assessments
- Electronic Health Records
- Internal GCHP Staff
- Practitioners
- Advanced data sources which may include, but are not limited to:
  - Health Information Exchanges
  - Homeless Data Integration Systems
  - MCAS / HEDIS® identified gaps

These data sources will be evaluated to develop actionable interventions to meet the care needs of targeted populations. GCHP offers Care Management services which includes Non-Clinical Care Coordination, Clinical Care Coordination / Non-complex Case Management and Complex Case Management. Care Management utilizes person centered planning and collaboration with the member and or the member's representative to address the member's stated health and/or psychosocial needs; this process may or may not include the development of an Individualized Plan of Care (IPC). Interventions are tailored in response to the member's assessed needs or stated goals. Throughout the care management process, the member's needs are reassessed, and adjustments are made as needed to provide the appropriate level of care. The Care Management team documents care coordination through GCHP's care management software, MedHok. The MedHok platform functions to communicate current IPC status, document member communications, and document provider communications, in order to coordinate care both across the organization and with providers as members transition from various settings. It also incorporates data from GCHP's health information exchange to identify members discharged from the hospital for identified diagnoses (e.g., substance use disorder) to ensure they are followed. Additionally the Care Management team utilizes both Indices and MedHok to identify, document, and close gaps for members enrolled in case management programs.

The CM Program functions under the direction of the Chief Medical Officer.

For additional information regarding the Care Management Program, refer to the 2023 Care Management Program Description.

Utilization Management

GCHP's Utilization Management (UM) Program is integrated with the QIHET Program to ensure continuous quality improvement. The UM Program is designed to ensure that medically appropriate services are provided to all GCHP members through a comprehensive framework that assures the provision of high quality, equitable, cost effective, and medically appropriate healthcare services in compliance with the benefit coverage and in accordance with regulatory and accreditation requirements. UM decisions are made by appropriately trained individuals in a fair and consistent manner.

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UM/CM staff will assist providers in making referrals to and in locating necessary carved-out and linked services. The UM Program includes continuous quality improvement process which are coordinated with QI Program activities and supported by the QI Department as appropriate. The UMC and QIC work together to collaborate on and resolve cross-related issues.

The Utilization Management Program functions under the direction of the Chief Medical Officer.

For additional information regarding the UM Program, refer to the 2023 UM Program Description.

Behavioral Health

The Behavioral Health Program ensures that members' behavioral health needs are met through oversight and coordination of the non-specialty mental health benefit, coordination with the County Mental Health Plan for specialty mental health services and substance use disorder treatment and implements incentive programs to advance innovative models of care. Behavioral Health is integrated into the QIHET Program through monitoring of various metrics and development of interventions for measures such as follow-up after an ED visit for mental illness or substance use. Behavioral Health then coordinates closely with Quality Improvement, Care Management, Population Health Management, and Utilization Management to implement interventions focused on behavioral health care.

The Behavioral Health Department functions under the direction of the Executive Director of Population Health and Equity as well as the Director of Behavioral Health and Social Services, a licensed clinical social worker. Clinical quality improvement guidance is also provided by the CMO. Additionally, GCHP leverages it's managed behavioral health organization (MBHO), Carelon (previously Beacon Health Options)'s National Medical Director for Provider Partnerships, a board-certified psychiatrist, within our delegated behavioral health network to provide clinical quality oversight through participating in GCHP's quality committees (UMC and QIC), participation in regular care management meetings, and the provision of clinical feedback to GCHP.

For additional information regarding behavioral health quality, refer to Carelon's 2023 Quality Improvement Program Description.

Pharmacy Services

GCHP's Pharmacy Services Program is responsible for developing and implementing effective retrospective Drug Utilization Review (DUR) processes to assure that drug utilization is appropriate, medically necessary, and not likely to result in adverse events. These programs are aligned with DHCS' requirements for GCHP to provide oversight and administration of the Medi-Cal Rx Pharmacy benefit and related activities.

Scope:

The scope may include, but is not limited to, the following data / activities / processes:

- Utilization Management
- Quality Improvement

- Grievance and Appeals
- Provider Materials / Communications
- Clinical Programs and Services
- Member Services

Pharmacy Services Objectives:

- Conduct DURs to analyze and evaluate the appropriate use of medications, to prevent potential overutilization or underutilization of medication, monitor for medication adherence, prevent adverse effects from medication usage, and identify any utilization patterns that require further education or intervention for enrolled member.s
- Communicate updates and news from DHCS regarding Medi-Cal Rx and other pharmacy related matters / services.
- Review and respond to all member and provider questions in a timely manner.
- Review any issues or concerns related to pharmacy quality, medication usage, medication safety and medication therapy management.
- Review pharmacy claims data to perform quality improvement and to identify opportunities for improvement.
- Identify and monitor for potential fraud or abuse of controlled substances by members, providers and/or pharmacies.
- Conduct educational programs for staff, providers, and/or pharmacies.
- Participate in DHCS Medi-Cal Global DUR Board and other DHCS organized pharmacy committee meetings.
- Participate and collaborate with other departments including, but not limited to, Integrated Care Team (ICT) meetings, Joint Operations meetings (JOMs).
- Review and update policies and procedures at least annually.

