Ventura County MediCal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)

Special Meeting
Monday, August 21, 2017, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

ROLL CALL

PUBLIC COMMENT

The public has the opportunity to address Ventura County Medi-Cal Managed Care Commission (VCMMCC) doing business as Gold Coast Health Plan (GCHP) on the agenda. Persons wishing to address VCMMCC should complete and submit a Speaker Card.

Persons wishing to address VCMMCC are limited to three (3) minutes. Comments regarding items not on the agenda must be within the subject matter jurisdiction of the Commission.

CONSENT CALENDAR (ROLL CALL VOTE REQUIRED)

1. **Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of June 26, 2017**

   Staff: Tracy Oehler, Clerk of the Board

   RECOMMENDATION: Approve the minutes.

2. **Approval of Contract Extension with Mahdavi Gutta, M.D., for Pre-Service, Inpatient, Post-Service, and Appeals Cases**

   Staff: Nancy Wharfield, M.D., Chief Medical Officer

   RECOMMENDATION: Approve a twenty-four month contract extension with Mahdavi Gutta, M.D., for pre-service, inpatient, post-service, and appeals cases for $100,800 with a not to exceed amount of $319,805.

3. Approval of Contract Extension with Timothy Donahue, M.D., for Pre-Service, Inpatient, Post-Service, and Appeals Cases

Staff: Nancy Wharfield, M.D., Chief Medical Officer

RECOMMENDATION: Approve a twenty-four month contract extension with Timothy Donahue, M.D., for pre-service, inpatient, post-service, and appeals cases for $96,000 with a not to exceed amount of $234,420.

FORMAL ACTION ITEMS

4. May 2017 Year to Date Financials

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION: Accept and file May 2017 Fiscal Year to Date Financials.

5. Quality Improvement Committee 2017 Second Quarter Report

Staff: Nancy Wharfield, M.D., Chief Medical Officer

RECOMMENDATION: Accept and file the Quality Improvement Committee 2017 Second Quarter Report.

6. 2016 Quality Improvement Work Plan Evaluation, 2017 Quality Improvement Program Description, and 2017 Quality Improvement Work Plan

Staff: Kim Osajda, Quality Improvement Director

RECOMMENDATION: Approve the 2016 Quality Improvement Work Plan Evaluation, 2017 Quality Improvement Program Description, and 2017 Quality Improvement Work Plan.

REPORTS

7. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

8. Pharmacy Benefits Manager (PBM) Update

RECOMMENDATION: Accept and file the report.

9. Chief Operating Officer (COO) Update

RECOMMENDATION: Accept and file the report.

10. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

11. Chief Administrative Officer (CAO) Update

RECOMMENDATION: Accept and file the report.

12. Chief Diversity Officer (CDO) Update

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

13. LIABILITY CLAIMS
Claimant: Cathy Curtis
Agency Claimed Against: Gold Coast Health Plan

14. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One Case

15. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Diversity Officer

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on September 25, 2017, 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 Commission after distribution of the agenda packet are available for public review during normal business hours at the office of the Clerk of the Board.

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5509. Notification for accommodation must be made by the Monday prior to the meeting by 3 p.m. to enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

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

June 26, 2017 Regular Meeting Minutes

CALL TO ORDER

Commissioner Darren Lee called the meeting to order at 2:03 p.m. in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

PLEDGE OF ALLEGIANCE

Commissioner Lee led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa (arrived at 2:07 p.m.), Michele Laba, M.D., Darren Lee, Gagan Pawar, M.D., Catherine Rodriguez, and Jennifer Swenson.

Absent: Commissioner Peter Foy.

PUBLIC COMMENT

None.

CONSENT CALENDAR (ROLL CALL VOTE REQUIRED)

Commissioner Alatorre requested the minutes for May 22, 2017 be changed from January 2017 to January 2014 on page 13, third paragraph. After reviewing the audio recording, it was determined only the month and date, January 1, were specified and the minutes have been amended to reflect this.

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of May 22, 2017

RECOMMENDATION: Approve the minutes as amended.

2. April 2017 Year to Date Financials

RECOMMENDATION: Accept and file April 2017 Fiscal Year to Date Financials.

3. Approval of Updated Credentialing for Organization Providers Policy

RECOMMENDATION: Approve the updated Credentialing for Organizational Providers policy.

4. Approval of Contract Extension with TEKsystems, Inc. for IT Resources to Support Regulatory Initiatives

RECOMMENDATION: Approve contract extension with TEKsystems, Inc. for IT resources to support regulatory initiatives with a not to exceed amount of $163,625.

5. Approval of Contract Amendment with Milliman Solutions LLC for the MedInsight Software Milliman Advanced Risk Adjusters (MARA) Component

RECOMMENDATION: Approve contract amendment with Milliman Solutions LLC for the MedInsight Software MARA component for four years with a not to exceed amount of $127,016.

6. Approval of Reinsurance Policy with StarLine for High Cost Claims

RECOMMENDATION: Approve and authorize binding reinsurance with StarLine for high cost claims with a not to exceed amount of $3,055,000.

Commissioner Dial moved to approve the recommendation to approve the Consent Calendar. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Espinosa and Foy.

Commissioner Lee declared the motion carried by a 9-0-2 roll call vote.

Commissioner Espinosa arrived at 2:07 p.m.

Scott Campbell, General Counsel, announced Agenda Item No. 7, Award of the Community Health Investments' Social Determinants of Health I Grant Funding, with Commissioners Lee and Egan recusing themselves due to grants being awarded to St. John's Healthcare Foundation and Ventura County Public Health.

FORMAL ACTION ITEMS

7. Award of the Community Health Investments' Social Determinants of Health I Grants Funding

RECOMMENDATION: Approve $1,501,217 in grant funds to be awarded to sixteen (16) organizations through the Community Health Investment's Social Determinants of Health Request for Applications.

Karen Escalante-Dalton, KED Consultants, reviewed the grant-funding process including the Request for Applications and presented the sixteen organizations identified for funding.

Commissioner Espinosa expressed concern regarding the Santa Clara Valley is not being addressed.

Dale Villani, Chief Executive Officer, stated this is a first year rollout for the grant-funding program and a broader reach will occur with the next generation of the program.

Commissioner Atin moved to approve the recommendation. Commissioner Laba seconded.

AYES: Commissioners Alatorre, Atin, Dial, Espinosa, Laba, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: Commissioners Egan and Lee.

ABSENT: Commissioner Foy.

Commissioner Alatorre declared the motion carried.

Commissioners Lee and Egan returned at 2:24 p.m.

8. Approval of the Fiscal Year 2017/2018 Proposed Operating Budget

RECOMMENDATION: Approve the proposed Fiscal Year 2017/2018 Operating Budget.

Patricia Mowlavi, Chief Financial Officer, stated the key budget assumptions include the annual membership remaining stable over the next year; total revenue to remain essentially flat increasing by 0.16%; the cost of health care benefits for members continues to exceed the state rate assumption at 92.6% of revenue; administrative expenses being consistent and are budgeted at 7.3% of revenue; and the Tangible Net Equity (TNE) is projected to end the year at 547% of the state required minimum which is the lowest TNE of all the County Organized Health Systems. A projected loss of $1M is expected for fiscal year 2016/2017 with an expected slight gain for next fiscal year. It was noted the Alternative Resources for Community Health (ARCH) programs are not included in the budget proposal and recommendations to fund ARCH programs will be brought to the Commission for review and approval per policy guidelines.

Commissioner Rodriguez recommended a future discussion item on the Plan's policy regarding maintaining a realistic TNE level.

Lyndon Turner, Director of Financial Analysis, reviewed the Income Statement Summary, Balance Sheet, and Operational Metrics. It was noted the Plan received the largest rate increase (1.8%) for all of the COHS.

A discussion followed between the Commissioners and staff regarding the County's population aging out faster than aging in; the importance of good encounter data on rate development; the last market survey for salary ranges and targeting the 60th percentile for job offers; three percent merit increase being the standard in the managed care industry; and to correct the balance sheet net position so it ties to the income statement.

Melissa Scrymgeour, Chief Information and Strategy Officer, reviewed the project portfolios including positioning the Plan for financial stability, regulatory mandates, "keep the lights on" projects, and the implementation of new technology efficiencies.

Commissioner Swenson moved to approve the recommendation. Commissioner Rodriguez seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Foy.

Commissioner Lee declared the motion carried.

9. Request to Receive and Approve Resolution No. 2017-003 Approving Electronic Communications Policy in Accordance with *City of San Jose v. Superior Court* California Supreme Court Case

RECOMMENDATION: Receive and Approve Resolution No. 2017-003.

Mr. Campbell stated on March 2, 2017, the California Supreme Court published its decision in *City of San Jose vs. Superior Court*, determining all electronic communication regardless of where the information is located can constitute and is a public record if it deals with agency business. In response to the Court's decision, staff has prepared an Electronic Communications Policy to ensure all of Gold Coast Health Plan business is conducted on Gold Coast Health Plan emails. Email accounts will be set-up for the Commissioners by July 1, 2017, and training will be provided once the policy has been adopted. The Court has stated if an agency has adopted a policy and provided training, when a Public Records Act request is received, an individual may review their personal accounts and devices and self-certify.

Commissioner Dial moved to approve the recommendation. Commissioner Egan seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Foy.

Commissioner Lee declared the motion carried.

REPORTS

10. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

Mr. Villani recognized Dr. Al Reeves' work in the community and the Plan as he is retiring at the beginning of July. The Plan has engaged Witt Kieffer for the Chief Medical Officer replacement. Two candidates have been selected for interviews with the interview panel consisting of at least two physicians from the Commission or from within the County as well as three other interviewers for one candidate and four additional interviewers for the second candidate. The single payer health care system is no longer an option, as it did not make it to an Assembly Health Committee hearing due to activity at the federal level. The Senate Majority Leader, Mitch McConnell, intends on taking the Better Care Reconciliation Act of 2017 to the Senate floor though the bill does not appear to have enough votes to support it. The Plan is concerned with the loss of coverage for the Adult Expansion members and the significantly reduced Federal matching dollars to the State as it would reduce coverage or create different benefit structures for the Medi-Cal members. The annual on-site medical audit is completed and a draft report is anticipated for July/August 2017. The Provider Network 274 File work is going well and timelines are being met. Estonien is conducting an audit of the Auto Assignment for the Adult Expansion per a Commissioner's request with the scope of January 1, 2017, to the end of May.

11. Chief Operating Officer (COO) Update

RECOMMENDATION: Accept and file the report.

Ruth Watson, Chief Operating Officer, stated membership is at 201,455 and noted the numbers in the COO update are from the eligibility file, which does not reflect some of the reactivity that occurs throughout the month. The typo has been corrected from 75% to 50% for the AB 85 Auto Assignment for the new Adult Expansion members who had not chosen a primary care provider within the first 30 days of enrollment. Claims are at 4.6 days receipt on hand and claim turnaround

time is now at the 90% requirement. The top claim denial reasons were reviewed and are consistent to the industry standards. Staff will be investigating duplicate claims to determine whether they are possibly mislabeled. Call center quality is at 94.4% due to the failure of authenticating membership on one call. It was noted on page 102 of the agenda packet the monthly membership lookback aid code was for the Adult Expansion membership and not the Plan's total membership. A new contract with Conduent begins July 1, 2017, and outlines increased service level agreements, greater liability terms, and Conduent's responsibility for cyber liability issues. The first report for the Child Access Initiative (Enhanced Access for Well Child Visits) was received and is being analyzed by staff. The Transition of Care pilot is designed to enhance care transition interventions for members discharged from the hospital by addressing the broader aspect of the member's care in order to keep them out of the emergency room and to avoid hospital readmissions. Once the pilot is complete and the results are received, the goal is to expand the program to other entities. The out of county referrals information has been received and staff will be reporting at the next Commission meeting.

Clarification was made the Auto Assignment and primary care provider audit would be from the start of the program beginning January 1, 2014, through May 2017.

12. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

C. Albert Reeves, M.D., Chief Medical Officer, stated staff is available for questions on the health education outreach and the pharmacy statistics contained in the CMO update.

13. Pharmacy Benefits Manager (PBM) Update

RECOMMENDATION: Accept and file the report.

Anne Freese, PharmD, Director of Pharmacy, stated the PBM went live effective June 1, 2017, and gave an update on the status. Through June 15, the first billing cycle, OptumRx had paid over 70,000 prescription claims, which is in alignment of the Plan's typical claim volume. Several issues were identified and resolved in the first several days of the implementation. Outstanding issues include transition/grandfathering benefit coding not complete; Kaiser pharmacies contracts not executed; 340B eligible drugs claims discounts; and concern expressed from individual pharmacies regarding low reimbursement rates.

A discussion followed between the Commissioners and staff regarding individual pharmacies' level of reimbursement issues and what is being done to resolve this issue quickly; the status of the 340B program; and preauthorizations. Staff stated they have contacted OptumRx requesting they expedite the claim reviews as well as contacting the pharmacies though dialogue is limited due to contractual issues. In May, a proposal was received from Script Care outlining the continuation of work with the Plan and with OptumRx being the PBM. The proposal is currently under review by staff but the cost element has not been determined. Currently, claims

are being excluded from the 340B program for the entities resulting in the Plan paying more on certain drugs and staff is working on how to analyze the 340B claims. It was noted overall this was not costing the Plan as it was receiving other discounts from OptumRx. Staff stated OptumRx was contacted early in the implementation process to correct how the call center agencies were instructing doctor offices on the preauthorization process.

14. Chief Diversity Officer (CDO) Update

RECOMMENDATION: Accept and file the report.

Douglas Freeman, Chief Diversity Officer, stated the strategy has been simplified to the three "C"s compliance, community, and culture; and is working on developing a code of conduct.

Brandy Armenta, Director of Compliance, stated as part of the Department of Health Care Services contract, a compliance program is required, which includes a code of conduct that all employees and Commissioners have signed. The current code of conduct has been approved by the Compliance Committee and vetted by legal counsel.

A discussion followed between the Commissioners and staff on whether the proposed code of conduct is an update to the existing policy or a separate policy. Direction was given to staff to work together and to determine if one or two policies are needed. Mr. Campbell noted the CDO's scope of work is limited by the Ordinance and the job description and work on the policy should be coordinated with Human Resources for the non-diversity matters.

Commissioner Lee inquired about the budget for the CDO projects and emphasized the importance of expenditures being outlined in a budget for the Commission to review. Mr. Freeman stated focus has been on the compliance component and will provide a budget outline at the next Commission meeting. Clarification was made money has been allocated to the CDO in the budget presented, but that line item details had not been provided.

Commissioner Rodriguez left the meeting.

Commissioner Dial moved to approve the recommendations for Agenda Items 10 through 14. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Laba, Lee, Pawar, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Foy and Rodriguez.

Commissioner Lee declared the motion carried.

Commissioner Rodriguez returned to the meeting.

Mr. Campbell stated there are four closed session items with two items associated with formal action items and two items on personnel matters. He suggested the Commission hear the two formal action items in Closed Session and reconvene in Open Session to take action.

Mr. Campbell announced Closed Session Agenda Item No. 15 – Conference with Legal Counsel – Anticipated Litigation involving the initiation of litigation concerning the Plan's rights against Conduent arising out a previous lawsuit with Clinicas del Camino Real and Agenda Item No. 16 – Anticipated Litigation concerning whether there is a valid contract with AmericasHealth Plan (AHP). Commissioners Alatorre and Pawar will be recusing themselves from both the open and closed agenda items for AHP.

CLOSED SESSION

The Commission adjourned to Closed Session at 4:07 p.m.

15. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: One Case

16. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One Case

OPEN SESSION

The Regular Meeting reconvened at 5:20 p.m.

Mr. Campbell stated the Commission unanimously approved a settlement agreement with Conduent.

FORMAL ACTION ITEMS

17. Approval of Contract with Conduent Health Administration, Inc. for Administrative Services

RECOMMENDATION: Approve contract with Conduent Health Administration, Inc. for two years with a fee for services based on a "per member/per month" fee schedule.

Commissioner Dial moved to approve the recommendation. Commissioner Swenson seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Foy.

Commissioner Lee declared the motion carried.

Commissioners Alatorre and Pawar recused themselves due to a potential conflict of interest for Agenda Item No. 18.

18. Approval of Plan-to-Plan Subcontracting Program as Proposed by AmericasHealth Plan

RECOMMENDATION: Approve Plan-to-Plan subcontracting program as proposed by AmericasHealth Plan.

Commissioner Dial made the motion to direct staff to begin a negotiation for an at risk contract with AmericasHealth Plan and the contract would be a pilot contract in compliance with the Plan's policies specifically identifying goals, outcomes, and financials with a limited number of patients. Commissioner Atin seconded.

AYES: Commissioners Atin, Dial, Egan, Espinosa, Laba, Lee, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: Commissioners Alatorre and Pawar.

ABSENT: Commissioner Foy.

Commissioner Lee declared the motion carried.

Mr. Campbell announced Closed Session Agenda Item No. 16 – Conference with Legal Counsel – Anticipated Litigation involving allegations of bullying and harassment complaint.

CLOSED SESSION

The Commission adjourned to Closed Session at 5:22 p.m.

Mr. Campbell left the meeting at 5:22 p.m. Scott Howard, Counsel from Colantuono, Highsmith, Whatley, PC, was present.

Commissioner Rodriguez left at 5:24 p.m. and returned at 5:40 p.m.

16. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: Two Cases

Mr. Campbell returned to the meeting at 6:10 p.m.

OPEN SESSION

The Regular Meeting reconvened at 6:44 p.m.

Mr. Campbell stated there was no reportable action taken.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

The meeting was adjourned at 6:45 p.m.

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, Chief Medical Officer

DATE: August 21, 2017

SUBJECT: Contract Extension Approval – Mahdavi Gutta, M.D.

SUMMARY:

Dr. Mahdavi Gutta is an individual contractor providing medical reviews for pre-service, inpatient, post-service, and appeals cases. Dr. Gutta has been providing these services since January 1, 2013 and has consistently delivered high quality results. The current agreement expires on September 30, 2017. The Plan is recommended extension of this agreement for an additional twenty-four month period.

FISCAL IMPACT:

The agreement is a non-requirements contract which allows the Plan to use services ad-hoc at rates specified. The agreement can be terminated for convenience at any time with a fourteen (14) day notice. The rates are hourly. The renewal amount is projected to be $50,400 annually or a total amount of $100,800 for the contract extension.

The cumulative value of the current contract with the requested 24-month contract extension would be approximately $319,805.

RECOMMENDATION:

The Plan recommends the approval for an additional twenty-four (24) month contract extension with Mahdavi Gutta, M.D., for pre-service, inpatient, post-service, and appeals cases for $100,800 with a not to exceed amount of $319,805.

If the Commission desires to review this contract extension, it is available at Gold Coast Health Plan's Finance Department.

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, Chief Medical Officer

DATE: August 21, 2017

SUBJECT: Contract Extension Approval – Timothy Donahue M.D.

SUMMARY:

Dr. Timothy Donahue is an individual contractor providing medical reviews for pre-service, inpatient, post-service, and appeals cases. Dr. Donahue has been providing these services since January 1, 2015 and has consistently delivered high quality results. The current agreement expires on September 30, 2017. The Plan is recommending extension of this agreement for an additional twenty-four month period.

FISCAL IMPACT:

The agreement is a non-requirements contract which allows the Plan to use services ad-hoc at the rates specified. The agreement can be terminated for convenience at any time with a fourteen (14) day notice. The rates are hourly. The renewal amount is projected to be $48,000 annually or a total amount of $96,000 for the contract extension.

The cumulative value of the current contract with the requested 24-month contract extension would be approximately $234,420.

RECOMMENDATION:

The Plan recommends the approval for an additional twenty-four (24) month contract extension with Timothy Donahue, M.D., for pre-service, inpatient, post-service, and appeals cases for $96,000 with a not to exceed amount of $234,420.

If the Commission desires to review this contract extension, it is available at Gold Coast Health Plan's Finance Department.

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Patricia Mowlavi, Chief Financial Officer

DATE: August 21, 2017

SUBJECT: May 2017 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached May 2017 fiscal year-to-date (FYTD) financial statements (unaudited) of Gold Coast Health Plan ("Plan") for the Commission to accept and file. The Executive/Finance Committee did not review these financials.

BACKGROUND/DISCUSSION:

The staff has prepared the May 2017 FYTD financial package, including statements of financial position, statement of revenues, expenses and changes in net assets, and statement of cash flows.

FISCAL IMPACT:

Financial Highlights

Overall Performance – For the eleven-month period ended May 31, 2017, the Plan's performance was a decrease in net assets of $7.8 million, which was $4.9 million more than budget. Cost of health care was higher than budget by $7.1 million driven by higher contracted rates. The medical loss ratio increased to 94.5 percent of revenue which was1.8 percent higher than the budget. Administrative savings were realized through lower than projected administrative expenses – most notably those expenses related to projects and those whose variability are determined by membership levels.

Membership – May's membership of 204,140 was 10,138 members below budget. For FYTD, membership is 2,281,212 or 48,896 below budget.

Revenue – May FYTD net revenue was $625.2 million or $4.4 million below budget due to the aforementioned below budget membership. On a PMPM basis, FYTD revenue was $3.85 above budget due to membership mix, with higher than expected Adult Expansion membership.

MCO Tax – MCO tax is a pre-determined liability in accordance with Senate Bill X2-2 passed in October 2016. The Plan's MCO tax liability for FY2017 is $84.1 million, accrued at a rate of approximately $7.0 million per month. A total of $77.1 million of MCO tax has been expensed FYTD. The last quarterly installment of MCO tax for the fiscal year will be paid on July 6, 2017.

Health Care Costs – Health care costs through May 31, 2017 were $590.6 million or $7.1 million more than budget. The FYTD medical loss ratio (MLR) was 94.5% versus 92.7% for budget.

Adult Expansion Population 85% Medical Loss Ratio – The Balance Sheet contains a $131.3 million reserve for return of potential Medi-Cal capitation revenue to the DHCS under the terms of the MLR contract language.

	Expansion Population			Classic Population
	1/1/14-6/30/15 MLR Period 1	7/1/15-6/30/16 MLR Period 2	7/1/16-5/31/17 MLR Period 3	7/1/16-5/31/17
Total Revenue (net of MCO tax)	361,237,234	293,172,661	246,220,878	375,245,219
Total Estimated Medical Expense	206,719,452	238,300,734	216,536,996	374,034,188
	57.2%	81.3%	87.9%	99.7%
Total MLR Reserve	**118,168,494**	**13,101,452**	**-**	

Administrative Expenses – May FYTD administrative costs were $45.4 million or $4.6 million below budget. As a percentage of revenue, administrative costs (or ACR) were 7.3% versus 7.9% for budget.

Cash and Medi-Cal Receivable – At May 31, the Plan had $514.9 million in cash and short-term investments and $65.4 million in Medi-Cal Receivable for an aggregate amount of $580.3 million. The AE overpayment due to DHCS (related to incorrect rate payments and to achieve 85% MLR) totals $280.2 million. The Plan anticipates AE repayment to commence in October 2017 or shortly thereafter. As consistent with prior fiscal years, the State delays the May and June capitation payments until late July or early August.

Investment Portfolio – At May 31, 2017, the value of the investments (all short term) was $279.2 million. The portfolio included Cal Trust $50.9 million; Ventura County Investment Pool $85.8 million; LAIF CA State $63.5 million; Bonds and Commercial Paper $79.0 million.

RECOMMENDATION:

Staff requests that the Commission accept and file the May 2017 financial package.

CONCURRENCE:

N/A

ATTACHMENT:

May 2017 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended May 31, 2017

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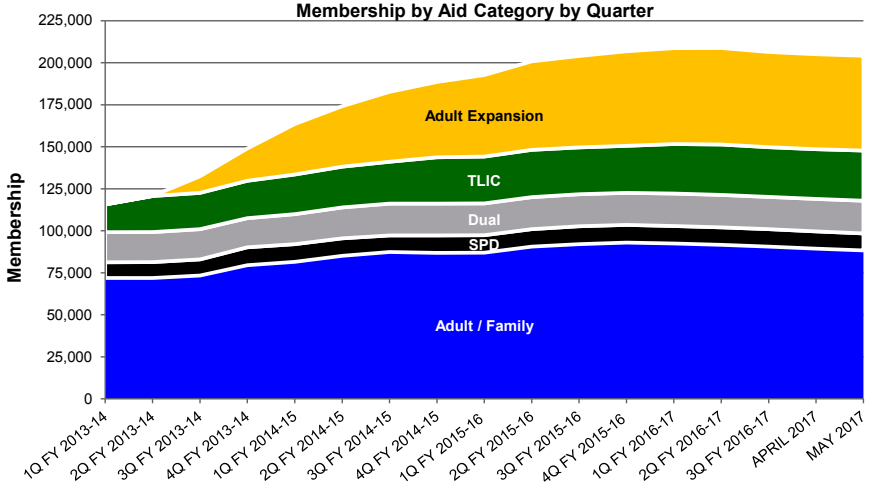
APPENDIX

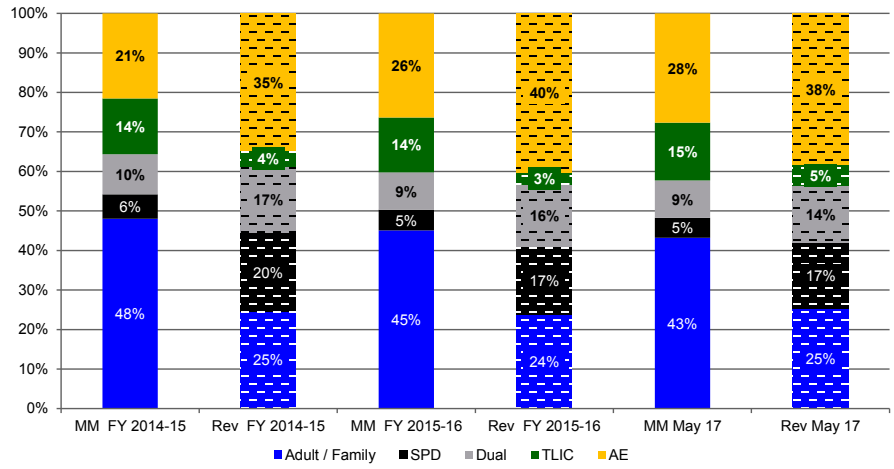
Description	AUDITED FY 2014-15	AUDITED FY 2015-16	FY 2016-17 JUL - SEP 16	FY 2016-17 OCT - DEC 16	FY 2016-17 JAN - MAR 17	FY 2016-17 APR 17	FY 2016-17 MAY 17	FY 2016-17 FYTD MAY 17	Budget Comparison Budget FYTD	Budget Comparison Variance Fav / (Unfav)
Member Months	**2,130,979**	**2,413,136**	**626,084**	**626,419**	**619,463**	**205,106**	**204,140**	**2,281,212**	**2,330,108**	(48,896)
Revenue	**595,607,370**	**675,629,602**	**148,815,746**	**190,063,083**	**175,648,323**	**55,364,984**	**55,290,640**	**625,182,776**	**629,603,481**	(4,420,704)
pmpm	*279.50*	*279.98*	*237.69*	*303.41*	*283.55*	*269.93*	*270.85*	*274.06*	*270.20*	3.85
Health Care Costs	**509,183,268**	**583,149,780**	**155,478,257**	**156,886,345**	**161,064,037**	**52,160,568**	**64,981,977**	**590,571,184**	**583,498,195**	(7,072,989)
pmpm	*238.94*	*241.66*	*248.33*	*250.45*	*260.01*	*254.31*	*318.32*	*258.88*	*250.42*	(8.47)
% of Revenue	85.5%	86.3%	104.5%	82.5%	91.7%	94.2%	117.5%	94.5%	92.7%	-1.79%
Admin Exp	**34,814,049**	**38,256,908**	**12,063,462**	**12,399,366**	**12,325,129**	**4,029,965**	**4,572,081**	**45,390,004**	**50,016,365**	4,626,362
pmpm	*16.34*	*15.85*	*19.27*	*19.79*	*19.90*	*19.65*	*22.40*	*19.90*	*21.47*	1.57
% of Revenue	5.8%	5.7%	8.1%	6.5%	7.0%	7.3%	8.3%	7.3%	7.9%	0.68%
Non-Operating Revenue / (Expense)		**1,790,949**	**596,568**	**647,800**	**1,004,824**	**330,298**	**350,681**	**2,930,171**	**1,005,972**	1,924,200
pmpm		*0.74*	*0.95*	*1.03*	*1.62*	*1.61*	*1.72*	*1.28*	*0.43*	0.85
% of Revenue		0.3%	0.4%	0.3%	0.6%	0.6%	0.6%	0.5%	0.2%	0.31%
Total Increase / (Decrease) in Unrestricted Net Assets	**51,610,053**	**56,013,863**	**(18,129,405)**	**21,425,172**	**3,263,981**	**(495,251)**	**(13,912,736)**	**(7,848,240)**	**(2,905,108)**	(4,943,132)
pmpm	*24.22*	*23.21*	*(28.96)*	*34.20*	*5.27*	*(2.41)*	*(68.15)*	*(3.44)*	*(1.25)*	(2.19)
% of Revenue	8.7%	8.3%	-12.2%	11.3%	1.9%	-0.9%	-25.2%	-1.3%	-0.5%	-0.79%
YTD										
100% TNE	22,556,530	25,246,284	26,097,131	27,075,526	27,709,401	28,612,411	30,128,937	30,128,937	29,285,406	843,531
% TNE Required	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Minimum Required TNE	22,556,530	25,246,284	26,097,131	27,075,526	27,709,401	28,612,411	30,128,937	30,128,937	29,285,406	843,531
GCHP TNE	**107,145,264**	**155,959,127**	**137,829,722**	**159,254,894**	**162,518,875**	**162,023,623**	**148,110,887**	**148,110,887**	**150,152,048**	**(2,041,161)**
TNE Excess / (Deficiency)	**84,588,734**	**130,712,843**	**111,732,591**	**132,179,367**	**134,809,474**	**133,411,212**	**117,981,950**	**117,981,950**	**120,866,642**	**(2,884,692)**
% of Required TNE level	**475%**	**618%**	**528%**	**588%**	**587%**	**566%**	**492%**	**492%**	**513%**	

FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING MAY 31, 2017

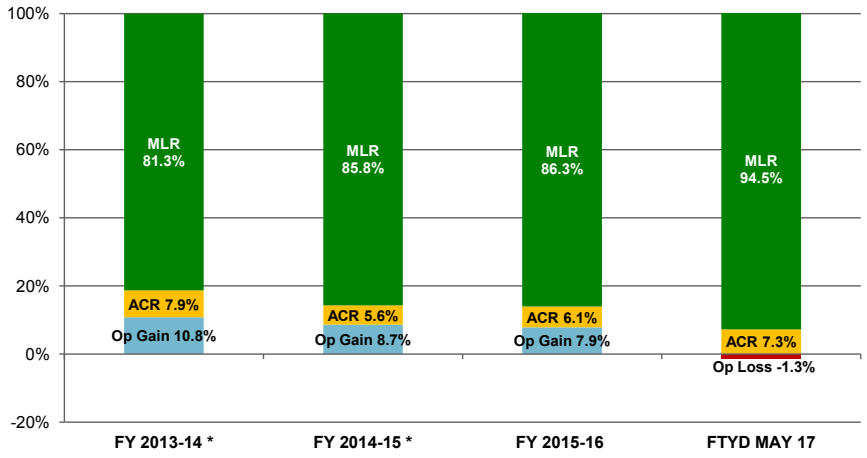
Membership and Growth
Membership by Aid Category by Quarter



Membership Mix and Revenue Impact

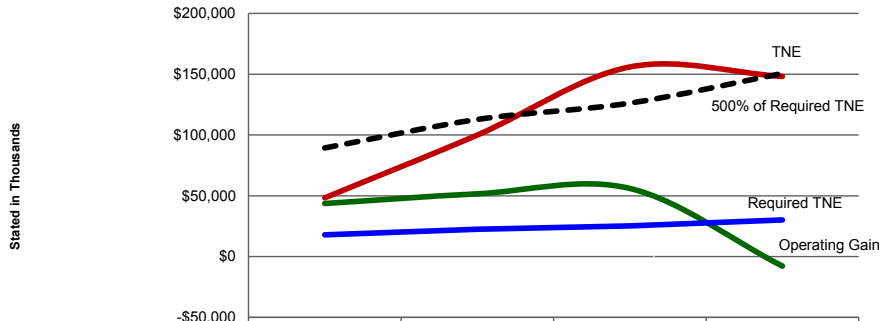


Key Performance Indicators



Note: FY 14 and FY 15 differs from Budget Presentation due to Auditors' Adjustments. Medical Loss Ratio (MLR), Administrative Cost Ratio (ACR)

Operating Gain and Tangible Net Equity

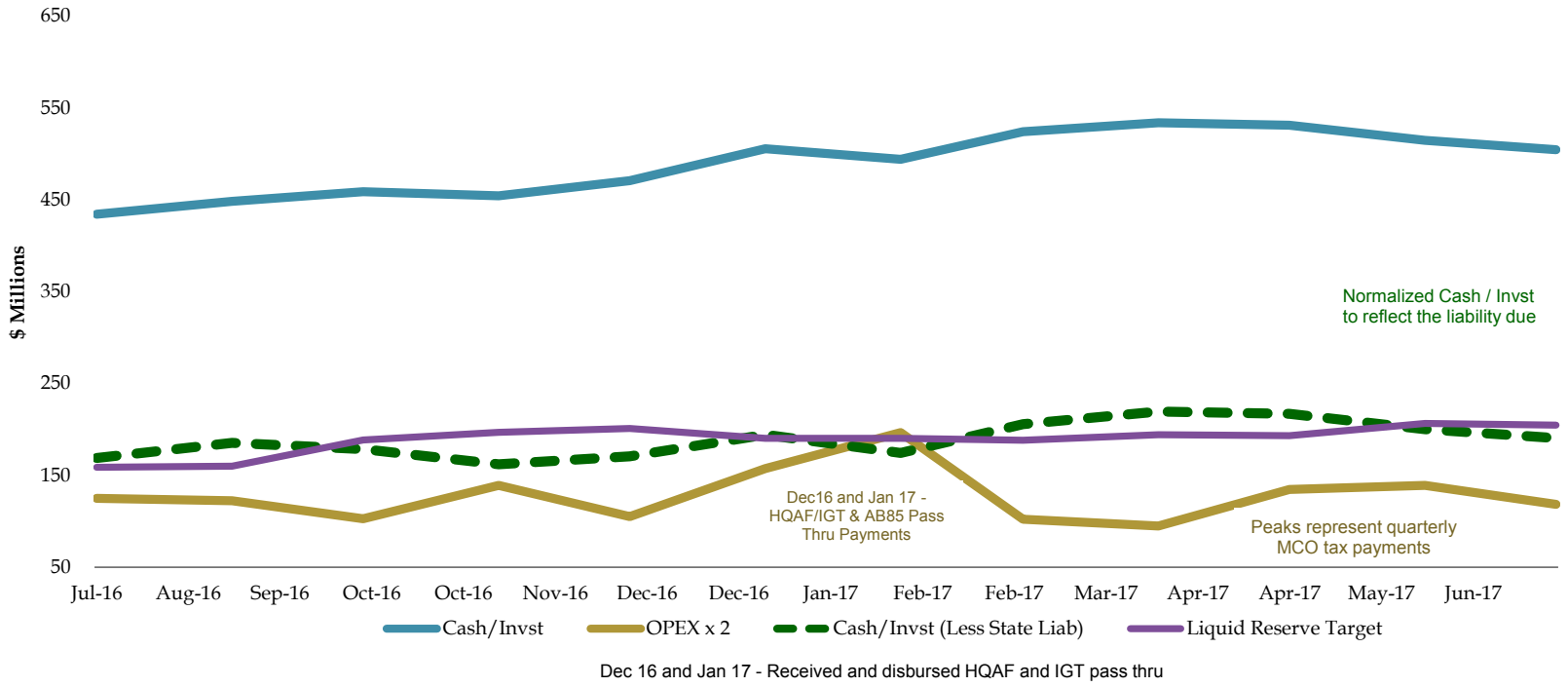


	FY 2013-14 *	FY 2014-15 *	FY 2015-16	FYTD MAY 2017
Operating Gain	$43,644	$51,610	$56,014	$(7,848)
TNE	$48,335	$99,945	$155,959	$148,111
Required TNE	$17,868	$22,557	$25,246	$30,129
500% of Required TNE	$89,340	$112,783	$126,231	$150,645

* FY 14 and FY 15 differs from Budget Presentation due to audit adjustments. FY 16 updated for Operating Gain and TNE Only
TNE excludes LOC ($7.2M)

GOLD COAST HEALTH PLAN
FY 2016 - 17

Cash & Operating Expense Requirements



Dec 16 and Jan 17 - Received and disbursed HQAF and IGT pass thru

Gold Coast Health Plan℠
A Public Entity

For the month ended May 31, 2017

APPENDIX

- Statement of Financial Position
- YTD Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Cash Flows
- Membership
- Paid Claims and IBNP Composition

STATEMENT OF FINANCIAL POSITION

	05/31/17	04/30/17	03/31/17
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**$ 235,633,348**	**$ 252,321,190**	**$ 275,089,340**
Total Short-Term Investments	**279,295,844**	**279,137,218**	**258,959,818**
Medi-Cal Receivable	65,412,833	59,897,643	66,185,676
Interest Receivable	593,285	532,839	624,606
Provider Receivable	585,831	655,718	481,141
Total Accounts Receivable	**66,591,949**	**61,086,200**	**67,291,423**
Total Prepaid Accounts	2,003,556	1,423,907	1,681,886
Total Other Current Assets	133,545	133,545	133,545
Total Current Assets	**583,658,242**	**594,102,059**	**603,156,013**
Total Fixed Assets	**2,256,975**	**2,417,225**	**2,462,002**
Total Assets	**$ 585,915,217**	**$ 596,519,284**	**$ 605,618,015**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 54,406,013	$ 59,143,280	$ 55,118,983
Claims Payable	16,032,342	16,146,292	13,955,262
Capitation Payable	57,113,252	57,092,423	57,064,473
Physician ACA 1202 Payable	591,696	591,696	591,696
AB 85 Payable	1,458,214	1,461,995	1,464,483
DHCS - Reserve for Capitation Recoup	131,269,946	131,269,946	0
Accounts Payable	3,441,721	2,882,782	2,434,125
Accrued ACS	1,668,431	1,669,857	1,668,962
Accrued Expenses	155,989,637	155,346,947	156,614,148
Accrued Premium Tax	13,727,855	6,507,001	20,519,903
Accrued Payroll Expense	1,083,361	1,361,309	1,374,754
Total Current Liabilities	**436,782,470**	**433,473,527**	**310,806,788**
Long-Term Liabilities:			
DHCS - Reserve for Capitation Recoup	0	0	131,269,946
Other Long-term Liability-Deferred Rent	1,021,861	1,022,133	1,022,406
Total Long-Term Liabilities	**1,021,861**	**1,022,133**	**132,292,352**
Total Liabilities	**437,804,330**	**434,495,661**	**443,099,140**
Net Assets:			
Beginning Net Assets	155,959,127	155,959,127	155,959,127
Total Increase / (Decrease in Unrestricted Net Assets)	(7,848,240)	6,064,497	6,559,748
Total Net Assets	**148,110,887**	**162,023,623**	**162,518,875**
Total Liabilities & Net Assets	**$ 585,915,217**	**$ 596,519,284**	**$ 605,618,015**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR ELEVEN MONTHS ENDED MAY 31, 2017

	MAY 2017 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	2,281,212	2,330,108	(48,896)
Revenue			
Premium	$ 698,615,888	$ 707,640,267	$ (9,024,379)
Reserve for Rate Reduction	3,350,000	(2,265,466)	5,615,466
MCO Premium Tax	(77,149,792)	(75,771,320)	(1,378,472)
Total Net Premium	**624,816,096**	**629,603,481**	**(4,787,384)**
Other Revenue:			
Miscellaneous Income	366,680	0	366,680
Total Other Revenue	366,680	**0**	366,680
Total Revenue	**625,182,776**	**629,603,481**	**(4,420,704)**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	59,858,333	55,447,557	(4,410,777)
FFS Claims Expenses:			
Inpatient	124,197,011	116,688,149	(7,508,862)
LTC / SNF	108,380,708	105,736,267	(2,644,441)
Outpatient	53,772,897	45,266,087	(8,506,810)
Laboratory and Radiology	3,249,767	2,677,019	(572,748)
Emergency Room	20,321,250	19,868,306	(452,944)
Physician Specialty	51,308,399	52,742,544	1,434,145
Primary Care Physician	14,312,033	17,222,487	2,910,454
Home & Community Based Services	16,746,653	14,508,056	(2,238,598)
Applied Behavior Analysis Services	4,742,944	1,319,236	(3,423,708)
Mental Health Services	5,239,224	3,810,207	(1,429,018)
Pharmacy	106,007,374	107,921,387	1,914,013
Provider Reserve	349,507	11,149,184	10,799,677
Other Medical Professional	2,802,134	2,294,710	(507,424)
Other Medical Care	201,880	0	(201,880)
Other Fee For Service	7,582,379	6,977,250	(605,128)
Transportation	1,539,778	1,426,372	(113,406)
Total Claims	520,753,938	509,607,262	(11,146,676)
Medical & Care Management Expense	11,112,201	12,897,719	1,785,517
Reinsurance	946,903	5,545,657	4,598,754
Claims Recoveries	(2,100,192)	0	2,100,192
Sub-total	9,958,912	18,443,376	8,484,464
Total Cost of Health Care	**590,571,184**	**583,498,195**	**(7,072,989)**
Contribution Margin	**34,611,593**	**46,105,286**	**(11,493,693)**
General & Administrative Expenses:			
Salaries, Wages & Employee Benefits	20,705,918	22,099,017	1,393,099
Training, Conference & Travel	388,079	510,999	122,920
Outside Services	25,341,980	26,826,634	1,484,655
Professional Services	3,894,656	5,711,557	1,816,900
Occupancy, Supplies, Insurance & Others	6,171,572	7,765,877	1,594,306
Care Management Credit	(11,112,201)	(12,897,719)	(1,785,517)
Total G & A Expenses	**45,390,004**	**50,016,365**	**4,626,362**
Total Operating Gain / (Loss)	**$ (10,778,411)**	**$ (3,911,079)**	**$ (6,867,332)**
Non Operating			
Revenues - Interest	2,930,171	1,005,972	1,924,200
Total Non-Operating	2,930,171	1,005,972	1,924,200
Total Increase / (Decrease) in Unrestricted Net Assets	**$ (7,848,240)**	**$ (2,905,108)**	**$ (4,943,132)**
Net Assets, Beginning of Year	155,959,127		
Net Assets, End of Current Period	148,110,887		

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2016-17 Monthly Trend			Current Month		
	Feb 17	Mar 17	Apr 17	MAY 2017 Actual	MAY 2017 Budget	Variance Fav / (Unfav)
Membership (includes retro members)	206,970	205,829	205,106	204,140	214,278	(10,138)
Revenue:						
Premium	$ 63,438,477	$ 62,813,120	$ 62,371,164	$ 62,297,031	$ 65,011,789	$ (2,714,758)
Reserve for Rate Reduction	1,500,000	4,000,000	0	0	(195,834)	195,834
MCO Premium Tax	(7,006,118)	(7,006,094)	(7,006,180)	(7,006,391)	(6,965,062)	(41,329)
Total Net Premium	**57,932,359**	**59,807,026**	**55,364,984**	**55,290,640**	**57,850,893**	**(2,560,253)**
Total Revenue	**57,932,359**	**59,807,026**	**55,364,984**	**55,290,640**	**57,850,893**	**(2,560,253)**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,029,586	5,227,526	4,925,418	5,109,110	5,094,083	(15,026)
FFS Claims Expenses:						
Inpatient	9,355,847	12,784,974	11,425,679	14,792,275	10,734,188	(4,058,087)
LTC / SNF	11,439,236	9,891,367	8,511,453	11,760,337	9,658,963	(2,101,374)
Outpatient	4,477,337	4,028,914	4,851,932	9,266,158	4,164,375	(5,101,783)
Laboratory and Radiology	226,793	312,311	355,908	406,545	246,473	(160,072)
Emergency Room	2,113,200	2,177,348	1,909,550	2,087,934	1,826,536	(261,398)
Physician Specialty	3,959,094	4,747,630	4,820,252	6,295,447	4,857,995	(1,437,452)
Primary Care Physician	1,176,119	1,175,549	1,690,721	1,543,446	1,585,516	42,070
Home & Community Based Services	1,805,214	1,459,004	1,471,628	1,476,855	1,343,004	(133,851)
Applied Behavior Analysis Services	460,227	621,128	467,688	706,081	120,600	(585,481)
Mental Health Services	892,933	542,188	412,599	(1,019,269)	349,687	1,368,956
Pharmacy	9,204,612	10,301,143	9,184,491	10,141,893	9,908,139	(233,754)
Provider Reserve	0	166,667	0	82,840	1,022,758	939,918
Other Medical Professional	241,561	293,662	295,072	336,526	211,215	(125,311)
Other Medical Care	234	0	0	0	0	0
Other Fee For Service	630,149	601,990	785,269	758,238	640,562	(117,676)
Transportation	115,093	91,625	240,721	216,162	130,746	(85,416)
Total Claims	46,097,649	49,195,501	46,422,962	58,851,468	46,800,755	(12,050,713)
Medical & Care Management Expense	1,085,264	1,066,266	907,107	1,131,145	1,194,970	63,825
Reinsurance	231,721	256,032	254,509	(88,325)	509,982	598,306
Claims Recoveries	(1,439)	(263,948)	(349,428)	(21,421)	0	21,421
Sub-total	1,315,547	1,058,350	812,188	1,021,399	1,704,952	683,553
Total Cost of Health Care	**52,442,783**	**55,481,377**	**52,160,568**	**64,981,977**	**53,599,790**	**(11,382,186)**
Contribution Margin	**5,489,576**	**4,325,650**	**3,204,416**	**(9,691,336)**	**4,251,103**	**(13,942,439)**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	1,749,737	1,982,336	1,667,223	2,047,525	2,079,959	32,434
Training, Conference & Travel	44,206	28,317	20,403	44,185	29,970	(14,215)
Outside Services	2,246,393	2,353,686	2,324,945	2,307,093	2,460,877	153,784
Professional Services	187,769	438,247	431,279	584,945	458,515	(126,430)
Occupancy, Supplies, Insurance & Others	743,167	613,892	493,222	719,478	738,487	19,010
Care Management Credit	(1,085,264)	(1,066,266)	(907,107)	(1,131,145)	(1,194,970)	(63,825)
Total G & A Expenses	**3,886,007**	**4,350,212**	**4,029,965**	**4,572,081**	**4,572,839**	**757**
Total Operating Gain / (Loss)	**1,603,570**	**(24,562)**	**(825,549)**	**(14,263,418)**	**(321,736)**	**(13,941,682)**
Non Operating:						
Revenues - Interest	326,906	343,025	330,298	350,681	64,229	286,452
Total Non-Operating	**326,906**	**343,025**	**330,298**	**350,681**	**64,229**	**286,452**
Total Increase / (Decrease) in Unrestricted Net Assets	**1,930,476**	**318,463**	**(495,251)**	**(13,912,736)**	**(257,507)**	**(13,655,230)**
Full Time Employees				**184**	**200**	**16**