The Pharmacy Services Program functions under the direction of the Chief Medical Officer.

XIII. DELEGATION OF QUALITY IMPROVEMENT

Delegation is the formal process by which the health plan gives an external entity the authority to perform certain functions on its behalf. These functions may include quality improvement, health equity, population health, utilization management, credentialing / recredentialing, and grievance and appeals. Gold Coast Health Plan (GCHP) retains accountability for ensuring the function is being performed according to expectations and standards set forth by the state Department of Health Care Services (DHCS) and GCHP.

GCHP will evaluate the delegated entity's capacity to perform the delegated activities prior to delegation. GCHP will only delegate activities to entities who have demonstrated the ability to perform those duties, and who have the mechanisms in place to document the activities and produce associated reports, prior to delegation of that activity. GCHP retains the right to delegate these functions.

Any delegated functions are fully described in a mutually agreed upon signed and written formal delegation agreement between GCHP and each delegated entity and includes an effective date. All agreements clearly define GCHP's and the delegate's specific duties, responsibilities, activities, reporting requirements and identifies how GCHP will monitor and evaluate the delegate's performance. The agreement also includes the GCHP's right to resume the responsibility for conducting the delegated function should the delegated entity fail to meet GCHP standards.

GCHP conducts ongoing oversight, evaluation and monitoring of the delegate. At a minimum, an annual audit is conducted using an audit tool that is based upon current NCQA, DHCS, and GCHP standards and modified on an as-needed basis. In the event any deficiencies are identified through the oversight process, corrective action plans are implemented based upon areas of non-compliance. If the delegate is unable to correct or does not comply with the corrective action plan within the required timeframe, GCHP will take action that may include imposing sanctions, de-delegation of the delegated function or termination of the contract or agreement. Focused audits may be performed to verify deficiencies have been corrected or if a quality issue is identified. Audit results and outcomes of corrective action plans are reported to the QIC.

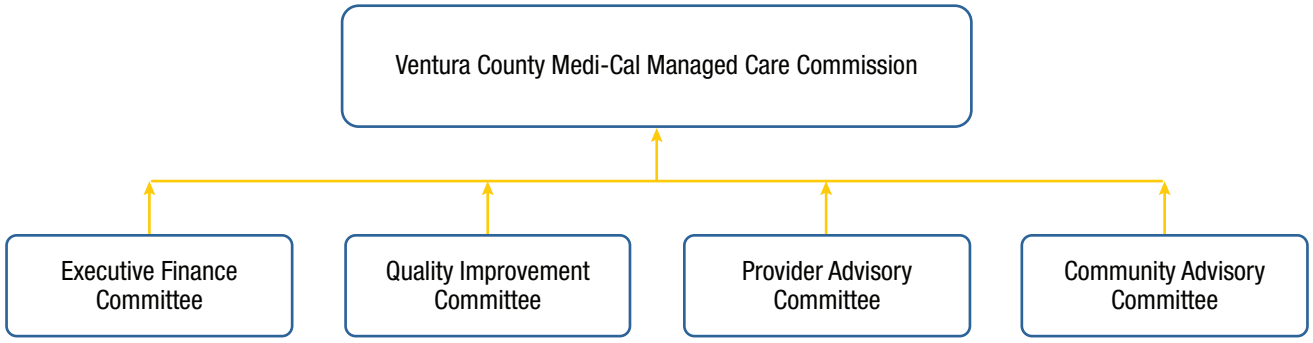
Delegated entities are required to submit at least semi-annual reports to GCHP according to the reporting schedule specified in the delegation agreement. Joint Operation Meetings (JOM) are held on a monthly or quarterly basis as a means of discussing performance measures and findings as needed. JOM includes representation from the delegate and GCHP departments as applicable.