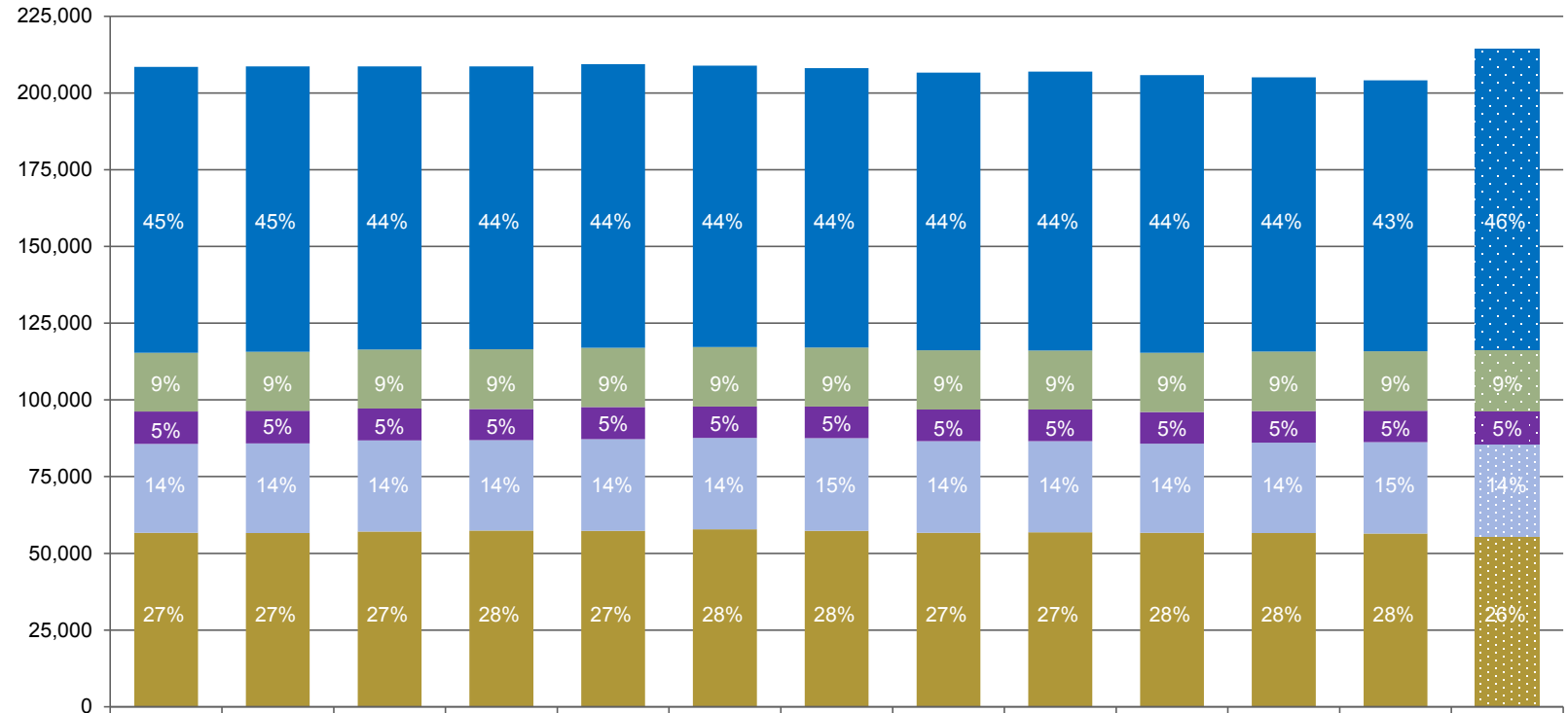
PMPM - STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2016-17 Monthly Trend			MAY 2017		Variance
	Feb 17	Mar 17	Apr 17	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	206,970	205,829	205,106	204,140	214,278	(10,138)
Revenue:						
Premium	306.51	305.17	304.09	305.17	303.40	1.77
Reserve for Rate Reduction	7.25	19.43	0.00	0.00	(0.91)	0.91
MCO Premium Tax	(33.85)	(34.04)	(34.16)	(34.32)	(32.50)	(1.82)
Total Net Premium	**279.91**	**290.57**	**269.93**	**270.85**	**269.98**	**0.87**
Total Revenue	**279.91**	**290.57**	**269.93**	**270.85**	**269.98**	**0.87**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	24.30	25.40	24.01	25.03	23.77	(1.25)
FFS Claims Expenses:						
Inpatient	45.20	62.11	55.71	72.46	50.09	(22.37)
LTC / SNF	55.27	48.06	41.50	57.61	45.08	(12.53)
Outpatient	21.63	19.57	23.66	45.39	19.43	(25.96)
Laboratory and Radiology	1.10	1.52	1.74	1.99	1.15	(0.84)
Emergency Room	10.21	10.58	9.31	10.23	8.52	(1.70)
Physician Specialty	19.13	23.07	23.50	30.84	22.67	(8.17)
Primary Care Physician	5.68	5.71	8.24	7.56	7.40	(0.16)
Home & Community Based Services	8.72	7.09	7.17	7.23	6.27	(0.97)
Applied Behavior Analysis Services	2.22	3.02	2.28	3.46	0.56	(2.90)
Mental Health Services	4.31	2.63	2.01	(4.99)	1.63	6.62
Pharmacy	44.47	50.05	44.78	49.68	46.24	(3.44)
Provider Reserve	0.00	0.81	0.00	0.41	4.77	4.37
Other Medical Professional	1.17	1.43	1.44	1.65	0.99	(0.66)
Other Medical Care	0.00	0.00	0.00	0.00	0.00	0.00
Other Fee For Service	3.04	2.92	3.83	3.71	2.99	(0.72)
Transportation	0.56	0.45	1.17	1.06	0.61	(0.45)
Total Claims	222.73	239.01	226.34	288.29	218.41	(69.88)
Medical & Care Management Expense	5.24	5.18	4.42	5.54	5.58	0.04
Reinsurance	1.12	1.24	1.24	(0.43)	2.38	2.81
Claims Recoveries	(0.01)	(1.28)	(1.70)	(0.10)	0.00	0.10
Sub-total	6.36	5.14	3.96	5.00	7.96	2.95
Total Cost of Health Care	253.38	269.55	254.31	318.32	**250.14**	**(68.18)**
Contribution Margin	**26.52**	**21.02**	**15.62**	**(47.47)**	**19.84**	**(67.31)**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	8.45	9.63	8.13	10.03	9.71	(0.32)
Training, Conference & Travel	0.21	0.14	0.10	0.22	0.14	(0.08)
Outside Services	10.85	11.44	11.34	11.30	11.48	0.18
Professional Services	0.91	2.13	2.10	2.87	2.14	(0.73)
Occupancy, Supplies, Insurance & Others	3.59	2.98	2.40	3.52	3.45	(0.08)
Care Management Credit	(5.24)	(5.18)	(4.42)	(5.54)	(5.58)	(0.04)
Total G & A Expenses	18.78	21.14	19.65	22.40	21.34	(1.06)
Total Operating Gain / (Loss)	7.75	(0.12)	(4.02)	(69.87)	(1.50)	(68.37)
Non Operating:						
Revenues - Interest	1.58	1.67	1.61	1.72	0.30	1.42
Total Non-Operating	1.58	1.67	1.61	1.72	0.30	1.42
Total Increase / (Decrease) in Unrestricted Net Assets	9.33	1.55	(2.41)	(68.15)	(1.20)	(66.95)

STATEMENT OF CASH FLOWS	MAR 17	APR 17	MAY 17	FYTD
Cash Flows Provided By Operating Activities				
Net Income (Loss)	318,463	(495,251)	(13,912,736)	(7,848,240)
Adjustments to reconciled net income to net cash provided by operating activities				-
Depreciation on fixed assets	47,452	44,777	29,082	544,494
Amortization of discounts and premium	(38,568)	(29,586)	(30,899)	(91,438)
Changes in Operating Assets and Liabilites				-
Accounts Receivable	537,654	6,205,223	(5,505,749)	63,414,323
Prepaid Expenses	67,758	257,979	(579,649)	(398,430)
Accounts Payable	(2,093,274)	(833,853)	918,201	77,984,634
Claims Payable	597,407	2,218,979	(93,120)	7,882,427
MCO Tax liablity	7,005,967	(14,012,903)	7,220,855	8,151,860
IBNR	3,211,641	4,024,297	(4,737,267)	(1,905,379)
Net Cash Provided by Operating Activities	9,654,501	(2,620,336)	(16,691,283)	147,734,252
Cash Flow Provided By Investing Activities				
Proceeds from Restricted Cash & Other Assets				-
Proceeds from Investments	30,000,000	20,000,000		95,000,000
Proceeds for Sales of Property, Plant and Equipment				-
Payments for Restricted Cash and Other Assets				-
Purchase of Investments	(37,105)	(40,147,814)	(127,727)	(150,936,642)
Purchase of Property and Equipment	-	-	131,168	(256,729)
Net Cash (Used In) Provided by Investing Activities	29,962,895	(20,147,814)	3,441	(56,193,371)
Cash Flow Provided By Financing Activities				
None				-
Net Cash Used In Financing Activities	-	-	-	-
Increase/(Decrease) in Cash and Cash Equivalents	39,617,397	(22,768,151)	(16,687,842)	91,540,881
Cash and Cash Equivalents, Beginning of Period	235,471,944	275,089,340	252,321,190	144,092,466
Cash and Cash Equivalents, End of Period	275,089,340	252,321,190	235,633,348	235,633,348

GOLD COAST HEALTH PLAN

Membership - Rolling 12 Month

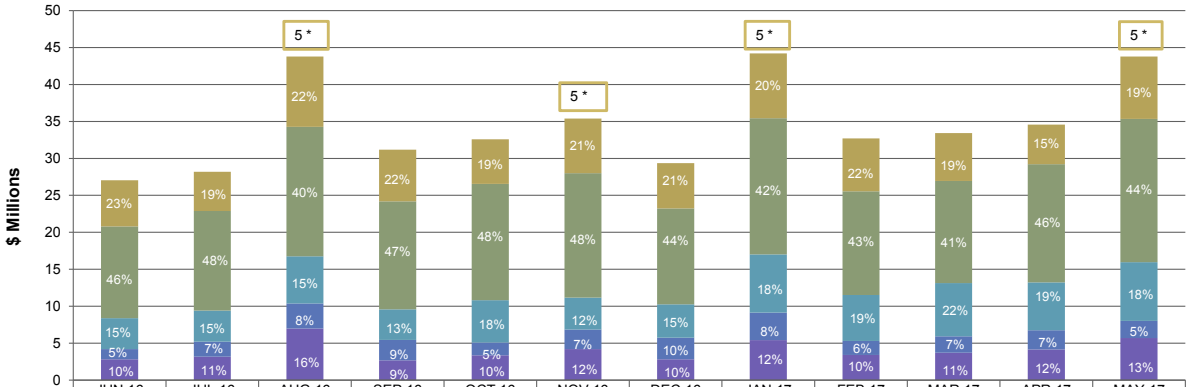


	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	Budget May 17
Total	208,533	208,714	208,680	208,690	209,381	208,890	208,148	206,664	206,970	205,829	205,106	204,140	214,278
FAMILY	93,158	93,007	92,221	92,213	92,364	91,653	91,071	90,477	90,911	90,456	89,311	88,281	97,861
DUALS	19,147	19,224	19,259	19,481	19,381	19,376	19,250	19,352	19,213	19,329	19,401	19,375	20,007
SPD	10,577	10,645	10,406	10,095	10,438	10,277	10,282	10,246	10,321	10,326	10,319	10,219	10,741
TLIC	28,952	29,209	29,672	29,511	29,858	29,788	30,238	29,858	29,682	29,038	29,495	29,831	30,113
AE	56,699	56,629	57,122	57,390	57,340	57,796	57,307	56,731	56,843	56,680	56,580	56,434	55,556

SPD = Seniors and Persons with Disabilities TLIC = Targeted Low Income Children AE = Adult Expansion

GOLD COAST HEALTH PLAN
MAY 2017

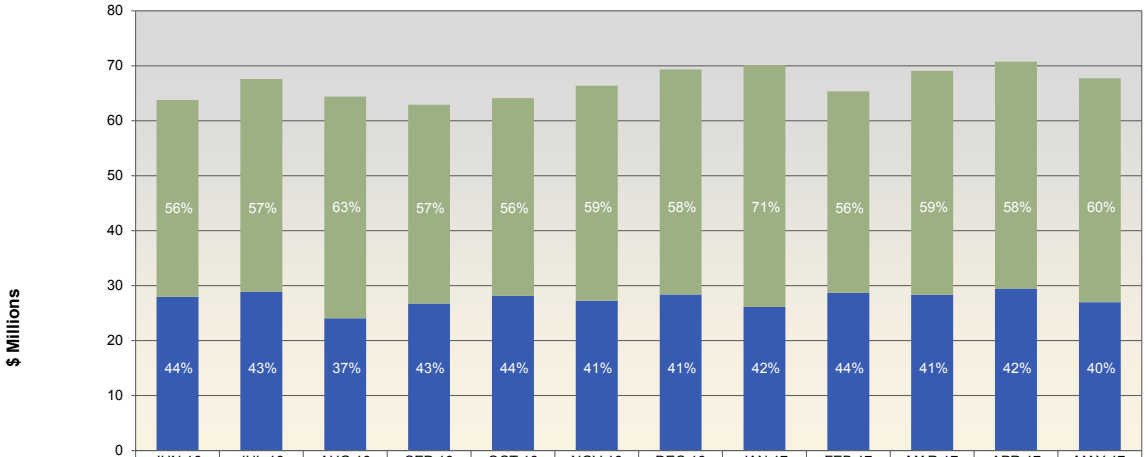
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	MAY 17
Current	6.24	5.31	9.51	6.99	6.03	7.39	6.12	8.76	7.17	6.49	5.35	8.44
30	12.42	13.47	17.52	14.62	15.73	16.84	12.98	18.43	14.01	13.80	16.01	19.39
60	4.18	4.23	6.38	4.15	5.73	4.32	4.51	7.87	6.24	7.21	6.47	7.96
90	1.38	2.03	3.38	2.75	1.73	2.64	2.92	3.73	1.87	2.23	2.59	2.31
120+	2.81	3.17	6.99	2.68	3.36	4.21	2.82	5.42	3.42	3.70	4.16	5.69

Note: Paid Claims Composition - reflects adjusted medical claims payment lag schedule.
Months Indicated with 5* represent months for which there were 5 claim payments. For all other months, 4 claim payments were made.

IBNP Composition (excluding Pharmacy and Capitation)



	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	MAY 17
Prior Month Unpaid	35.80	38.68	40.34	36.17	35.98	39.12	40.94	43.98	36.66	40.73	41.27	40.74
Current Month Unpaid	27.96	28.92	24.06	26.74	28.14	27.26	28.41	26.14	28.68	28.34	29.47	26.99
Total Unpaid	63.77	67.60	64.40	62.91	64.12	66.38	70.12	62.14	65.34	69.07	70.74	67.73
Current Month Unpaid	56%	57%	63%	57%	56%	59%	58%	71%	56%	59%	58%	60%
Prior Month Unpaid	44%	43%	37%	43%	44%	41%	41%	42%	44%	41%	42%	40%

Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: August 21, 2017

SUBJECT: Quality Improvement Committee Report

RECOMMENDATION:

To accept and file the Quality Improvement Committee 2017 Second Quarter Report.

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Quality Improvement Committee Report

Second Quarter 2017

Commission Meeting August 21, 2017

Nancy Wharfield, MD, CMO

Integrity
Accountability
Collaboration
Trust
Respect

Quality Improvement

Legend:

Met or exceeded Benchmark

Did not meet Benchmark

Measure	Description	Benchmark Source	Benchmark	2014	2015	2016	2017 Q1	2017 Q2	Quarterly Trend	Interventions
Facility Site Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS site audit criteria met.	DHCS/ Title 22	80%	**99%**	**92%**	**99%**	**96%**			
Facility Site Audit (Medi-Cal) - Compliance	The percentage of providers that passed facility audits without or following completion of a corrective action plan.	DHCS/ Title 22	NA	**100%**	**100%**	**100%**	**100%**			
Medical Record Quality Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS medical record audit criteria met.	DHCS/ Title 22	80%	**96%**	**88%**	**94%**	**96%**			
Medical Record Quality Audit (Medi-Cal) - Compliance	The percentage of providers that passed medical record audits without or following completion of a corrective action plan.	DHCS/ Title 22	NA	**100%**	**88%**	**100%**	**100%**			
Coordination of Care	The overall percentage of applicable DHCS Coordination of Care criteria met as determined by medical record audits.	NA	Tracking	**100%**	**93%**	**99%**	**83%**			On site instruction at time of medical record audit.
IHA Monitoring	The overall percentage of all IHA criteria met	DHCS	100%	**NR**	**NR**	**21%**	**7%**			Written instruction with each monthly audit. 1 on 1 training to new provider sites. Group presentations to staff & provider groups when needed and/or requested.

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Approval of Work Plans and Program Description

Review and approval of GCHP's: (see attached documents)

- 2016 Quality Improvement Work Plan Evaluation
- 2017 Quality Improvement Program Description
- 2017 Quality Improvement Work Plan

Review and approval of Kaiser's:

- 2016 Quality Improvement Work Plan Evaluation
- 2017 Quality Improvement Program Description
- 2017 Quality Improvement Work Plan

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Other Quality Improvement Activities

1. Initial Health Assessment (IHA) Monitoring – an IHA is to be done on any new member within 120 days of enrollment in GCHP. DHCS expects the Plan to monitor for compliance.

   The GCHP goal is 90% compliance.

   797 records reviewed; 468 passed (59%) and 329 scored below the goal (41%). Primary reasons for failing the IHA monitoring are absent or incomplete Staying Healthy Assessment and age appropriate preventive health screenings. Clinics received counseling regarding the reasons for failure – including a copy of the audit form and explanation, clinic staff training, 1 on 1 training of new staff.

Facility Site Reviews – new providers are reviewed at time of contracting, and existing primary care providers are reviewed every 3 years.

- 2 new sites were reviewed.
- 23 periodic and interim sites were reviewed and all passed.
- 1 corrective action plan was issued and closed.

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Smoking cessations – screening for smoking and counseling and offering treatment.

DHCS requires managed care plans to screen for smoking and if positive provide counseling to stop and offer cessation treatments

Chart Reviews conducted – 101 age 18 and older

99% screened

47% positive for smoking

30% given cessation counseling

17% offered cessation medication

GCHP QI Dept. provides counseling to offices regarding smoking cessation.

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Approval of Updated Quality Policies

The Quality Improvement Committee approved updated versions of the following policies:

1. QI-030 Provider Preventable Conditions Reporting

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Compliance Delegation Oversight

Delegation Oversight : Assessment of Delegated Quality Activities								
Legend:								
Met or exceeded Benchmark								
Did not meet Benchmark								
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**Quarterly Trend**	**Interventions**
Delegation of UM	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 5; NCQA Standard UM 15	DHCS Contract	**100%**[1]	**100%**[4]	**100%**		
Delegation of CR	Number required & percentage of current delegates assessed	Exhibit A, Attachment 4; NCQA Standard CR 9	DHCS Contract 10-87128	**100%**[2]	**100%**[5]	**100%**		
Delegation of QI	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard QI 12	DHCS Contract	**100%**[3]	**100%**[6]	**100%**		
Delegation of RR	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard RR 7	DHCS Contract	**100%**[3]	**100%**[6]	**100%**		
Delegation of Claims	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 8	DHCS Contract	**100%**	**100%**[7]	**100%**		

[1]2015 data available for Q2 and Q4 only.
[2]2015 data available for Q1 and Q2 only.
[3]2015 data available for Q1 and Q4 only.
[4]2016 data available for Q1, Q2 and Q3
[5]2016 data available for Q1 and Q4 only.
[6]2016 data available for Q4 only.
[7]2016 data available for Q2, Q3 and Q4

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Delegation Oversight Updates

Beacon Health Options

1. A corrective Action Plan (CAP) was issued to Beacon on April 11, 2017. On May 2, 2017 Beacon acknowledged the Plan's findings. Staff continues monthly desk audits and will continue until there is a minimum of three months of sustained compliance
2. A CAP was issued on April 3, 2017 as a result of Utilization Management and Member rights and Responsibilities audit done on February 20, 2017. A response letter was received on April 12, 2017 and the Cap was closed.
3. The CAP for call center problems issued in Dec. 2015 was closed.
4. Vision Service Plan (VSP) – found to be out of compliance in several areas. Notice has been given and a follow-up audit will be done.

Pharmacy

Pharmacy									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Responsible Department**	**Compliance Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**Quarterly Trend**	**Interventions**
PA Accuracy	All prior authorization requests were decided in accordance with GCHP clinical criteria.	Pharmacy	DHCS Contract	99%	**98%**	**98.76%**	**99%**		Weekly meetings with the PBM to clarify criteria and expectations for the decisions. Any approvals that the plan believes should have been denied, will remain and not be overturned. Any denials that the plan believes should have been approved are overturned and the member and physician are made aware of the approval.
PA Timliness	All prior authorization requests were completed within 1 business day.	Pharmacy	DHCS Contract	99%	**98%**	**100%**	**100%**		
Appropriate Decision Language on PA	All denied prior authorization requests contained appropriate and specific rationale for the denial	Pharmacy	DHCS Contract	99%	**98%**	**99.54%**	**99%**		GCHP is reviewing the denial language that is sent out and making revisions to the pre-set language as needed; this is an annual exercise and will continue going forward. Existing interventions include a second review of the language for all spelling, punctuation and grammar checks.
Annual Review of all UM Criteria	The P&T committee must review all utilization management criteria at least annually.	Pharmacy	GCHP	Met	**Met**	**Met**			
Review of New FDA Approved Drugs	The P&T committee must review all new FDA approved drugs and/or all drugs added to the Medi-Cal FFS Contract Drug List.	Pharmacy	DHCS Contract	Met	**Met**	**Met**			

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Pharmacy and Therapeutics

Newly Approved Drugs and Formulary Management

8 New Drugs or new drug combinations were reviewed:

- 4 approved to be added to the formulary because they provide significant clinical advantages.
- 4 drugs were denied formulary placement as not providing a significant new therapy.

Opiate Program for Appropriate Treatment of Pain

It was reported to the committee that the Plan has begun providing Opiate Toolkits to over 300 providers identified as prescribing opiate medications in 2016. In addition the number of opiate prescriptions adjusted for membership has decreased about 16% compared to 2 years ago.

Drug Utilization Policy – approved the DHCS required policy.

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Credentials/Peer Review

Credentials								
Legend:								
Met or exceeded Benchmark								
Did not meet Benchmark								
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**Quarterly Trend**	**Interventions**
Access Indicators								
Monitoring of Medicare/Medicaid sanctions	An OIG query is performed on every provider at the time of intitial and re-credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	100%		
Monitoring of sanctions and limitations on licensure	An Medical Board of California (MBOC) query is performed on every provider at the time of initial and re-credentialing. Other state licensing boards are also queried as needed	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	100%		
Monitoring of Complaints	Member complaint data is considered during re-credentialing.	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	NA	NA	NA		
Monitoring of adverse events	Quality of Care concerns are reviewed at a minimum of every 6 months and are forwarded to Credentials/Peer Review Committee (CPRC) as indicated.	DHCS/ Title 22	Biannually	100%	100%	100%		
	HIPDB queries are performed within 180 days prior to the date of initial and re-credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	100%		
Timeliness of provider notification of credentialing decisions	Providers will be notified of the credentialing decision in writing within 60 days	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	100%		
Timeliness of verifications	All credentialing verifications are performed within 180 days prior to the credentialing date, as required	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	98%	98%	99%		GCHP Compliance changed the audit tool used by Credentialing from NCQA to ICE which requires audits within 180 days instead of the historical 365 days. Any historical files that were previously on a 365 day audit cycle will transistion to a 180 days audit and be caught up over the next 2 quarters.
# of provider terminations for quality issues	Credentials/Peer Review Committee (CPRC) denial of a credentialing application for quality issues will cause termination of the provider from the network	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	None	None	None		

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Credentials/Peer Review

Credentials								
Legend:								
Met or exceeded Benchmark								
Did not meet Benchmark								
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**Quarterly Trend**	**Interventions**
Access Indicators								
Timeliness of processing of initial applications	Initial applications will be processed within 90 days	DHCS/ Title 22	Standard met for 90% of applications received	**93%**	**97%**	**99%**		
Timeliness of processing of re-credentialing applications	Recredentialing applications will be processed within 90 days	DHCS/ Title 22	Standard met for 90% of applications received	**95%**	**96%**	**98%**		
Quality Indicators (under NMC purview)								
Timeliness of Physician Recredentialing	Percent of physicians recredentialed within 36 months of the last approval date	NCQA: CR Standards	Standard met for 90% of providers	**93%**	**94%**	**99%**		
Continuous Monitoring of Allied Providers	Percent of allied providers' expirable elements that are current	NA	Standard met for 90% of elements	**100%**	**100%**	**100%**		
Timeliness of Organization Reassessment	Percent of organizations reassessed within 36 months of the last assessment	NCQA: CR Standards	Standard met for 90% of providers	**98%**	**95%**	**100%**		

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Credentials/Peer Review

Policy review and approval:

Approved an updated Policy for Organizational Providers to include Free-Standing Birth Centers in the policy.

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Credentials/Peer Review

Monitoring of Medical Board of California (MBC) Actions against GCHP Providers - unchanged

- 3 providers on probation by the Medical Board of California (MBC) - unchanged
- 3 providers with accusations, but no action taken by the MBC – 1 provider's case was completed with a public reprimand and the requirement to take a Professionalism Course within 90 days.
- 1 provider arrested for issues of prescribing controlled medications. The provider has no actions by the MBC and the legal action is pending with a date set for June 21, 2017

Credentials/Peer Review

Credentialing

- 23 new providers were approved.
- 1 provider (midlevel) who was pended from the previous quarter to research the appropriateness of procedures was approved following the Plan's receiving information on her experience and proctoring.
- 49 providers were recredentialed.
- 1 facility is pended for recredentialing pending research into the facility's compliance with new accreditation policy requirements.

Peer Review

- 10 new PQI cases
- 3 cases incomplete and pending
- 1 case rated a "3" for system issues. This involved a delay in a member receiving a single source specialty medication. There was a breakdown at several levels. A conference call meeting was held involving all entities to determine solutions to prevent reoccurrence.

Cultural and Linguistics

Cultural & Linguistics (C&L)							
Legend:							
Met or exceeded Benchmark							
Did not meet Benchmark							
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2016**	**2017 Q1**	**Quarterly Trend**	**Interventions**
Sign Language Services	Percent of sign language services fulfilled	DHCS/Title 22	100%	89%	100%		

[1] 2016 Q1 Rate corrected due to calculation error
[2] 2016 Q3 & Q4 Rates include requests that were cancelled and fulfilled after appointment was rescheduled

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Health Education, Cultural Linguistic Services

Outreach and Education Activities

April and May 2017:

- Events – 34
- Participants contacted – 3000

Interpreter and Translation Services (2 mo):

- Telephonic Interpreter – 520
- Sign Language Interpreter Services – 73
- In-Person Interpreter Services – 9
- Translation Services – 27 requests

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Grievance and Appeals

Grievance & Appeals								
Legend:								
Met or exceeded Benchmark								
Did not meet Benchmark								
Measure	**Description**	**Compliance Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**Quarterly Trend**	**Interventions**
Resolution Turnaround Times (TAT) Grievances	100% TAT within 30 calendar days	GCHP	100%	76%	99%	77%		Due to misrouted correspondence it caused a delay in the case review process. Continuously working towards training and educating Conduent on correctly routing correspondence to prevent these delays.
Post Service TAR Provider Appeals Processing Time - Resolution	The percentage of provider appeals processed within 30 business days from receipt.	GCHP	100%	100%	99%	97%		
Provider Grievances: Complaint, Appeal, or Inquiry	Timely resolution of provider grievances	GCHP	100%	66%	99%	99%		
Monitoring of Complaints	Member complaints are monitored at a minimum of every six months to assess for trends/outliers	GCHP	Monitoring	100%	100%	100%		

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Grievance and Appeals

Grievances Received – 1st Quarter 2017

Total Grievances – 551 total

- 517 Administrative Grievances: top reason – Claims billing disputes 508
- 34 Clinical – Top 3 are – 30 quality of care

Clinical Appeals – 12 cases: 5 upheld, 6 overturned, 0 pending, 1 withdrawn

State Fair Hearings – cases: 3 – all dismissed

Quality Workgroup Reviews – 5 referred for PQI

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Member Services

Call Center Statistics – 1st Quarter 2017

Member Services								
Legend:								
Met or exceeded Benchmark								
Did not meet Benchmark								
Measure	**Description**	**Compliance Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**Quarterly Trend**	**Interventions**
Call Center - Aggregate Average Speed of Answer (ASA)	Average Speed to Answer (in seconds)		<= 30 seconds	**57.5**	**29.5**	**23.0**		
Call Center - Aggregate Abandonment Rate	Percentage of aggregate Abandoned calls to Call Center		<= 5%	**16.7%**	**1.30%**	**1.30%**		
Call Center - Aggregate Call Center Call Volume	Monitored to ensure adequate staffing and identification of systemic issues.			117,039	121,068	34,882		
Call Center - IVR Satisfaction Survey	Combined percentage of callers who answered "Very Helpful" and "Helpful" to their IVR satisfaction				80.29%	83.69%		

Member Services

- Interactive Voice Response (IVR) optimization second phase – satisfaction survey – 1508 callers completed the survey – 81% indicated that the IVR was “helpful” or “very helpful”. 67% were providers. Member services will reach out to those callers who indicated that the IVR was “not helpful”

- Call metrics – average speed to answer, and abandonment rate goals were met.

Network Operations

Network Operation QI Dashboard - Access and Availability										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**Quarterly Trend**	**Interventions**
Access to Network / Availability of Practitioners										
# & geographic distribution of PCPs	Network of PCPs located within 30 minutes or 10 miles of a member's residence to ensure each member has a PCP who is available and physically present at the service site for sufficient time to ensure access for assigned members upon member's request or when medically required and to personally manage the member on an on-going basis.	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members	Met	**Met**		**99.9%**	**99.9%**		
# & geographic distribution of SCPs	Adequate numbers and types of specialists within the network through staffing, contracting, or referral to accommodate members' need for specialty care.	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members	Met	**Met**		**99.6%**	**99.6%**		
Ratio of members to physicians	1:1200	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members	Met	**Met**		**1:193**	**1:217**		
Ratio of members to PCPs	1:2000	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members	Met	**Met**		**1:867**	**1:848**		

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Network Operations

Network Operation QI Dashboard - Access and Availability								
Legend:								
Met or exceeded Benchmark								
Did not meet Benchmark								
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**Quarterly Trend**	**Interventions**
Access to Network / Availability of Practitioners								
After Hours Access	After-hours machine messages or service staff is in threshold languages	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members					Provider After-Hour (SPH Analytics) Script missing language threshhold, therefore not surveyed. Will include in next survey, also remind those who did not meet timely access After-Hours standard recordings must be in English and Spanish.
	After-hours answering machine message or service includes instructions to call 911 or go to ER in the event of an emergency	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members	NA		71.2%		
Time Elapsed Standards	Urgent Care appointments for services that do not require prior authorization: within 48 hours of the request for appointment	DHCS, Exhibit A, Attachment 9	Standards met for minimum of 90% of providers	NA		100%		Based on DMHC standard of 48 hrs.
	Non-urgent appointments for primary care: within 10 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA		90.2%		
	Non-urgent appointments with specialist physicians: within 15 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA		48.4%		48.4% Specialist Physcian's met the criteria however still fell short of benchmark. Providers who did not meet standards efforts initiated to identify to discuss findings and alternatives.
	Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA		23.5%		Only 23.5% of Ancillary service type surveyed met criteria. Providers who did not meet standards efforts initiated to identify to discuss findings and alternatives.

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Network Operations

Network Operation QI Dashboard - Access and Availability								
Legend:								
Met or exceeded Benchmark								
Did not meet Benchmark								
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**Quarterly Trend**	**Interventions**
Access to Network / Availability of Practitioners								
Appointment Availability	Availability of appointments within GCHP's standards by type of encounter	DHCS, § 7.5.4	Standards met for minimum of 95% of providers	NA				In discussion with vendor to repeat survey for Q2
Provider Surveys	Measure provider satisfaction	GCHP	Satisfaction expressed in each of 6 areas for 80% of providers	**Not Met**				In discussion with vendor to repeat survey for Q2
Provider Training	Number of new PCPs / Providers receiving orientation within 10 days of contracting (Note: Provider is offered an orientation within 10 days, but may be completed within 30 days, or if provider declines training, a declination req'd)	DHCS Exhibit A, Attachment 7	100% within 10 days of contracting	**Met**	**100%**	**100%**		
Provider Visits	Number of Provider Services Representative provider visits	GCHP	Department goal = 100/quarter (400/year)	**Met**	**392**	**95**		Slight decrease in department goal per quarter due to critical regulatory project (274) as well as a departure of one of the provider reps.

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Network Operations

After Hours Survey Q1, 2017

Purpose – to ensure that providers have a communication protocol that assists members after regular hours

- 954 providers surveyed (275 primary care, 679 specialists)
- 93.6% of calls were answered by a live agent or recorded message/auto attendant.
- 93.7% gave advise to call 911 or go to the nearest ER if it was an emergency.
- GCHP will reach out to the 6% that did not answer and repeat the survey later in the year.

Health Services

Utilization Management Committee

Utilization Management												
Legend:												
Met or exceeded Benchmark												
Did not meet Benchmark												
Health Services												
UM Authorization Processing Time												
Measure	**Description**	**Responsible Department**	**Benchmark Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**2017 Q2**	**2017 Q3**	**2017 Q4**	**Quarterly Trend**	**Interventions**
Turn around time for standard prior authorization	Percentage of requests processed ≤ 5 working days from receipt of information necessary to make the determination.	Health Services	NCQA; contract, Title 22	95%	**98.10%**	**98.33%**	**98.86%**				-	
Turn around time for expedited prior authorization	Percentage of authorizations processed within 3 days of receiving the request	Health Services	NCQA; contract, Title 22	95%	**98.66%**	**98.43%**	**98.82%**				-	
Turn around time for post service	Percentage of decisions made within 30 calendar days of receipt of request (NCQA, contract, Title 22)	Health Services	NCQA; contract, Title 22	95%	**96.78%**	**98.04%**	**99.00%**				-	
Care Management Workload												
Measure	**Description**	**Responsible Department**	**Benchmark Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**2017 Q2**	**2017 Q3**	**2017 Q4**	**Quarterly Trend**	**Interventions**
Total Careplans Opened	Number of care plans opened during specific reporting period. (excludes DM, Health Ed, Health Nav)	Health Services	N/A	N/A	309	291	238				-	
Total Careplans Closed	Number of care plans closed during specific reporting period. (excludes DM, Health Ed, Health Nav)	Health Services	N/A	N/A	293	280	270				-	
Average Careplans in Case Load	Average number of careplans active during specific reporting period (CM only)	Health Services	N/A	N/A	175	236	201				-	

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Utilization Management

- Turn around times meet or exceed goals and State requirements.
- Utilization measures – Hospital admits, hospital days, ER visits, appeals, and denials remain in the same ranges.
- Specialty Referrals – Monthly audits of specialty referrals for member visits fulfilled – 99% of authorizations approved resulted in the member being seen. Those that are identified as not being seen are referred for follow-up by care management.
- Approved the 2017 UM Program Description and work Plan

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Medical Advisory Committee

Medical Policy Approvals:

- American Diabetes Assn. Diabetes Clinical Guidelines 2017
- Intravenous Sedation and General Anesthesia for Dental Services Guidelines
- Home Health Guideline

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kim Osajda, Quality Improvement Director

DATE: August 21, 2017

SUBJECT: 2016 Quality Improvement Work Plan Evaluation
2017 Quality Improvement Program Description
2017 Quality Improvement Work Plan

SUMMARY:

A managed care health plan is expected to have a Quality Improvement Program Description, a yearly Quality Improvement Work Plan, and do a written review of the accomplishments of the year's work plan at years end. These documents must be presented to the Commission and be approved by the Commission. The 2016 Quality Improvement Work Plan Evaluation, the 2017 Quality Improvement Program Description and the 2017 Quality Improvement Work Plan are presented here.

BACKGROUND:

The Department of Health Care Services requires contracted managed care plans to have a yearly quality improvement program description and a yearly quality improvement work plan. In addition, it is required that each managed care plan do an evaluation of the year's work plan at the end of the year.

RECOMMENDATION:

GCHP is requesting the Commission's approval of the 2016 Quality Improvement Work Plan Evaluation, the 2017 Quality Improvement Program Description, and the 2017 Quality Improvement Work Plan.

ATTACHMENTS:

2016 Quality Improvement Work Plan Evaluation
2017 Quality Improvement Program Description
2017 Quality Improvement Work Plan

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Quality Improvement Program Evaluation Executive Summary

2016

Al Reeves, M.D.

Chief Medical Officer

Approved June 20, 2017 by Quality Improvement Committee (QIC)

Approved June XX, 2017 by Ventura County Medi-Cal Managed Care Commission (VCMMCC)

Overview

The overall goal of the 2016 Gold Coast Health Plan Quality Improvement (QI) Program Evaluation is to assess the effectiveness of the organization's QI Program with respect to quality, accessibility, safety of clinical care, quality of service, and member experience. Committees, departments and data analysts annually analyze and evaluate the effectiveness of the prior year's Quality Improvement Work Plan.

Oversight and Approval

The annual QI Program Evaluation is reviewed and approved annually by the Quality Improvement Committee (QIC). Committee members and department managers provide input for the evaluation.

The annual QI Work Plan serves as the roadmap for the QI Program, lists measurable objectives for key indicators, and includes interventions to improve performance. The QI Work Plan is developed largely from recommendations from the annual QI Program Evaluation. Areas of significant focus include partially resolved and unresolved activities from the previous year. These activities include clinical and service improvement activities that have the greatest potential impact on quality of care, service and patient safety. The work plan also reflects the contractual requirements of GCHP.

The Chief Medical Officer reviews the 2016 QI Program Evaluation, 2017 QI Program Description and 2017 QI Work Plan with the Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) that is accountable to review and approve these documents.

Overall Effectiveness Summary

Adequate resources were dedicated to program activities. The resources and infrastructure were adequate to support a positive impact on the care and quality of services of the Plan's members. Highlights of the quality accomplishments for clinical and service performance include:

- Implemented a texting pilot to engage members in the Diabetes Disease Management (DM) Program (may to July)
- Hired two Registered Nurses for health coaching of members in the DM Program
- Launched the Asthma Home Assessment Pilot, targeting 50 high-risk GCHP members with asthma.
    - Target population is members with 2+ ED visits/hospitalization for asthma within one year. Program provides in-home asthma education, trigger identification and asthma supplies and appropriate cleaning solutions and materials. Community Health Worker accompanies members to a PCP visit to make sure Asthma Action Plan is current and understood by

member. PCP visit also addresses health system navigation and issues of health literacy.

- Successfully developed and implemented two mandatory Department of Health Care Services (DHCS) Improvement Projects for the following HEDIS® measures; Cervical Cancer Screening and Well Child Visits in the Third, Fourth, Fifth and Sixth Years.
- Successfully implemented the first of two DHCS Performance Improvement Projects (PIP) in collaboration with a clinic partner; improve the rates of immunizations for two year olds.
- Successfully implemented the second of two DHCS Performance Improvement Projects (PIP) in collaboration with a clinic partner; improve the utilization of standardized child developmental screening tools during well-child exams.

The 2016 QI Work Plan Evaluation contains the detailed qualitative and quantitative analyses of the Plan's numerous initiatives and strategies to strengthen the QI Program and to provide direction to the 2017 QI Work Plan.

Performance Measure Results

HEDIS Results

GCHP is required to annually collect and report HEDIS® measures and are selected by the Department of Health Care Services Medi-Cal Managed Care Division (DHCS-MMCD).

DHCS sets a Minimum Performance Level (MPL) and a High Performance Level (HPL) for each required measure. To establish the HPLs and MPLs, DHCS uses the National Committee of Quality Assurance (NCQA) Quality Compass HEDIS® 2016 national Medicaid benchmarks. The Quality Compass HEDIS® 2016 national Medicaid benchmarks reflects the previous year's benchmark percentiles. Performance levels are based on the prior year's HEDIS® reporting from all NCQA national Medicaid plans. MPLs and HPLs align with NCQA's national Medicaid 25th percentiles and 90th percentiles respectively.

DHCS annually assesses GCHP's performance against the established MPL and requires the plan to submit an improvement plan (IP) for each measure with a rate below the MPL.

Below are the HEDIS® measures that were a focus for quality improvement during 2016:

- Appropriate Testing for Children with Pharyngitis (not reportable to DHCS)

- Appropriate Treatment for Children with Upper Respiratory Infection (not reportable to DHCS)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Cervical Cancer Screening (DHCS IP)
- Children and Adolescents Access to Primary Care
- Counseling for Nutrition for Children and Adolescents
- Counseling for Physical Activity for Children and Adolescents
- Immunizations for Adolescents
- Postpartum Care
- Well Child Visits in the Third, Fourth, Fifth and Sixth Years (DHCS IP)

The following measures improved resulting in these measures moving from the 25th percentile in 2015 MY to the 50th percentile in 2016 MY:

- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Use of Imaging Studies for Low Back Pain
- Timeliness of Prenatal Care
- Postpartum Care

Cervical Cancer Screening improved 3.89% and is now 6.24% above the MPL.

The rate for All Cause Readmissions improved from 15.77% in 2015 to 14.70% in 2016.

GCHP's performance on the following HEDIS® measures also improved in 2016 when compared to 2015:

- Children and Adolescent's Access to Primary Care Practitioners
    - 25 months – 6 years
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- All-Cause Readmission
- Appropriate Testing for Children with Pharyngitis

The rate for *Appropriate Treatment for Children with Pharyngitis* improved significantly (8.00%) in 2016 but remains below the 25th percentile.

Notable Declines

The following HEDIS® measures and sub-measures saw rate declines, some significant, compared to the previous measurement year resulting in these measures falling below the Department of Health Care Services (DHCS) Minimum Performance Level (MPL). These declines will result in a mandatory DHCS Improvement Project.

- Annual Monitoring for Patients on Persistent Medications (MPM)
  - ACE Inhibitors or ARBS ↓ 1.85%; 0.54% below MPL
  - Diuretics ↓ 2.23%; 0.05% below MPL
  - Total ↓ 1.79%; 0.26% below MPL
- Controlling Blood Pressure (CBP) ↓ 19.71%; 2.02% below MPL
- Comprehensive Diabetes Care (CDC)
  - Blood Pressure Control ↓ 17.03%; 3.6% below MPL
  - HbA1c Poor Control (>9) ↓ 16.79%; 2.24% below MPL
  - HbA1c Adequate Control (<8) ↓ 17.52%; 2.82% below MPL

Two additional measures also saw declines but remained above the MPL.

- Childhood Immunization Status ↓ 10.47%
- CDC Eye Exam (Retinal) ↓ 30.90%

The significant decline in the retinal eye exam can be partly contributed to the incorrect rate reported in 2015. During the administrative rate reconciliation between our new vendor and the previous vendor, this rate was unable to be reconciled. Despite extensive research and updated code mapping, a gap of 32.78% remained for the rate. GCHP submitted an extensive root cause analysis to our HEDIS® auditor at which time they determined that it was likely that the previous vendor had an error in the rate calculation.

GCHP's performance on the following HEDIS® measures declined slightly in 2016 when compared to 2015:

- *Weight Assessment: Counseling for Nutrition and Physical Activity*
- *Immunizations for Adolescents Combination #1*
- *Comprehensive Diabetes Care – Medical Attention for Nephropathy*
- *Comprehensive Diabetes Care – HbA1c Testing*
- *Children and Adolescent's Access to Primary Care Practitioners*
  - *12 - 24 months*
  - *7 - 11 years*
  - *12 - 19 years*
- *Appropriate Treatment for Children with Upper Respiratory Infection*

With the exception of the *Children and Adolescent's Access to Primary Care Practitioners ages 7 – 11 years and 12 – 19 years* all measures that saw slight declines remain above the MPL. All four *Children and Adolescents' Access to Primary Care* measures are not held to the MPL due to the small range of variation between the MPL and HPL threshold for each measure.

Those measures with significant declines will become the priority for GCHP in 2017.

Staff in the Quality Improvement (QI) department conducted an extensive review to determine the root cause of these declines. The review consisted of the following:

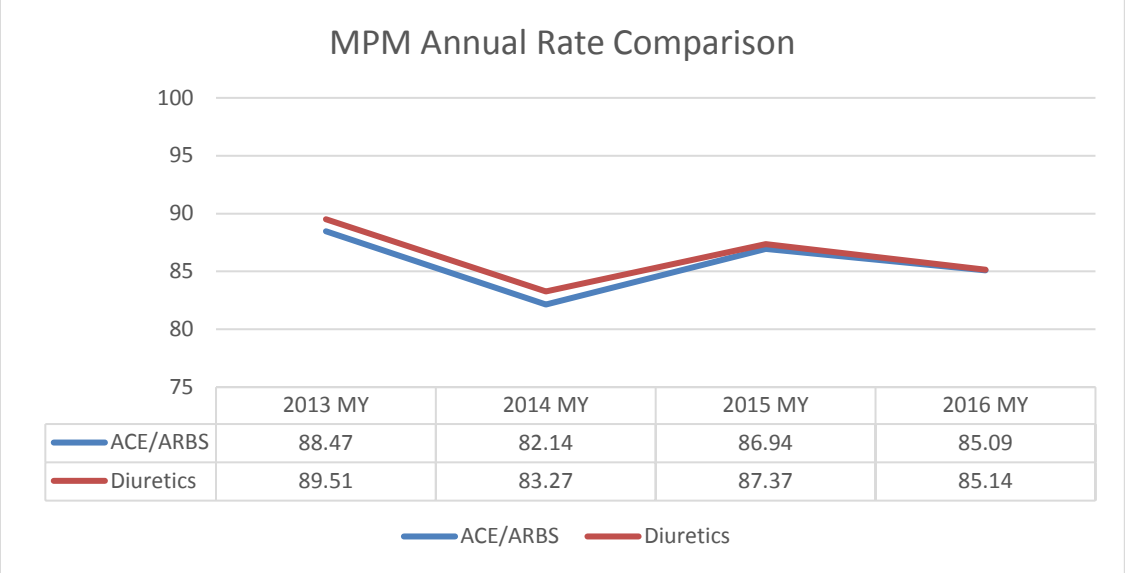
- chart reviews
- claim reviews
- research into our HEDIS vendor systems used for the medical record retrieval project
- project management of the record retrieval project

Results of this analysis is presented on the following pages.

Please refer to the tables on pages 14 - 16 which contains the rates for all HEDIS® measures that GCHP reports to DHCS (exception is *Appropriate Treatment for Children with Upper Respiratory Infection* and *Appropriate Treatment for Children with Pharyngitis* which GCHP chose to monitor as part of monitoring for over and underutilization).

Annual Monitoring for Patients on Persistent Medications (MPM)
This measure looks at the percentage of members 18 years and older on persistent medications who received annual monitoring of drugs. Although no specific clinical guideline recommendation on the frequency of monitoring exists, the specification for this measure indicates that annual monitoring represents a conservative standard of care and is supported by FDA drug labeling recommendations for each drug.

Monitoring requires at least one serum potassium and a serum creatinine therapeutic monitoring test during the year. A lab panel or separate tests will meet the criteria.