XIV. GOLD COAST HEALTH PLAN QUALITY COMMITTEE ORGANIZATIONAL CHART

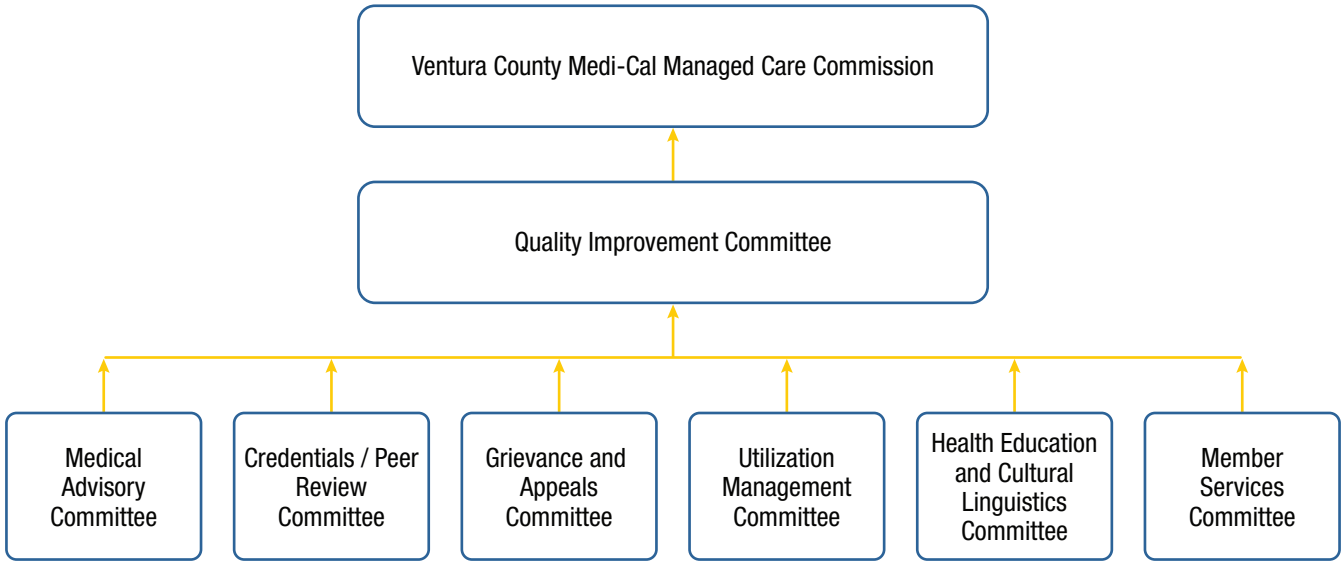
The following organizational chart shows the Gold Coast Health Plan (GCHP) Quality Committees that advise the Ventura County Medi-Cal Managed Care Commission and their reporting relationships:

Quality Improvement and Health Equity Transformation (QIHET) Program

Ventura County Medi-Cal Managed Care Commission Committee Reporting Structure



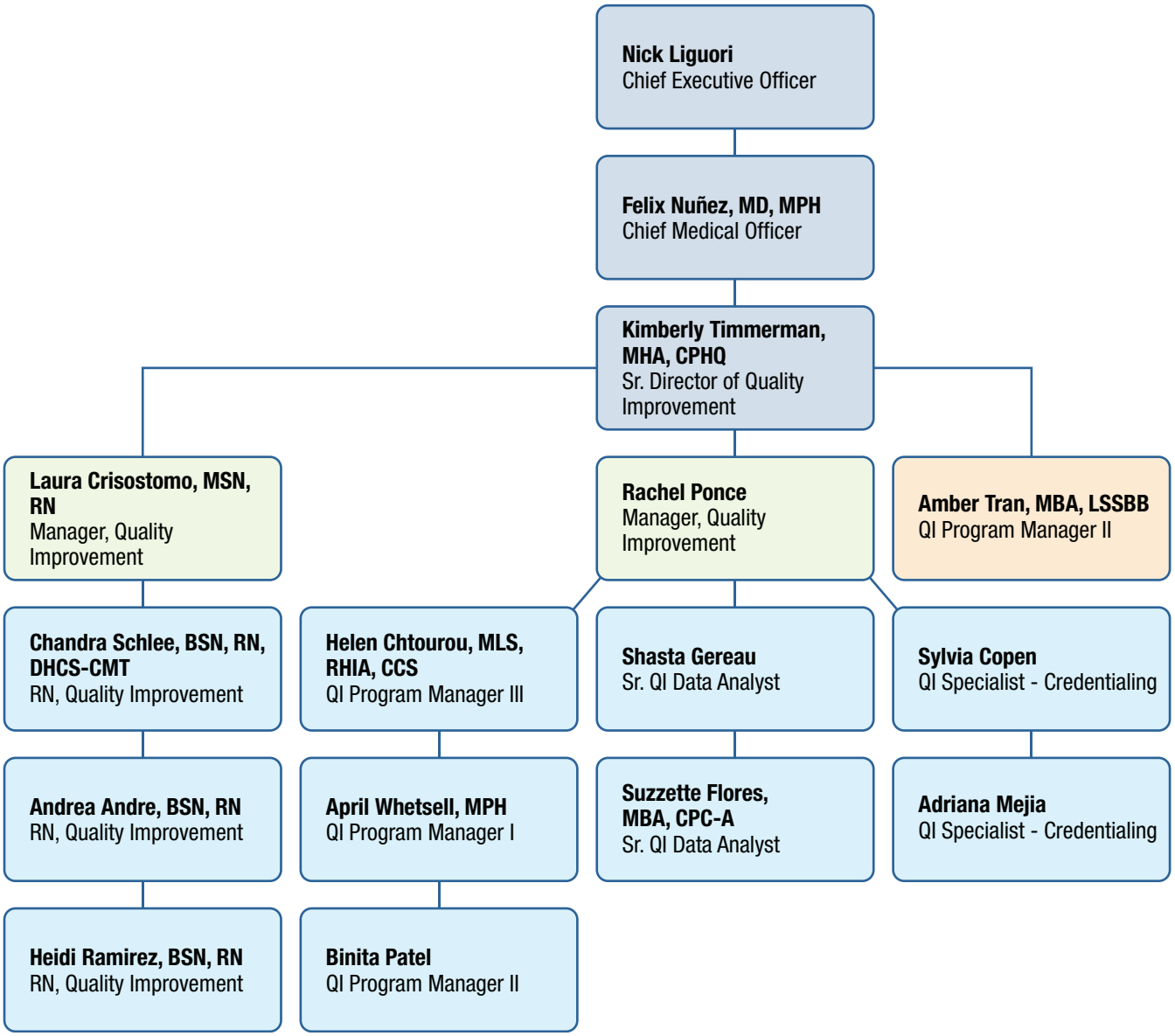
Quality Improvement Committee Reporting Structure