As indicated in the graph above there is a trend of increasing and decreasing rates every other year. ACE inhibitors or ARBs decreased by 1.85% (missing the MPL of 85.63 by 0.54%) and Diuretics decreased by 2.23% (missing the MPL of 85.19 by 0.05%).

QI staff conducted record reviews for two large clinic systems. Record reviews indicate that providers continue ordering these tests every other year or members are not going for the labs and there is no follow up by the provider. There were also significant amounts of records that indicated no labs were ordered. This pattern was also noted in 2014 when the rates fell below the MPL.

QI implemented a successful improvement project in 2015 that consisted of provider report cards and Performance Feedback Reports. Challenges faced with implementing the new HEDIS® vendor impacted QI's ability to implement a timely intervention to impact the MY2016 rates for this measure since we were unable to see the rate trends or generate current Performance Feedback Reports.

With the implementation of our new HEDIS® vendor QI is able to produce monthly prospective rates for all measures (administrative rates only). QI will generate and disseminate bi-monthly prospective report cards that will allow providers to see what their current rate is in comparison to the benchmark. In addition to these report cards, Performance Feedback Reports will be disseminated at least twice a year in conjunction with the prospective report cards.

Medical Record Retrieval Project

Medical record retrieval was problematic this year and impacted several measures.

Key findings are summarized below.

- Provider file was sent to the vendor that contained an error and caused a three week delay
- Shortened timeline to retrieve all required records
- Challenges with vendor's system
- Retrieval of large amount of records up until the record retrieval deadline

Compliance calculation is based on abstraction of data from the medical record. Therefore, if a medical record is not available for data abstraction, then the member is non-compliant for that measure. Chart review of all members where the vendor indicated there was no record revealed that there were records available for members that were not retrieved. The impact of this is noted below for each measure.

Controlling Blood Pressure (BP)

	Denominator	Hybrid Hits	Rate	MPL	2015	2015 – 2016 Rate Variance
Final	411	184	44.77	47.03	64.72	-19.95
Additional Records	411	214	52.06			-12.66

Comprehensive Diabetes Care (CDC) - BP Control

	Denominator	Hybrid Hits	Rate	MPL	2015	2015 – 2016 Rate Variance
Final	411	200	48.66	52.26	65.69	-17.03
Additional Records	411	241	58.63			-7.03

Had these records been retrieved, these measures would have exceeded the MPL.

Review of the data indicated that the largest number of reviews where there was no medical record attached was due to the record requests being sent to the incorrect provider. Based on the data reviewed it appears that there was an issue with the vendor identifying the larger clinic systems with their associated clinic site. While GCHP provided the vendor an associated clinic list, GCHP should have ensured the vendor

mapped the sites correctly prior to initiating the project. This will be reviewed prior to the next reporting season to ensure this issue doesn't occur in the next reporting season. GCHP will work with the vendor to ensure all records have been retrieved by actively reviewing the vendor's status report at the onset of the project. This will ensure all records have been received and ensures the requests are getting to the correct location.

HbA1c Screenings

It appears that there were two issues that contributed to the significant change in the HbA1c Poor Control (>9.0%) and HbA1c Control (<8.0%) sub-measures in the 2016 MY.

1. There was a significant underutilization of lab data in 2016 that resulted in the lowest number of administrative hits for the HbA1c Poor Control (>9.0%) and

   HbA1c Control (<8.0%) sub-measures since the 2013 when the health plan began utilizing five external lab data sources.

   The administrative hits for the HbA1c screening sub-measure was not impacted because most screenings are captured from different data sources, such as claims and encounter data.

2. The HEDIS® vendor did not retrieve 63 medical records which made these members non-compliant for all three HbA1c sub-measures.

The changes to the HbA1c Poor Control (>9.0%) and HbA1c Control (<8.0%) sub-measures does not appear to have been attributed to inadequate clinic care, but to data management issues. Of primary concern is the oversight of validating if all the health plan's data sources have been properly integrated into the HEDIS software because this impacts all HEDIS performance measures.

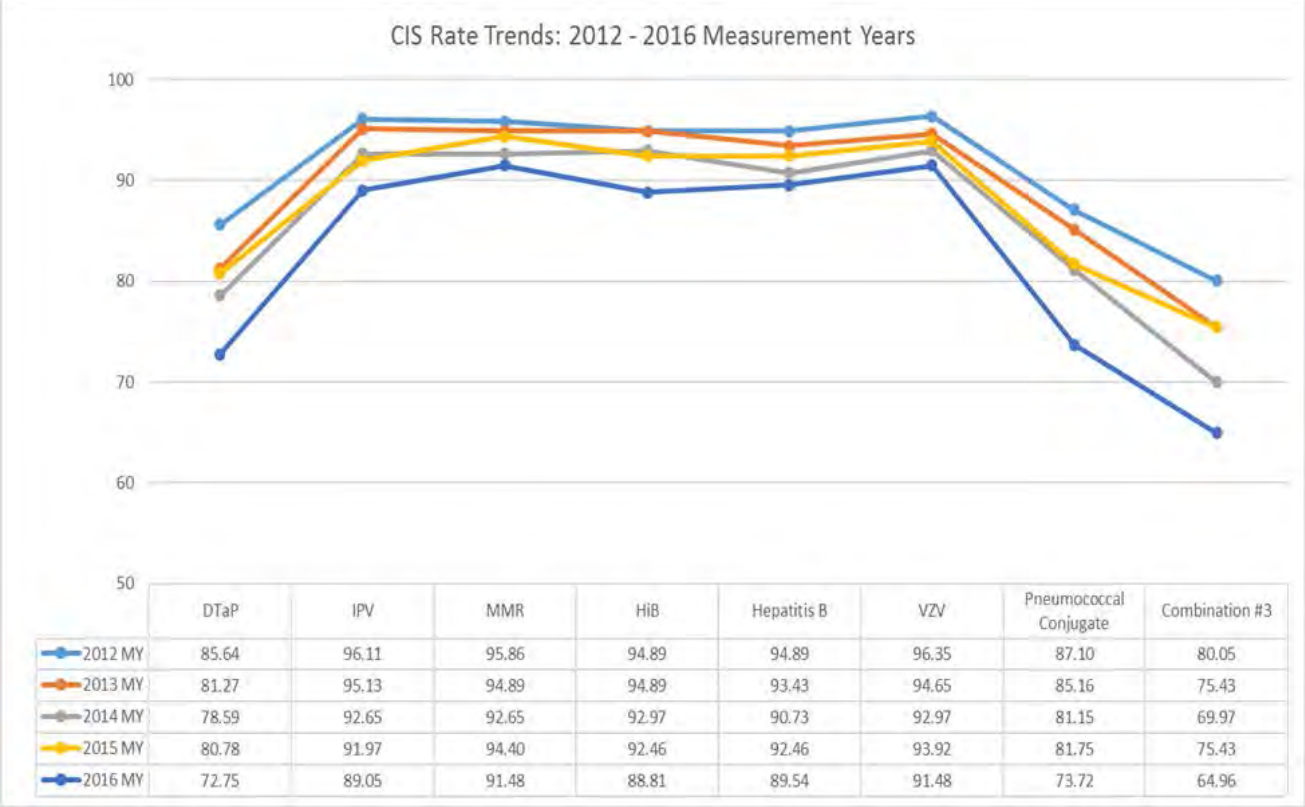
Childhood Immunization Status (CIS) Combo 3

The CIS Combo 3 performance measure which is a hybrid measure that evaluates the percentage of two-year old children who were administered a specific group of vaccines on or before their 2nd birthday. The CIS Combo 3 rates are based on a randomly selected sample of 411 children who turned two-years old during the measurement year. The seven vaccinations and required doses for each vaccine include:

- DTaP (4 doses)
- IPV (3 doses)
- MMR (1 dose)
- HiB (3 doses)
- Hep B (3 doses)
- VZV (1 dose)
- PCV (4 doses)

While the rates for Childhood Immunization Status Combo 3 remained above the MPL this measure also saw a significant decline of 10.47% over the previous year's rate of 75.43.

The graph below shows the trending for the CIS Combo 3 rates and demonstrates that immunization rates have been decreasing each year over the past five (5) measurement years. Pneumococcal Conjugate and DTaP have had the lowest compliance rates each year with a significant decline in 2016. In comparison, Hep B, HiB and IPV have better rates, but these rates have also declined each year.



	DTaP	IPV	MMR	HiB	Hepatitis B	VZV	Pneumococcal Conjugate	Combination #3
2012 MY	85.64	96.11	95.86	94.89	94.89	96.35	87.10	80.05
2013 MY	81.27	95.13	94.89	94.89	93.43	94.65	85.16	75.43
2014 MY	78.59	92.65	92.65	92.97	90.73	92.97	81.15	69.97
2015 MY	80.78	91.97	94.40	92.46	92.46	93.92	81.75	75.43
2016 MY	72.75	89.05	91.48	88.81	89.54	91.48	73.72	64.96

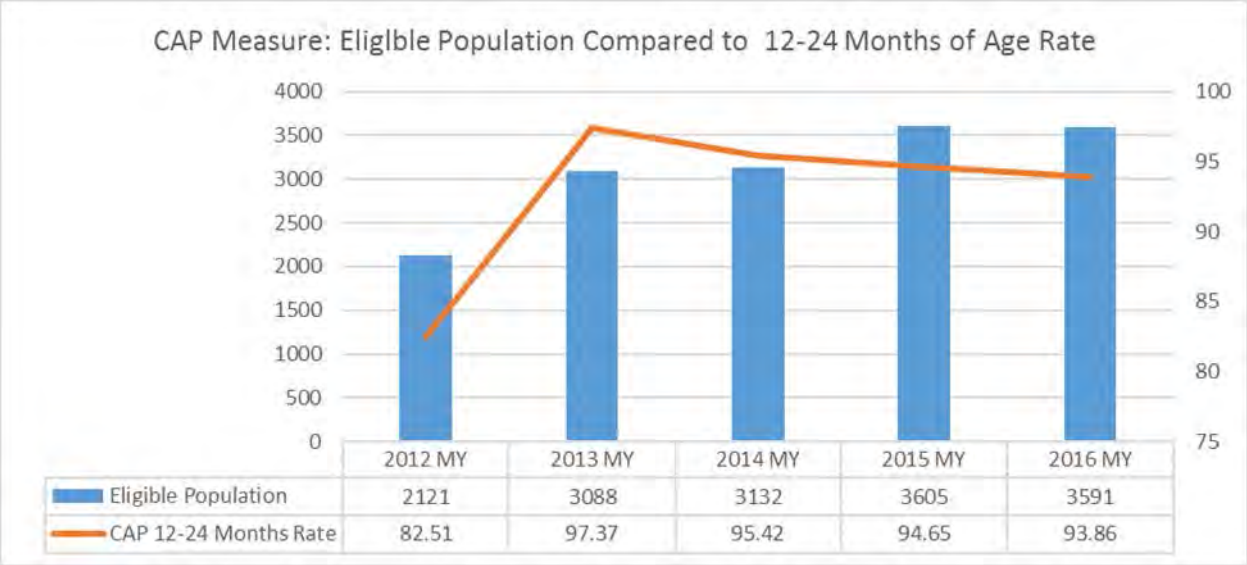
There appears to be an inverse correlation between the immunization rate and the number of doses required for each immunization (↑required doses → ↓rate).

- Pneumococcal Conjugate and DTaP rates have consistently been the lowest and each immunization requires four doses.
- Hep B, HiB and IPV have better rates and required three doses.
- MMR and VZV have the highest rates and require only one dose.

Additional research is needed to determine if vaccines with greater doses have lower rates due to missed administration or late administration after the 2nd birthday.

Staff then analyzed the impact of utilization rates for children 12 to 24 month of age (*Children and Adolescents' Access to Primary Care Practitioners - CAP*) on the decline in the CIS Combo 3 rates.

As noted in the graph below utilization rates exceed the immunization rates. This may indicate that children are going to the PCP but providers may be missing opportunities to administer immunizations while the child is in the office.



Based on the analysis, it appears that the reduced CIS Combo 3 rates is mostly attributed to children not receiving all required immunizations. More analysis is needed to determine if this is due to:

- Missed immunizations
- Immunizations administered after 2 years of age
- Higher dose immunizations incomplete

Access and Availability

GCHP met the access standards for primary care access and specialty care access.

The goal for after-hours availability was not met. Approximately 18% of the surveyed providers did not meet after-hours standards.

GCHP met the required availability ratios for practitioners as well as time and distance requriements.

GCHP's QI department completed an annual Six Month Member Access and Satisfaction Survey. There was an improvement of 2.5% in the aggregate (child and adult) score for overall appointment experience from 2015 to 2016. Ease of accessing

the care you need saw a slight improvement in the aggregate score of 1.3% from 2015 to 2016.

Provider Satisfaction

A Provider Satisfaction Survey was completed in late 2016. However, the results of that survey were determined to be of limited use given the poor response rate received from the primary care and specialty care providers. Network Operations is currently working with a vendor to field a new survey in the second quarter of 2017.

HEDIS Measure/Data Element	Domain of Care	2014	2015	2016	2015-16 Rate Difference	Current NCQA Percentile Ranking	2017 NCQA Percentile Ranking				
							10th	25th	50th	75th	90th
Effectiveness of Care: Prevention and Screening											
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	**Q**										
BMI Percentile		80.05	72.51	65.99	↓ 6.52	25th	40.14	54.5	67.54	77.78	86.37
Counseling for Nutrition		54.26	55.96	54.50	↓ 1.46	25th	42.92	51.84	62.65	70.88	79.52
Counseling for Physical Activity		41.85	49.88	48.66	↓ 1.22	25th	35.90	45.09	55.38	63.47	71.58
Childhood Immunization Status	**Q, A, T**										
DTaP		78.59	80.78	72.75	↓ 8.03	25th	66.89	72.51	77.97	82.24	85.15
IPV		92.65	91.97	89.05	↓ 2.92	25th	81.02	86.09	89.78	92.46	93.79
MMR		92.65	94.40	91.48	↓ 2.92	50th	83.76	87.86	90.47	92.70	94.25
HiB		92.97	92.46	88.81	↓ 3.65	25th	81.01	85.95	89.37	91.97	93.67
Hepatitis B		90.73	92.46	89.54	↓ 2.92	50th	79.16	85.64	90.05	93.19	94.81
VZV		92.97	93.92	91.48	↓ 2.44	50th	83.56	87.27	89.97	92.49	93.95
Pneumococcal Conjugate		81.15	81.75	73.72	↓ 8.03	25th	66.24	72.75	78.59	82.64	85.40
Combination #3		69.97	75.43	64.96	↓ 10.47	25th	57.84	64.3	71.06	75.60	79.81
Immunizations for Adolescents	**Q, A, T**										
Meningococcal		68.86	75.18	74.21	↓ 0.97	25th	58.48	67.26	77.21	84.47	88.52
Tdap/Td		80.00	82.00	81.75	↓ 0.25	25th	73.48	81.28	86.14	89.92	91.75
HPV		NR	NR	27.25	-	75th	13.64	17.66	22.30	27.09	32.25
Combination #1		63.80	67.88	67.88	-	25th	56.90	66.03	74.52	82.09	86.57
Breast Cancer Screening	**Q, A**	NR	NR	59.34	-	50th	47.38	52.28	58.10	65.06	71.44
Cervical Cancer Screening	**Q, A**	61.77	50.61	54.50	↑ 3.89	25th	41.12	48.26	55.92	63.70	69.89
Effectiveness of Care: Respiratory Conditions											
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	**Q**	21.15	25.58	29.27	↑ 3.69	50th	19.47	22.13	26.26	32.33	38.7
Asthma Medication Ratio	**Q**										
Medication Compliance 75% Total		NR	NR	51.24	-	25th	40.64	45.40	52.06	59.36	63.64
Effectiveness of Care: Cardiovascular											
Controlling High Blood Pressure	**Q**	55.01	64.72	44.77	↓ 19.95	10th	39.66	47.03	54.80	63.87	70.55

HEDIS Measure/Data Element	Domain of Care	2014	2015	2016	2015-16 Rate Difference	Current NCQA Percentile Ranking	10th	25th	50th	75th	90th
Effectiveness of Care: Diabetes											
Comprehensive Diabetes Care											
Hemoglobin A1c (HbA1c) Testing	**Q, A**	90.51	88.56	86.56	↓ 2.00	50th	79.56	82.98	85.96	89.43	92.88
HbA1c Poor Control (>9.0%)	**Q**	32.85	37.71	**54.50**	↓ 16.79	10th	61.23	52.26	43.92	36.95	29.29
HbA1c Control (<8.0%)	**Q**	57.91	54.50	**36.98**	↓ 17.52	10th	31.16	39.80	46.72	52.55	58.39
Eye Exam (Retinal) Performed	**Q, A**	60.10	81.51	50.61	↓ 30.90	25th	36.13	44.53	53.49	61.69	68.09
LDL-C Screening Performed	**Q**										
LDL-C Control (<100 mg/dL)	**Q**										
Medical Attention for Nephropathy	**Q, A**	83.70	91.24	89.05	↓ 2.19	25th	86.01	88.45	90.51	91.97	93.52
Blood Pressure Control (<140/90 mm Hg)	**Q**	63.75	65.69	**48.66**	↓ 17.03	10th	43.75	52.26	59.61	68.61	75.73
Effectiveness of Care: Overuse/Appropriateness											
Use of Imaging Studies for Low Back Pain	**Q**	75.71	73.51	73.89	↑ 0.38	50th	66.14	69.88	73.72	77.09	81.41
Effectiveness of Care: Medication Management											
Annual Monitoring for Patients on Persistent Medications	**Q**										
ACE Inhibitors or ARBs		**82.14**	86.94	**85.09**	↓ 1.85	10th	83.31	85.63	87.45	89.92	92.13
Digoxin		**56.25**	50.00	62.71	↑ 12.71	75th	46.15	49.57	54.03	59.09	62.86
Diuretics		**83.27**	87.37	**85.14**	↓ 2.23	10th	83.33	85.19	87.53	90.04	92.28
Total		**82.30**	86.74	**84.95**	↓ 1.79	10th	83.16	85.21	87.25	89.59	91.84
Access/Availability of Care											
Children and Adolescents' Access to Primary Care Practitioners	**A**										
12-24 Months		95.42	94.65	93.86	↓ 0.79	25th	89.89	93.14	95.74	97.28	97.85
25 Months - 6 Years		83.12	**84.87**	85.51	↑ 0.64	25th	81.16	84.83	87.69	90.98	93.34
7-11 Years		83.31	**85.62**	**84.54**	↓ 1.08	10th	84.16	87.91	91.00	93.25	96.1
12-19 Years		82.01	**84.14**	**82.32**	↓ 1.82	<10th	83.13	85.84	89.37	92.67	94.69

HEDIS Measure/Data Element	Domain of Care	2014	2015	2016	2015-16 Rate Difference	Current NCQA Percentile Ranking	2017 NCQA Percentile Ranking				
							10th	25th	50th	75th	90th
Access/Availability of Care											
Prenatal and Postpartum Care	**Q, A, T**										
Timeliness of Prenatal Care		85.68	82.24	84.18	↑ 1.94	50th	66.91	74.21	82.25	87.56	91
Postpartum Care		62.81	59.12	65.45	↑ 6.33	50th	48.94	55.47	60.98	67.53	73.61
Utilization											
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	**Q, A, T**	67.11	64.72	66.18	↑ 1.46	25th	60.64	64.72	71.42	77.57	82.97
Ambulatory Care		Visits/1000	Visits/1000	Visits/1000							
Outpatient Visits		209.28	246.05	252.22	↑ 6.17	N/A					
ED Visits		39.21	41.05	38.79	↓ 2.26	N/A					
Screening for Clinical Depression and Follow-Up Plan	**Q, A, T**					N/A					
Age appropriate screening (reporting rate)		NR	NR	0.10	-	N/A					
Screened positive AND had documented follow up plan (performance rate)		NR	NR	90.41	-	N/A					
Utilization: Risk Adjusted											
All-Cause Readmission	**Q,A**	17.87	15.77	14.70	↓ 1.07	NA					
Effectiveness of Care: Overuse/Appropriateness											
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	**Q**	92.67	94.82	94.80	↓ 0.02	75th	76.23	84.92	89.39	93.38	96.08
Effectiveness of Care: Respiratory Conditions											
Appropriate Testing for Children with Pharyngitis (CWP)	**Q**	41.49	51.46	59.46	↑ 8.00	10th	55.08	63.24	71.62	81.01	86.59
↑ = improvement											
↓ = decline											
Q = Quality											
A = Access											
T = Timeliness											

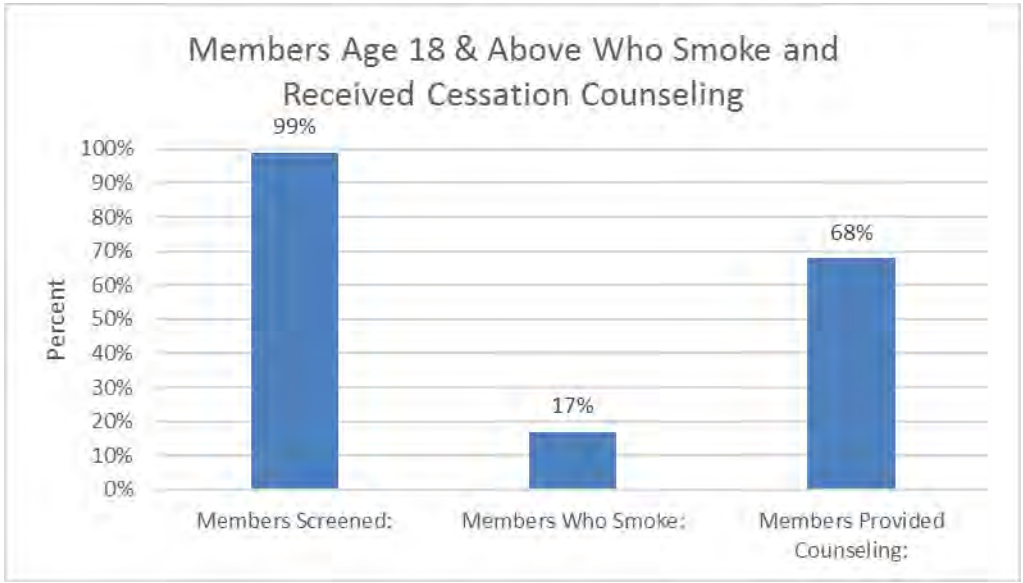
Breast Cancer Screening, Immunization for Adolescents – HPV, Asthma Medication Ratio and Screening for Clinical Depression and Follow-Up Plan are all new measures for 2016 and therefore have no previous rates to report.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
NCQA QI 7	Diabetes Clinical Practice Guideline (CPG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant CPGs Distribute if necessary	Q4 2016	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of each of the CPGs Distribute guidelines to appropriate practitioners	MAC
EVALUATION OF 2016 WORK PLAN					
RESULTS (Quantitative Analysis) Completed approved at MAC 1/28/16– no substantive changes made.					
RESULTS (Qualitative Analysis) NA					
BARRIER ANALYSIS Goal Met, no barriers presently identified					
NCQA QI 7	Preventive Health Guideline (PHG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant PHGs Distribute if necessary	Q4 2016	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of two PHGs Distribute guidelines to appropriate practitioners	MAC
EVALUATION OF 2016 WORK PLAN					
RESULTS (Quantitative Analysis) Completed approved at MAC 7/28/16– no substantive changes made.					
RESULTS (Qualitative Analysis) NA					
BARRIER ANALYSIS Goal Met, no barriers presently identified					

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
Advance Prevention					
DHCS	Increase percentage of members who smoke who report being counseled to quit in prior 6 months	90%	Q4 2016	Measure during IHA monitoring Educate providers based on results of IHA monitoring	QI
EVALUATION OF 2016 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Not Met.					



2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					

RESULTS (Qualitative Analysis) The 2015 CAHPS reported the rate for this measure as NA. Therefore, the 2016 rate of 68% will be the baseline as no year over year comparisons can be made. 611 medical records were reviewed. 103 (17%) of members indicated that they smoked.
Of those members who indicated that they smoked, 68 % (70 members) had evidence in the record that they were provided cessation counseling. Further analysis of the records indicated that while 38 members records contained the Staying Healthy Assessment (SHA) 65 records were missing the SHA. There was no evidence of counseling noted elsewhere in the record.

BARRIER ANALYSIS:

- Members who refuse counseling.
- Missing Staying Healthy Assessments (SHA) in member medical records.

- Information Technology – EMR systems that fail to transfer data from templates to the encounter documentation.

NEXT STEPS

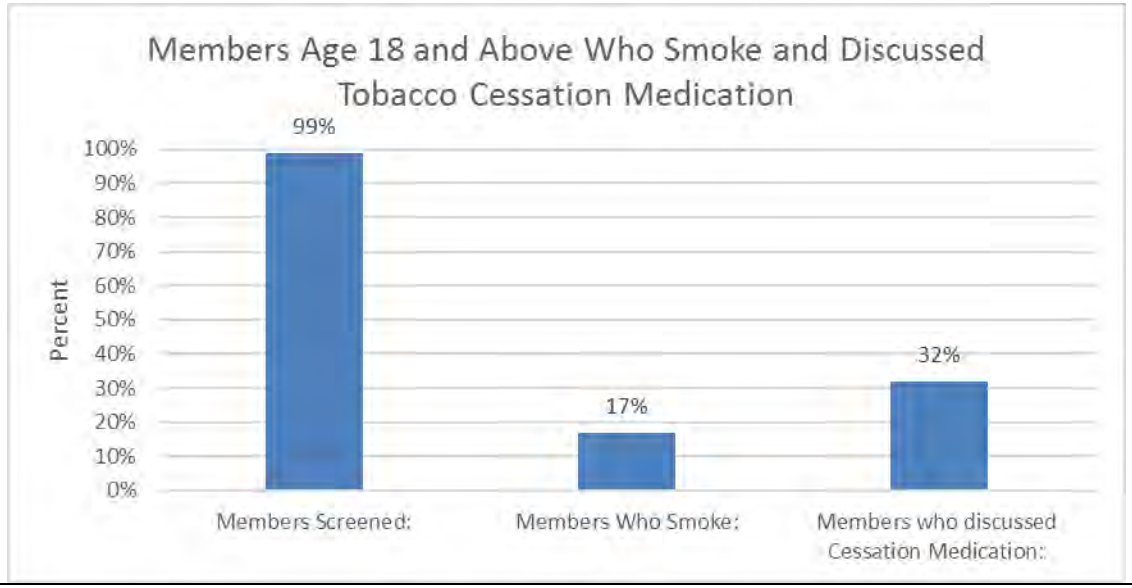
- Encourage providers to continue assessing for tobacco use to catch the patient when they are ready for change and desire to quit smoking.
- Training and education to clinic staff regarding the importance of offering the SHA to every Gold Coast Health Care member.
- Education to providers regarding the application of the SHA to detecting tobacco use.
- During medical record reviews in EMR systems, check template sections for documentation.
- Continue IHA monitoring.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
DHCS	Increase percentage of members who smoke who report a provider discussed tobacco cessation medication in the prior 6 months	60%	Q4 2016	Measure during IHA monitoring Educate providers based on results of IHA monitoring	QI

EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis)



RESULTS (Qualitative Analysis) The 2015 CAHPS reported the rate for this measure as NA. Therefore, the 2016 rate of 32% will be the baseline as no year over year comparisons can be made. 611 records were reviewed. 103 (17%) of members indicated that they smoked. Of those members who indicated that they smoked, 32 % (33 members) had evidence in the record that the provider discussed tobacco cessation medication with them.

BARRIER ANALYSIS

- Providers appear to provide cessation counseling only, possibly due a knowledge deficit regarding cessation medications or cessation support resources.
- Providers may not be aware cessation medications are covered by Gold Coast Health Plan without prior authorization.

NEXT STEPS

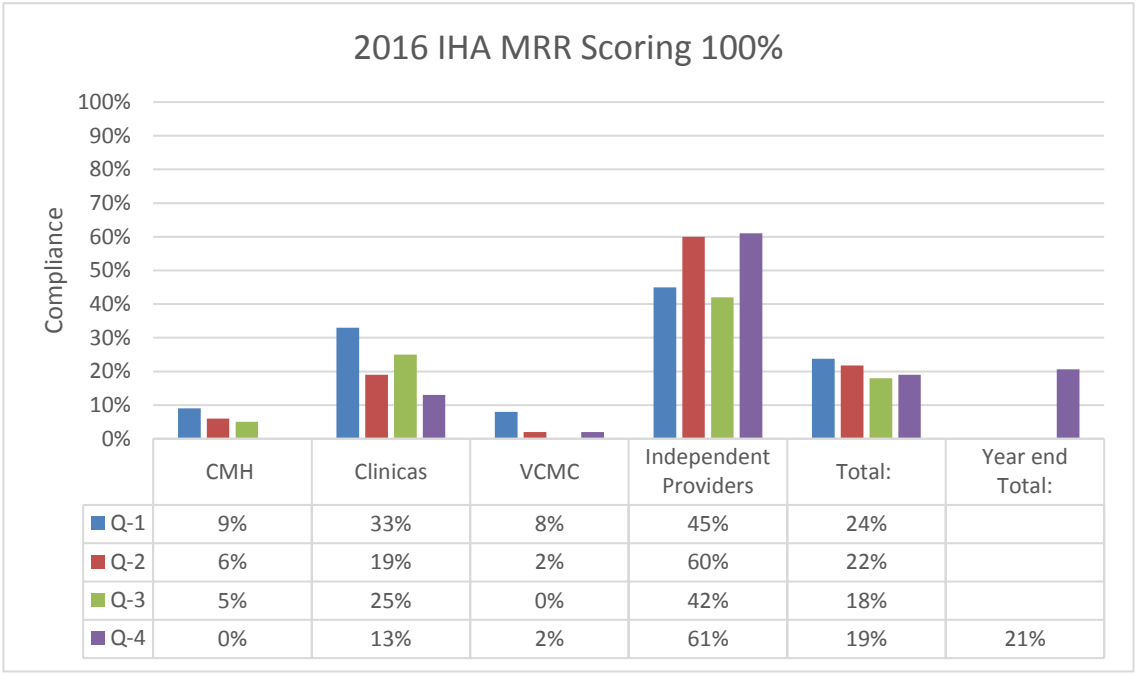
- Provide smoking cessation information, ICD 10 codes and resources to providers during 2017.
- Continue IHA monitoring.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
DHCS	Increase rates of Initial Health Assessment (IHA)	90%	Q4 2016	Measure during medical record reviews for IHA and provide performance feedback at time of completion of record review Educate providers of requirements and components of IHA Article in POB regarding requirements of IHA, including outreach requirements	QI
EVALUATION OF 2016 WORK PLAN					

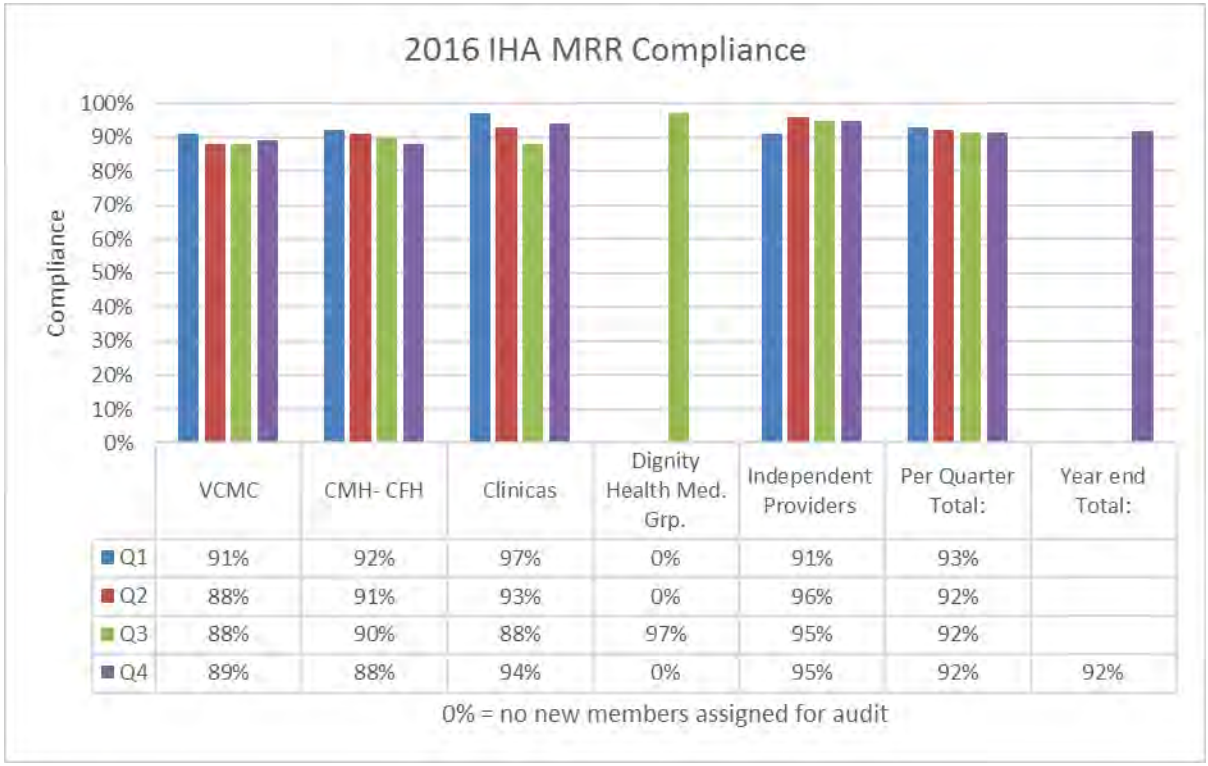
RESULTS (Qualitative Analysis) Goal Not Met.

Graph 1



	CMH	Clinicas	VCMC	Independent Providers	Total:	Year end Total:
Q-1	9%	33%	8%	45%	24%	
Q-2	6%	19%	2%	60%	22%	
Q-3	5%	25%	0%	42%	18%	
Q-4	0%	13%	2%	61%	19%	21%

Graph 2



	VCMC	CMH- CFH	Clinicas	Dignity Health Med. Grp.	Independent Providers	Per Quarter Total:	Year end Total:
Q1	91%	92%	97%	0%	91%	93%	
Q2	88%	91%	93%	0%	96%	92%	
Q3	88%	90%	88%	97%	95%	92%	
Q4	89%	88%	94%	0%	95%	92%	92%

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					
EVALUATION OF 2016 WORK PLAN					
RESULTS (Qualitative Analysis) Compliance for this metric is defined as having met 100% of all required IHA criteria**.** Graph 1 reflects the percent of records that met 100% of IHA required criteria. Compliance for this measure was 21% as noted in graph 1. Graph 2 reflects the percentage of compliance for all required IHA criteria. As noted in graph 2 there was very little improvement during 2016 despite continued education of providers and office managers. Primary reasons for not achieving 100 % on medical record audits: Incomplete, unsigned, or no Staying Healthy Assessment in the medical record and/or age appropriate preventive health screenings were missing documentation in the medical record.					
BARRIER ANALYSIS • Resistance to change by providers to the IHA and SHA process due to the lengthy SHA form and the time it takes during clinic visits. • High volume staff turn around in clinics results in staff not knowing the IHA / SHA process. Missed opportunities to offer the SHA occur. • Repeat poor performance by providers / staff requiring the need for re-training. • Reluctance to access IHA support offered by Gold Coast Health Plan Quality Improvement Department. **NEXT STEPS** • Share with providers clinic flow strategies used by other offices that are successful in performing the IHA /SHA. • Continue to monitor for staff turn around and offer training for new hires. • Continue monitoring clinic site performance and provide outreach to clinics with failing or declining scores. • Continue to educate providers and staff of the Gold Coast Health Plan IHA support resources available. Encourage requests for re-training or focused training to meet needs. • Continue monitoring via MRR					

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
HEDIS® Measures					
DHCS	Postpartum Care – Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	Increase rates by 5% over previous measurement year	Q4 2016	Develop member education mailings to compliment member incentive forms Provide provider performance feedback by means of 2015 HEDIS report cards Continue member incentive program to engage members; partner with CPSP staff at clinics and Ventura County Public Health to help promote	Health Education QI

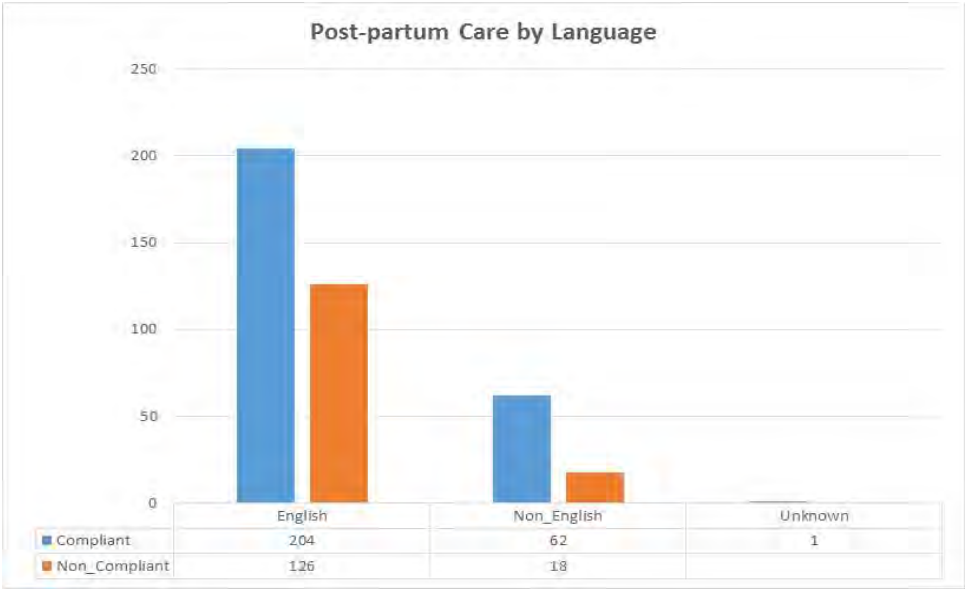
EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis) GOAL MET - 2016 rate increased by 6.33% compared to the previous year's rate of 59.12%.

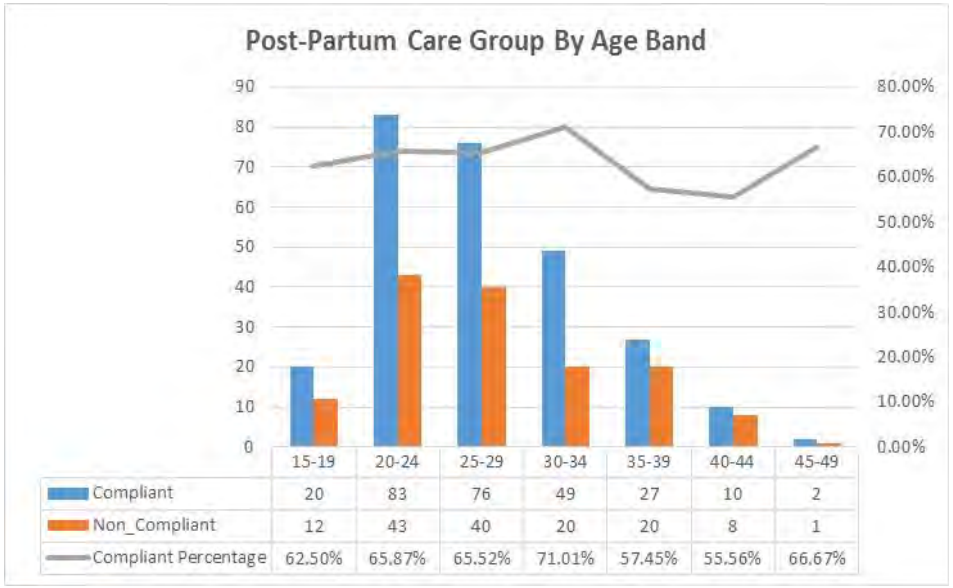
							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	**Domain of Care**	**2014**	**2015**	**2016**	**2015-16 Rate Difference**	**Current NCQA Percentile Ranking**	10th	25th	50th	75th	90th
Access/Availability of Care											
Prenatal and Postpartum Care											
Postpartum Care	Q	62.81	59.12	65.45	↑6.33	50th	48.94	55.47	60.98	67.53	73.61

RESULTS (Quantitative Analysis)

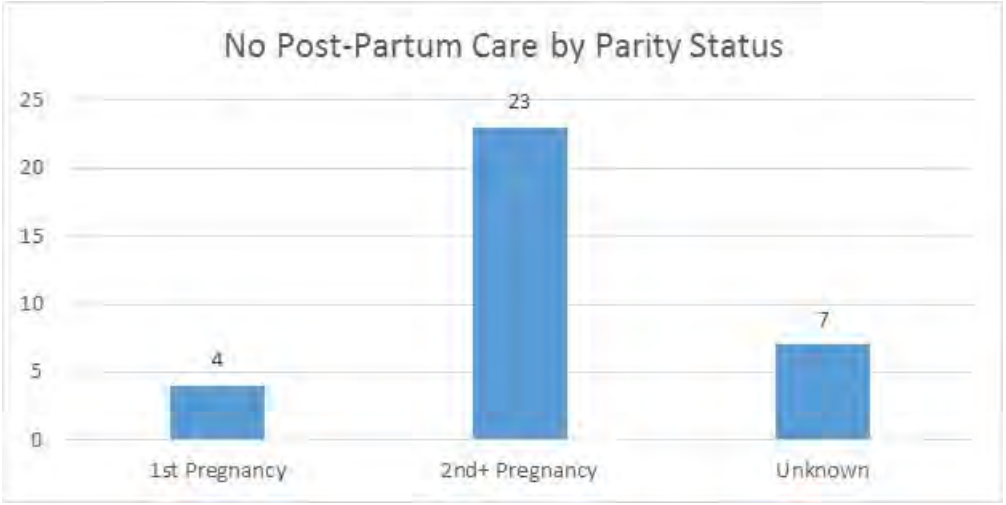
Graph #1



Graph #2



Graph# 3



Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee

Objective: Improve Quality and Safety of Clinical Care Services

RESULTS (Qualitative Analysis)

Disparities analysis of demographic data identified in graphs 1 and 2 represent compliance by age and language for postpartum care. The data represented in graphs 1and 2 indicate the highest incidence of non-compliance, identified by the English speaking cohort between the ages of 20 – 29. Women in the higher age groups (30 and older) had a lower representation in this measure, but had the highest rate of non-compliant with postpartum care.

The QI Department conducted an independent medical record review of 34 randomly selected women who did not have postpartum care during the 2016 measurement year. The results of the review, shown in Graph 5: No Post-Partum Care by Parity Status, indicate that 67.64% (23/34) of women with no postpartum care were multi-para mothers.

BARRIER ANALYSIS

Based on these analyses, the primary characteristic of women with no postpartum care was multi-parity.

NEXT STEPS

For the 2016 MY, we exceeded our goal of increasing the postpartum care rate by 5% - the rate increased 6.33% points from 59.12% in 2015 to 65.45% in 2016. We will continue outreach to this population through the postpartum member incentive program and continue collaborating with internal and external partners to promote the postpartum member incentive.

To improve educating our providers on their HEDIS rates and increase provider engagement we have planned the following changes:

- Revise our provider report cards to improve the visualization of their rates and goals using graphs instead of tables.
- Revise our performance feedback reports by generating them in Excel and including patient contact information.
- Increase the frequency of distributing these two prospective reports to providers during the year.

Analysis of 2016 Member Outreach Activities

- ***2016 Postpartum Member Incentive***
- Results
    - Member Incentives Mailed to Eligible Members = 2,162
    - Measurement Months: February 1, 2016 to December 31, 2016
    - Members Who Participated in Member Incentive = 98
        - *Participation by Clinic System*
            - VCMC – 47
            - CDCR – 22
            - CMHS 18
            - Independent Providers – 10

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee

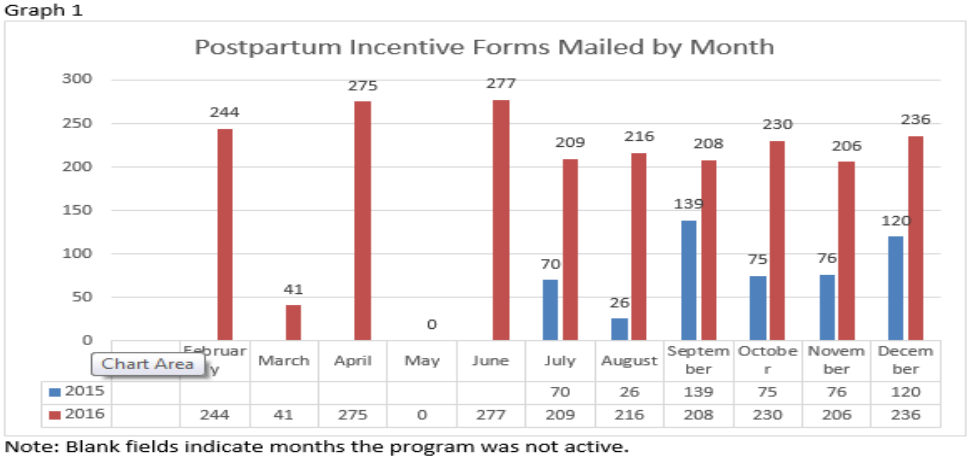
Objective: Improve Quality and Safety of Clinical Care Services (cont.)

- Kaiser Permanente – 1
- *Participation by Source of Outreach*
  - Member Mailings – 88
  - Physicians – 9
  - Case Manger – 1

- Analysis
  - Low member participation in 2016: 4.53% (98/2162) of the members contacted through all outreach sources completed the member incentive.
  - Participation by Outreach Source:
    - 90% (88/98) - Mail
    - 9% (9/98) - Provider
    - 1% (1/98) – GCHP Case Manager
  - Table 1: Incentives Mailed and Returned in 2015 and 2016

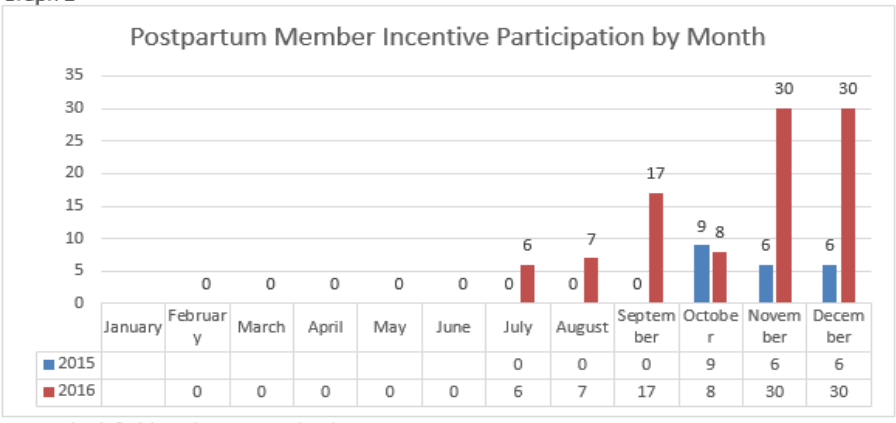
Year	Total Mailed	Total Returned	Participation Rate
2015	506	21	4.15%
2016	2162	98	4.53%

Graph 1



Note: Blank fields indicate months the program was not active.