XV. QUALITY IMPROVEMENT DEPARTMENT ORGANIZATIONAL CHART

The following organizational chart shows the GCHP Quality Improvement (QI) Department reporting relationships:

QI Department Organizational Structure



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XVI. QUALITY IMPROVEMENT COMMITTEE MEETINGS FOR CALENDAR YEAR 2023

Dates	
Tuesday	March 21, 2023
Tuesday	June 13, 2023
Tuesday	September 19, 2023
Tuesday	December 5, 2023
Location: Bell Canyon Conference Room or via teleconference or web conference (with audio)	

Availability of QIHET Program to practitioners and members

The QIHET Program is available on GCHP's website at www.goldcoasthealthplan.org. Printed copies are available upon request.

REFERENCES

- Gold Coast Health Plan Quality Improvement Committee Charter
- Gold Coast Health Plan Policy QI-002: Quality and Performance Improvement Requirements
- Gold Coast Health Plan Utilization Management Program Description
- Gold Coast Health Plan Care Management Program Description
- Carelon's 2023 Quality Improvement Program Description
- Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 19-017: Quality and Performance Improvement Requirements
- GCHP DHCS Contract 10-87128 A30, Exhibit A, Attachment 4
- HEDIS® - Healthcare Effectiveness Data and Information Set - a registered trademark of the National Committee for Quality Assurance (NCQA)
- CAHPS® - Consumer Assessment of Healthcare Providers and Systems - a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
- NCQA Standards and Guidelines for the Accreditation of Health Plans
- DHCS Comprehensive Quality Strategy, February 2022
- DCHS California Advancing and Innovating Medi-Cal (CalAIM)
- National Quality Strategy, Agency for Healthcare Research and Quality (AHRQ)
- Patient Protection and Affordable Care Act, Public Law No. 111-148, enacted March 23, 2010
- Kohn KT, Corrigan JM, Donaldson MS. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 1999
- Title 42, Code of Federal Regulations, Section 438.240 Quality Assessment and Performance Improvement Program

Attachments

- Attachment 1. 2023 QIHETP Resources
- Attachment 2. 2023 GCHP PHM Strategy 2023

The 2023 Quality Improvement and Health Equity Transformation Program Description and Work Plan were approved by the Quality Improvement Committee on March 21, 2023.

The 2023 Quality Improvement and Health Equity Transformation Program Description and Work Plan were approved by Ventura County Medi-Cal Managed Care Commission (VCMMCC) on April 24, 2023.

Gold Coast Health Plan℠
A Public Entity

Quality Improvement and Health Equity Transformation Program 2023

711 E. Daily Dr., Suite 106, Camarillo, CA 93010

Rev. 7/2023