Graph 2



Note: Blank fields indicate months the program was not active.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					

- ***Scheduling Assistance Outreach Pilot Program – Collaboration with Health Education***
- Results
- Measurement Months: October 1, 2016 to December 31, 2016.
- Postpartum Appointments Scheduled: 7
- Outcome of Call Attempts
  - Contacted - 26
  - Unreachable/Left VM – 33
  - Not Contacted/3 Call Attempts Made - 26
  - Not interested – 5
  - Ineligible - 3
- Analysis
  - Supplementing the member incentive program with scheduling assistance did not significantly increase member engagement. During the 3-month study the Health Navigator was successful with scheduling 7 postpartum exams.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					
EVALUATION OF 2016 WORK PLAN					

RESULTS (Qualitative Analysis)

Member Engagement

- Graph 2: Postpartum Member Incentive by Month, shows there was an increase in member engagement in September, November and December 2016. However, overall participation in 2016 was low with only 4.53% (98/2162) of members contacted through mailers and other outreach methods participated in the postpartum member Incentive.

Increased Provider Promotions Did Not Increase Member Participation

- Promoting the postpartum incentive program with providers through direct contact with clinics, publications in the Provider Operations Bulletin and memorandums so that providers could utilize the incentive program to engage their members with completing their postpartum exam did not increase participation.
- Only 9 of the 98-member incentive flyers returned were given to members from providers.

BARRIER ANALYSIS

Outreach through Mail and through Postpartum Scheduling Assistance

Outreach to members through mail is considered an indirect/passive form of outreach and this may make it more difficult to produce a change in behavior. Despite the significant increase in mailings to members (2162 mailings in 2016 compared to 506 mailings in 2015), the rate of participation increased only 0.38% from 4.15% in 2015 to 4.53% in 2016.

We attempted to make this outreach more active by adding follow-up calls to the members who were mailed the postpartum member incentive packet to assist these members with scheduling postpartum exams, but this intervention did not produce a significant increase in postpartum exams.

NEXT STEPS

We will continue the postpartum incentive program but will not supplement it with the follow-up postpartum scheduling assistance outreach. We will continue to monitor this measure and research best practices and innovative ways to improve member engagement.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
DHCS	Immunizations for Adolescents (Combo 1) – percentage of adolescents 13 years of age who received a meningococcal vaccine on or between the member's 11th and 13th birthday and Tdap or Td on or between the member's 10th and 13th birthdays (Combo1)	Increase rates by 5% over previous measurement year	Q4 2016	Provide provider performance feedback by means of 2015 HEDIS report cards Provide bi-annual member lists with members who have not received services Continue member incentive program and promote during HEDIS results visits with clinics	QI

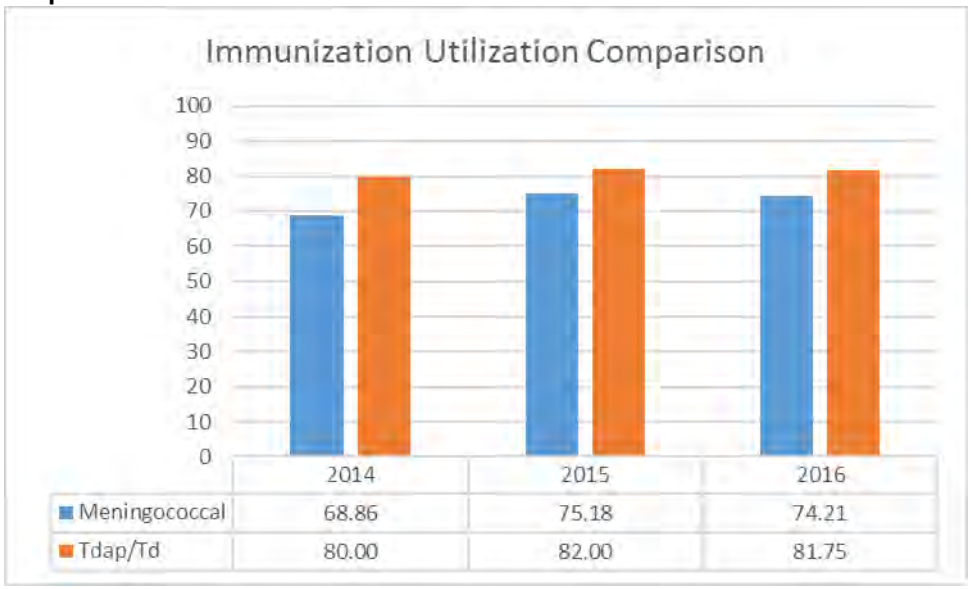
EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis) Goal Not Met The rate for this measure remained the same as last year's rate of 67.88.

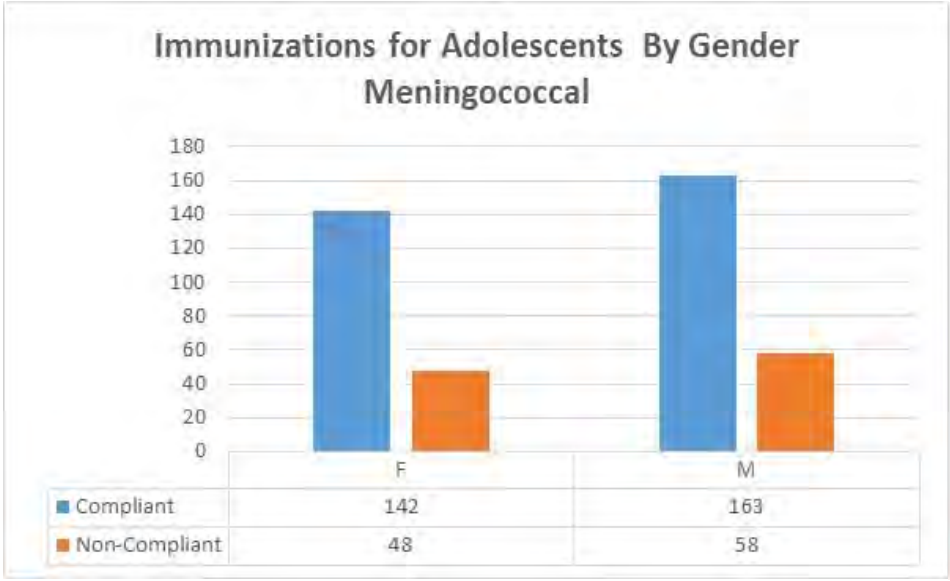
							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	**Domain of Care**	**2014**	**2015**	**2016**	**2015-16 Rate Difference**	**Current NCQA Percentile Ranking**	10th	25th	50th	75th	90th
Effectiveness of Care: Prevention and Screening											
Immunizations for Adolescents (IMA)	Q, A, T										
Meningococcal		68.86	75.18	74.21	↓ -0.97	25th	58.48	67.26	77.21	84.47	88.52
Tdap/Td		80.00	82.00	81.75	↓ -0.25	25th	73.48	81.28	86.14	89.92	91.75
Combination #1		63.80	67.88	67.88	**0.00**	25th	56.90	66.03	74.52	82.09	86.57

RESULTS (Quantitative Analysis)
COMBO 1 REQUIRED REPORTING

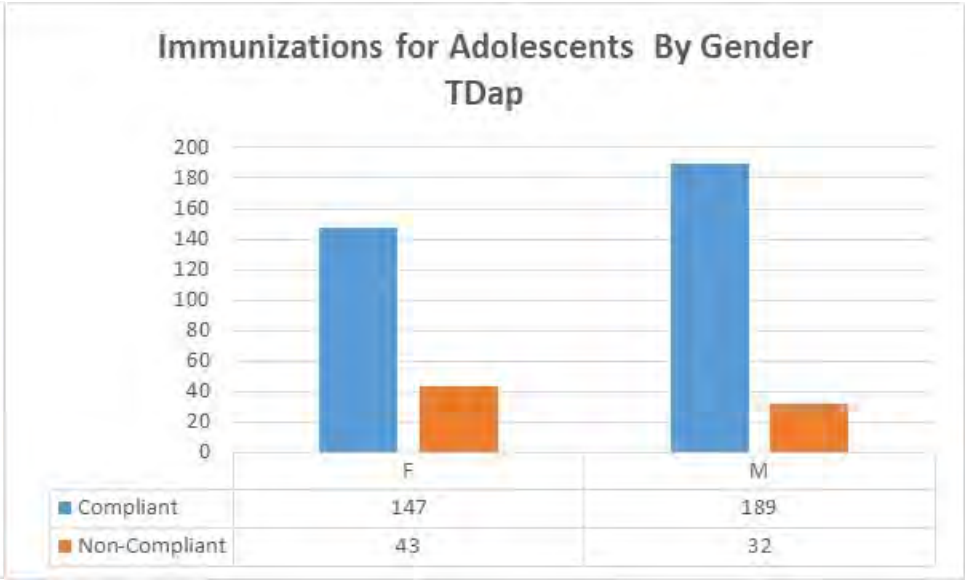
Graph #1


Immunization Utilization Comparison
100
90
80
70
60
50
40
30
20
10
0
2014
2015
2016
Meningococcal
68.86
75.18
74.21
Tdap/Td
80.00
82.00
81.75

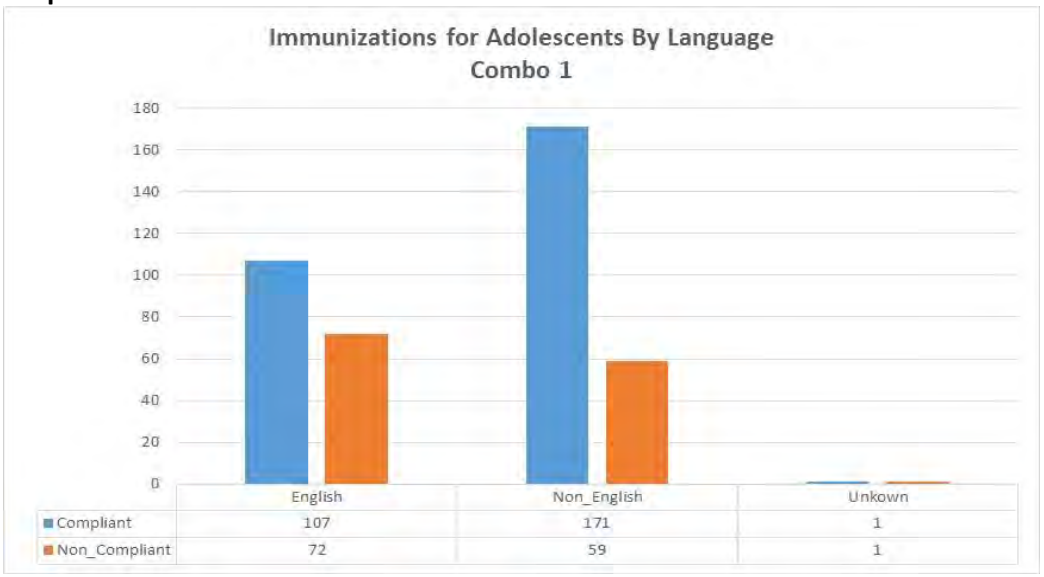
Graph #2



Graph #3

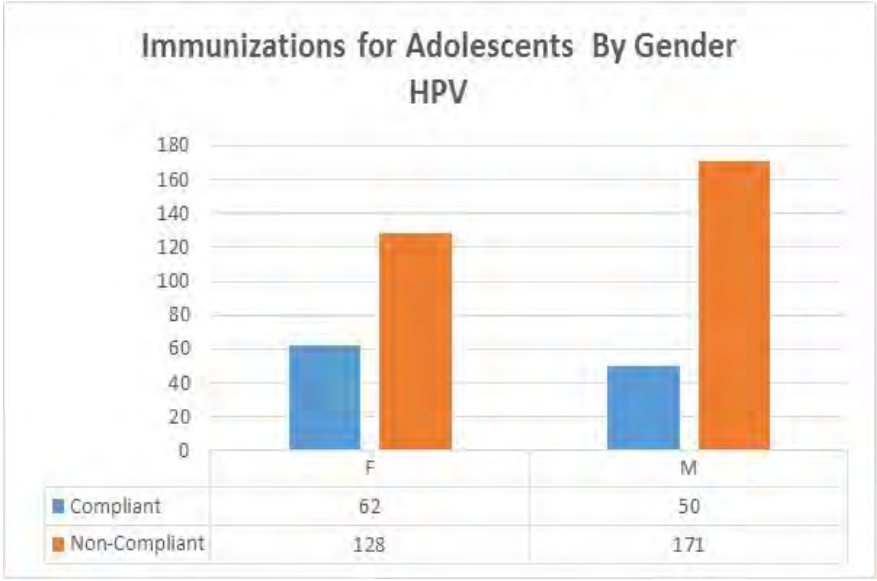


Graph #4

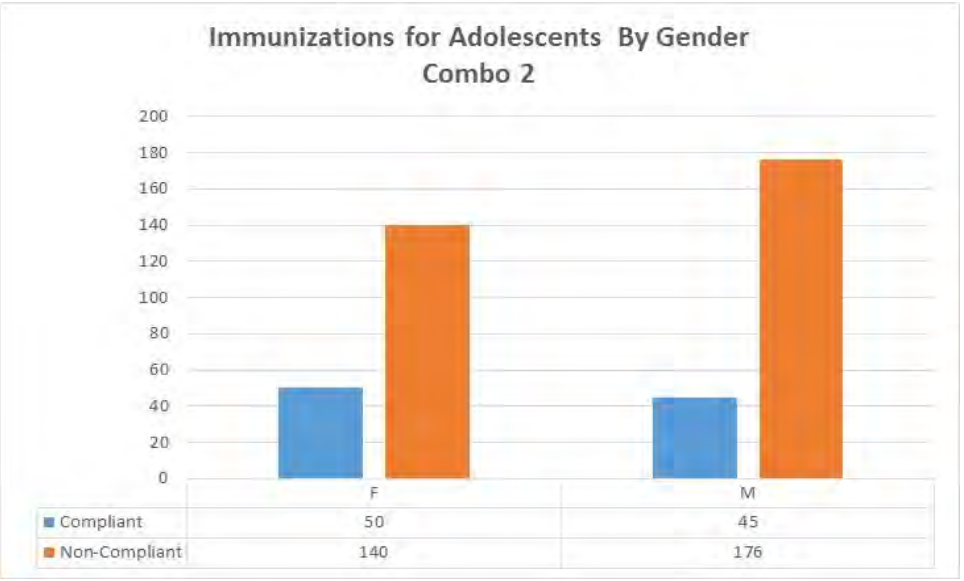

Immunizations for Adolescents By Language
Combo 1
180
160
140
120
100
80
60
40
20
0
English
Non_English
Unkown
Compliant
107
171
1
Non_Compliant
72
59
1

NEW MEASURE FOR MY2017

Graph #5



Graph #6



RESULTS (Qualitative Analysis)

Combo 1 - Disparities analysis represented in graphs 1-4 demonstrate compliance by sub-measure, gender and language. The Tdap and Meningococcal rates are what compose the Combo 1 rate. One Tdap vaccine must be administered between the member's 10th and 13th birthday and one Meningococcal vaccine must be administered between the members 11th and 13th birthday to be compliant with the Combo 1 measure. Graphs 2 and 3 indicate there is a slightly lower incidence of compliance with the Meningococcal vaccination across both the male and female cohorts. Additional research is required to determine if decreased compliance with Meningococcal could be attributed to having a shorter administration period. Graph #4 shows no significant language barrier.

Combo 2 – NEW MEASURE FOR MY2017 (includes HPV vaccine)

The Tdap, Meningococcal and Human Papilloma Virus (HPV) rates are what compose the Combo 2 rate. Based on the data in graphs 2, 3 and 5, there is significantly lower compliance with HPV administration compared to compliance with the Tdap and Meningococcal vaccines. The significant underutilization of the HPV vaccine caused the overall Combo 2 rate to be significantly low with only 95 of the 411 children in the sample being compliant with all three vaccines. (see Graph 6).

BARRIER ANALYSIS

Analysis of the Children and Adolescent Access to Primary Care Practitioners (CAP) metric, which measures outpatient encounters, showed there was a decline in outpatient encounters in 2016 for children 12 to 19 years of age. Based on these findings, we deduce that decreased outpatient encounters impacted the IMA measure resulting in a decrease of adolescents not receiving their scheduled immunizations. Also, with the HPV vaccine being a new requirement for the IMA measure, parents may need to be educated on the importance of the HPV vaccine and that it must be administered in either a 2 or 3 series.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee

Objective: Improve Quality and Safety of Clinical Care Services (cont.)

NEXT STEPS

For the 2017 MY a Children and Adolescent Access to Primary Care Practitioners (CAP) Pay-for-Performance (P4P) incentive program has been developed to help increase compliance with this measure. The P4P program aims to increase visits to PCPs. We will follow the P4P to determine if this incentive helps increase the IMA rates. Also, newly revised provider performance feedback reports and HEDIS report cards will be disseminated to clinics on a bi-monthly basis and rates discussed during the HEDIS results reviews.

Analysis of 2016 Member Outreach Activities

2016 Well-Child Exam – Parent/Child $25.00 Gift Card Monthly Raffle Incentive

- Results
  - Measurement Months: June 6, 2016 to December 31, 2016
  - Member Incentives Mailed to Eligible Members = 6,900
  - Members Who Participated in Member Incentive = 39
- Analysis
  - Low member participation in 2016: .056% (39/6900) of the members contacted through member incentive mailings participated in the member incentive program.
  - The IMA measure looks at children and adolescents, 10 to 13 years of age, who had all their required immunizations on or before their 13th birthday. Only 3 of the 39 participants in the well-child exam parent/child raffle were 10 to 13 years of age.

RESULTS (Qualitative Analysis)

Although the preliminary 2016 MY administrative rate for the IMA Combo 1 measure shows improvement by 2.30% points, we cannot infer that this member incentive had an impact on improving this rate due the low participation of members between 10 to 13 years of age. A monthly raffle may not be a strong incentive to engage members to schedule well-child exams because members may be less inclined to participate in a raffle program since there is no guaranteed reward.

BARRIER ANALYSIS

Due to delays with meeting due dates for updating the 2016-member incentive form and producing the supplemental preventive care letters, the first well-child member incentive mailing was delayed until June 6, 2016. One of the goals for 2016 was to send the member incentive mail earlier in the year to provide more time for member outreach and promoting the member incentive with providers, and to provide a longer period for members to participate in the program.

NEXT STEPS

We will retire the well-child exam parent/child raffle member incentive due to low participation. Although the preliminary 2016 MY IMA Combo 1 administrative HEDIS rate improved by 2.30% points, we will continue to monitor this measure due to changes in the measurement criteria that the National Committee of Quality Assurance (NCQA) implemented for the 2017 reporting year. The changes to this measure include tracking the administration of a third immunization for the Human Papilloma Virus and we anticipate that this change will impact the reported rate.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

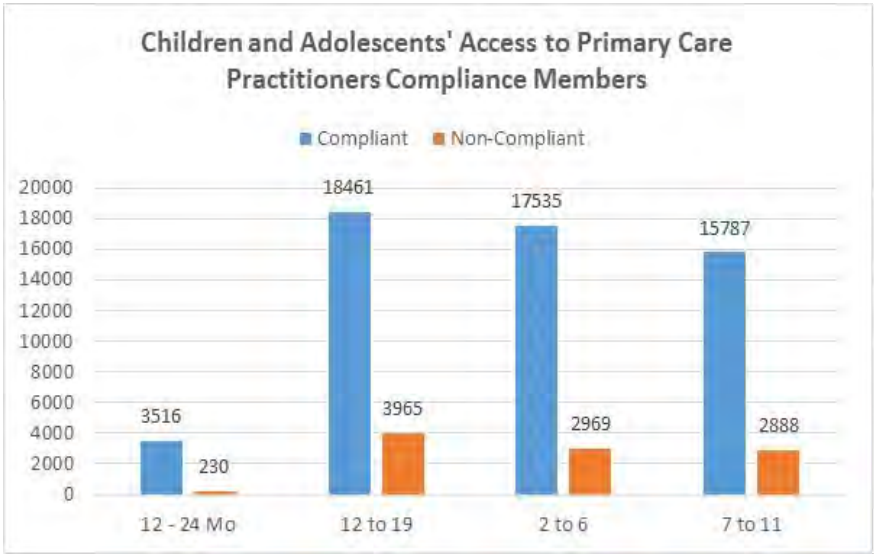
Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
DHCS	Children and Adolescents' Access to Primary Care Practitioners – percentage of members 12 months – 19 years of age who had a visit with a PCP	Meet or exceed DHCS MPL	Q4 2016	Continue member incentive program to engage members with addition of preventive care reminder letter Promote during HEDIS results review with clinics Collaborate with First5 Ventura to help promote incentive Provide provider performance feedback by means of 2015 HEDIS report cards Provide bi-annual member lists with members who have not received services Pay-for-Performance Program for childhood access to care	QI QI Network Operations
EVALUATION OF 2016 WORK PLAN					

RESULTS (Quantitative Analysis) Goal Partially Met We met the DHCS MPL in 2 out of 4 sub-measures; the 12 – 24 Months and 25 Months to 6 Years age groups meet the MPL. All but the 25 Months to 6 Years age group showed a slight decrease in rate. In looking further into the eligible population and utilization, the change in utilization is within 3 or fewer percentage points of the change in population.

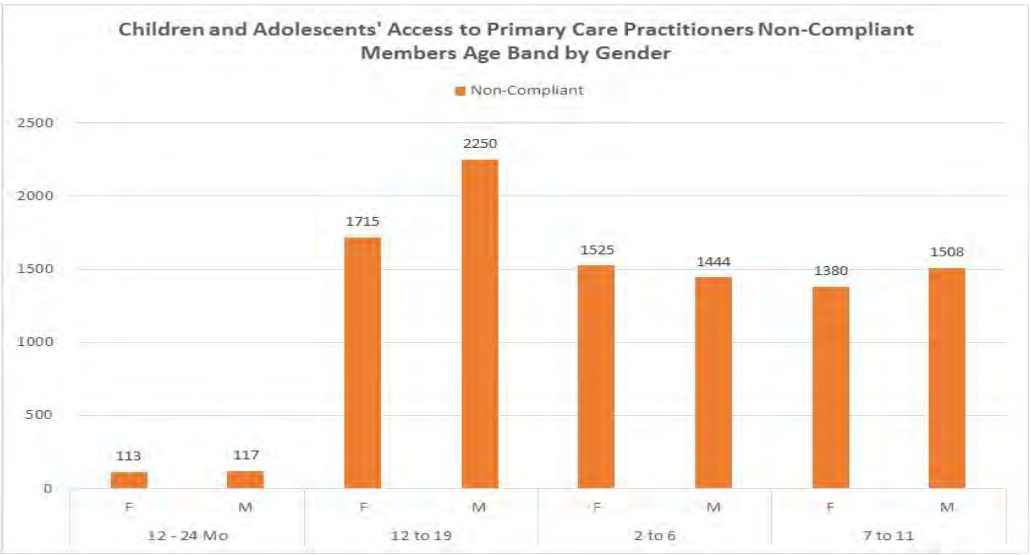
							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	**Domain of Care**	**2014**	**2015**	**2016**	**2015-16 Rate Difference**	**Current NCQA Percentile Ranking**	10th	25th	50th	75th	90th
Access/Availability of Care											
Children and Adolescents' Access to Primary Care Practitioners	A										
12-24 Months		95.42	94.65	93.86	↓ -0.79	25th	89.89	93.14	95.74	97.28	97.85
25 Months - 6 Years		83.12	84.87	85.52	↑ .65	25th	81.16	84.83	87.69	90.98	93.34
7-11 Years		83.31	85.62	84.54	↓ -1.08	10th	84.16	87.91	91.00	93.25	96.1
12-19 Years		82.01	84.14	82.32	↓ -1.82	10th	83.13	85.84	89.37	92.67	94.69

RESULTS (Quantitative Analysis)

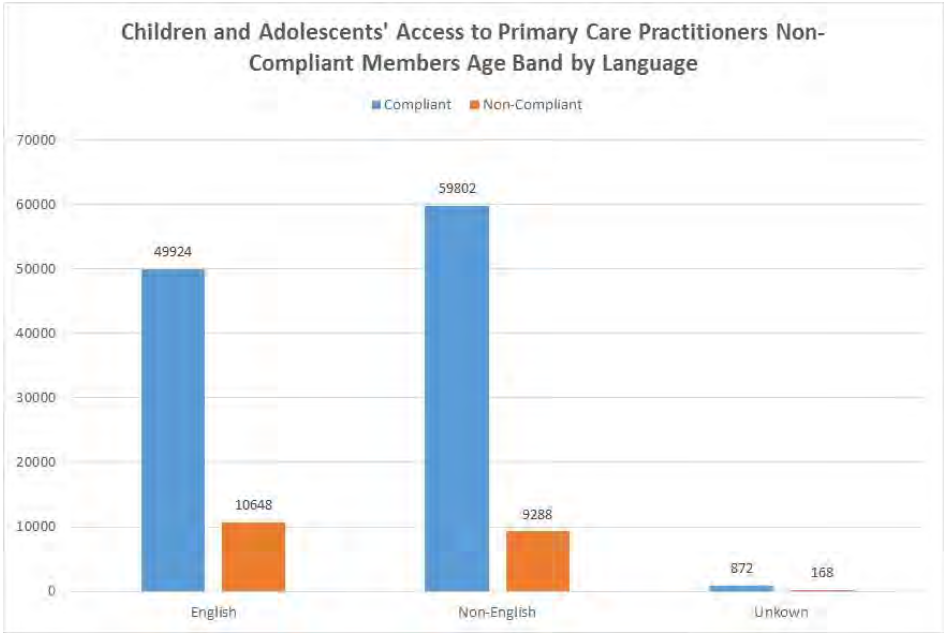
Graph #1



Graph #2



Graph #3



RESULTS (Qualitative Analysis)

Disparities Analysis identified no significant barriers PCP access. The data shows high incidence of compliance within each age category (Graph 1) and language category (Graph 3). Additional analysis of non-compliance by age group (Graph 2) indicates that the 12 to 19-month-old children have the lowest access to care.

NEXT STEPS

As stated in the IMA measure we will follow the newly developed CAP P4P incentive to see if there is any improvement in CAP rates. Newly revised rovider performance feedback reports and HEDIS report cards will be disseminated to clinics on a bi-monthly basis and rates discussed during the HEDIS results reviews.

Analysis of 2016 Member Outreach Activities

2016 Well-Child Exam – Parent/Child $25.00 Gift Card Monthly Raffle Incentive

- Results
  - Measurement Months: June 6, 2016 to December 31, 2016
  - Member Incentives Mailed to Eligible Members = 6,900
  - Members Who Participated in Member Incentive = 39

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee

Objective: Improve Quality and Safety of Clinical Care Services (cont.)

- Analysis
  - Low member participation in 2016: .056% (39/6900) of the member contacted through mailers completed the member incentive.
  - Participation by Age Group

Age Group	Member Incentive Participation
12 – 24 Months of Age	0
25 Months to 6 Years	15
7 Years to 11 Years	7
12 – 19 Years	17

RESULTS (Qualitative Analysis)

Member Outreach Activities
Low participation in this member incentive program shows that a monthly raffle may not be a strong incentive to engage members to schedule well-child exams because members may be less inclined to participate in a raffle program since there is no guaranteed reward.

BARRIER ANALYSIS
As stated for the IMA measure analysis above, due to delays with meeting due dates for updating the 2016-member incentive form and the supplemental preventive care letters, the first well-child member incentive mailing was delayed until June 6, 2016. One of the goals for 2016 was to send the member incentive mail earlier in the year to provide more time for member outreach and promoting the member incentive with providers, and to provide a longer period for members to participate in the program.

NEXT STEPS
As stated in the IMA measure, we will retire the well-child exam parent/child raffle member incentive due to low participation; however, we will continue to monitor this measure and identify new strategies to improve the CAP rates.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
DHCS	Counseling for Nutrition and Physical Activity for Children and Adolescents – percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling	Meet or exceed DHCS MPL	Q4 2016	Provide provider performance feedback by means of 2015 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates	QI

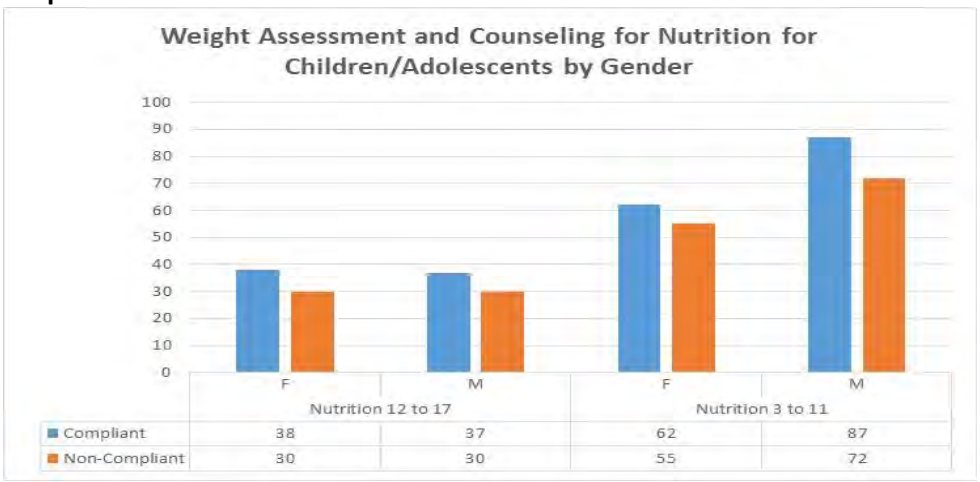
EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis) Goal Met While the rates for this measure met our goal both the rates for counseling for nutrition and physical activity declined slightly; counseling for nutrition declined 1.46% over the previous year and counseling for physical activity declined 1.22%.

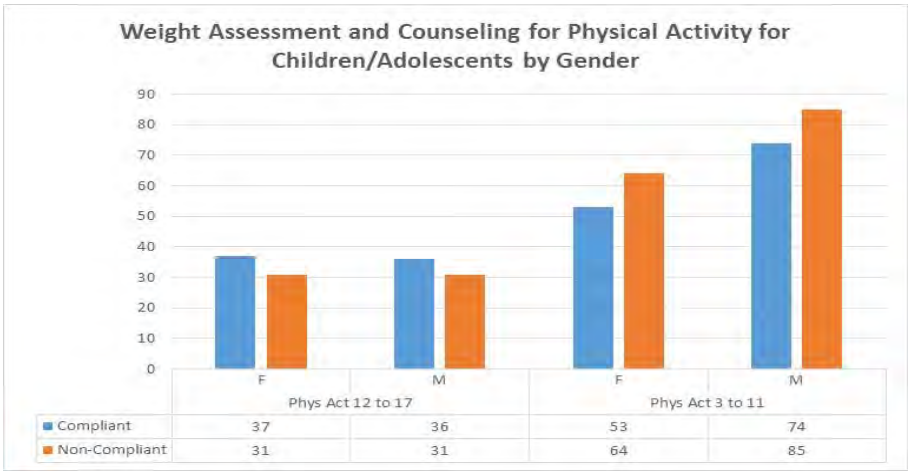
HEDIS Measure/Data Element	Domain of Care	2014	2015	2016	2015-16 Rate Difference	Current NCQA Percentile Ranking	10th	25th	50th	75th	90th
Effectiveness of Care: Prevention and Screening											
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Q										
Counseling for Nutrition		54.26	55.96	54.50	↓ -1.46	25th	42.92	51.84	62.65	70.88	79.52
Counseling for Physical Activity		41.85	49.88	48.66	↓ -1.22	25th	35.90	45.09	55.38	63.47	71.58

RESULTS (Quantitative Analysis)

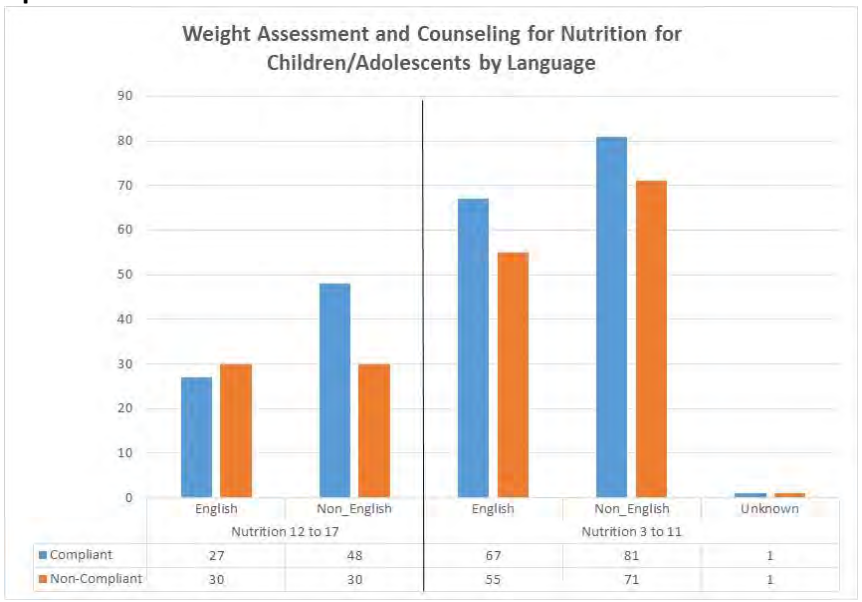
Graph #1



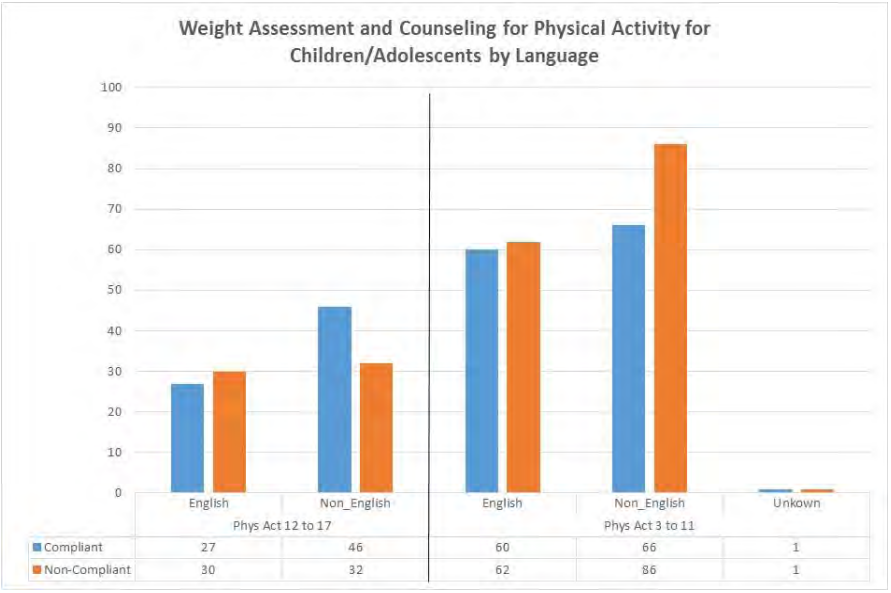
Graph #2



Graph #3



Graph #4



Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee	
Objective: Improve Quality and Safety of Clinical Care Services (cont.)						

RESULTS (Qualitative Analysis)

Disparities analysis by gender and age (Graphs 1 and 2) showed no significant disparity by gender but greater disparity by age with younger children, 3 to 11 years of age, not receiving counseling for nutrition and physical activity. Disparities analysis by language and age show non-English speaking children, 3 to 11 years of age, have the most non-compliance with counseling for nutrition and physical activity.

Due to barriers with retrieving and abstracting all medical records for this sample population, we hypothesis the rates for this measure decreased due to medical records with evidence of counseling for nutrition and physical activity were not collected and abstracted.

BARRIER ANALYSIS

Further analysis into this measure will need to be completed to determine if there were compliant records that were not collected and/or abstracted

NEXT STEPS

Conduct a medical record analysis on the non-compliant medical records. Also, newly revised provider performance feedback reports and the HEDIS report cards will be disseminated to clinics and rates discussed during the HEDIS results reviews.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
Over/Under Utilization					
DHCS	Appropriate Testing for Children with Pharyngitis - percentage of children 2 – 18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic **and received a group A strep test.**	Meet or exceed NCQA 25th percentile; 2015 rate of 51.46 was below the NCQA 10th percentile	Q4 2016	Provide provider performance feedback by means of 2015 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI

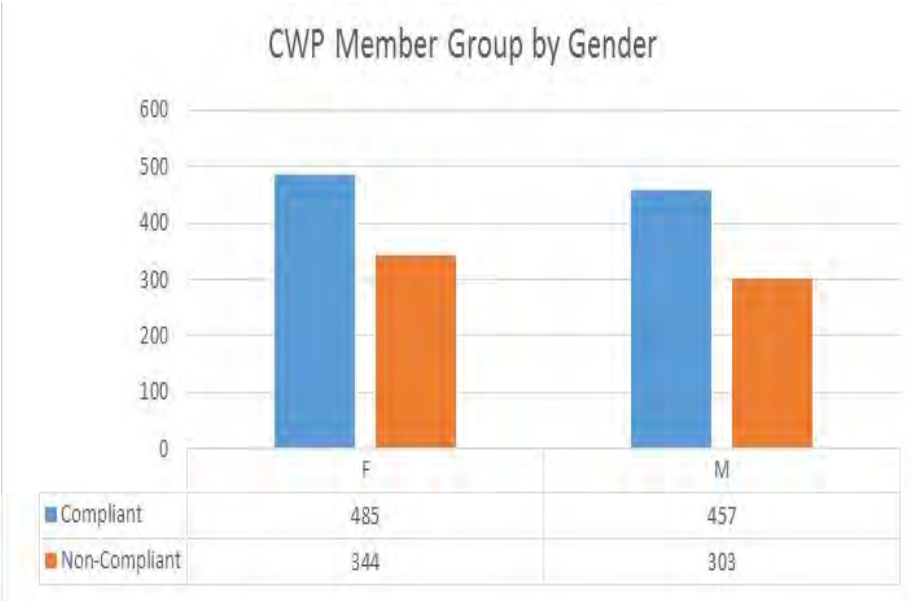
EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis) Goal Not Met While the rate showed an improvement of 8.0% points over the previous year's rate of 51.46, the rate missed the 25th percentile by only 3.78%

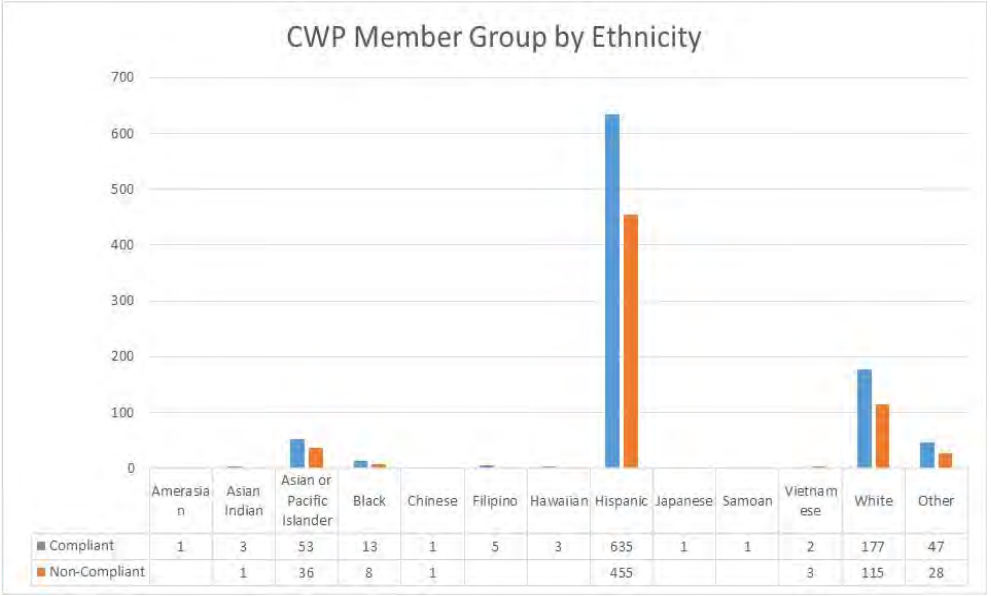
							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	**Domain of Care**	**2014**	**2015**	**2016**	**2015-16 Rate Difference**	**Current NCQA Percentile Ranking**	10th	25th	50th	75th	90th
Effectiveness of Care: Respiratory Conditions											
Appropriate Testing for Children with Pharyngitis (CWP)	Q	41.49	51.46	59.46	↑8.0	25th	55.08	63.24	71.62	81.01	86.59

RESULTS (Quantitative Analysis)

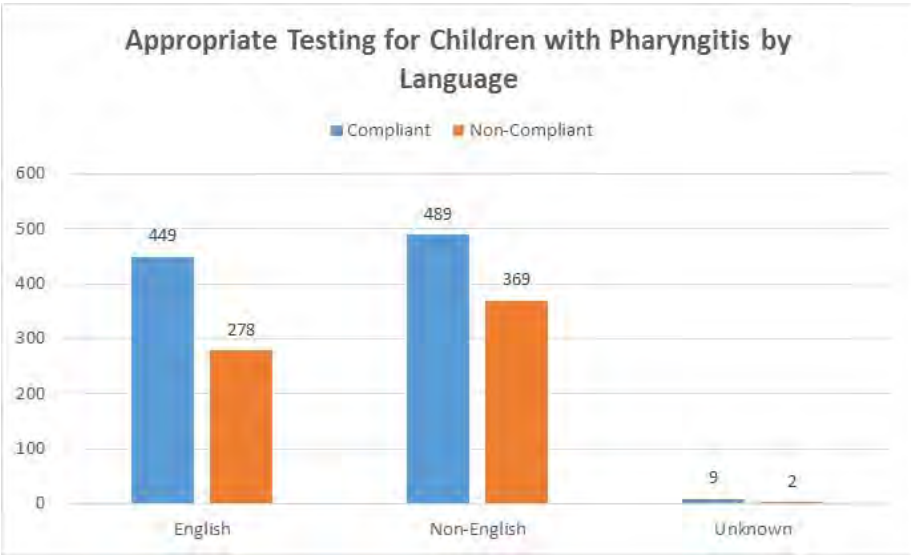
Graph #1



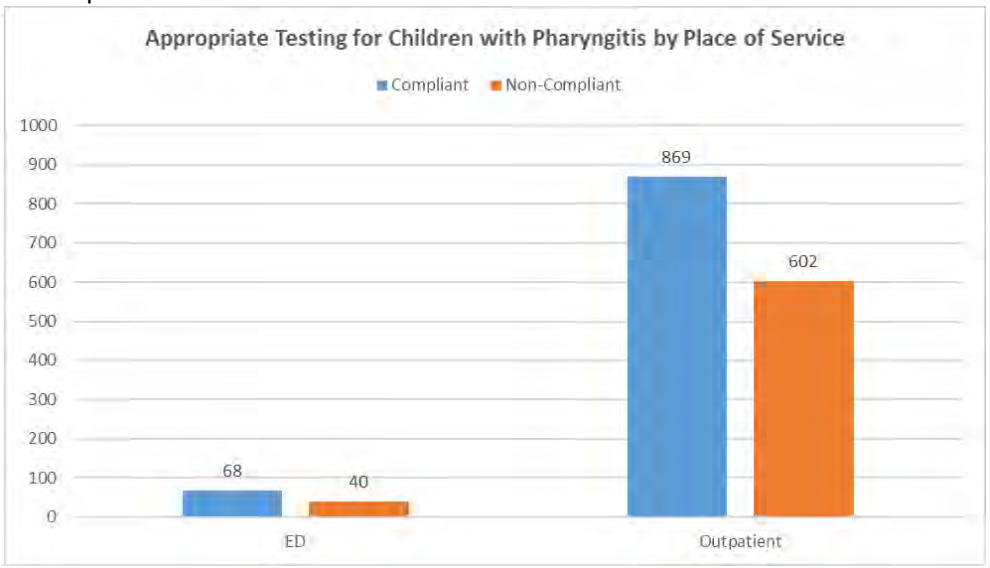
Graph #2:



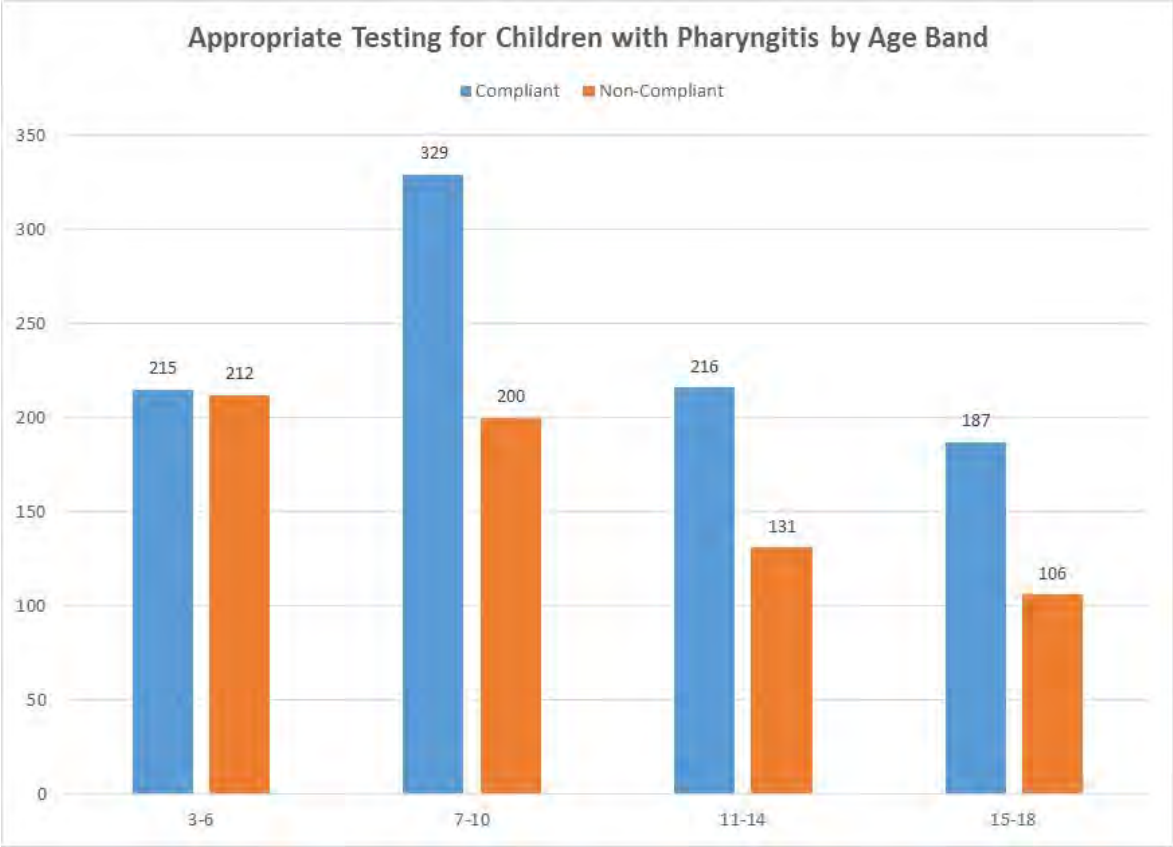
Graph #3



Graph #4



Graph #5



RESULTS (Qualitative Analysis)

There were no significant variances identified by gender represented in graph #1. The Hispanic cohort in graph #2 indicates a higher prevalence of non-compliance; however, this cohort as also represents the largest ethnic population. Graph #3 shows comparable compliance between the English and Non-English speaking populations. Graph #4 indicates that ED visits do not account for the large majority of non-compliance. When comparing age ranges it appears that the younger age ranges of 3 to 10 years account for the highest noncompliance (Graph #5).

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					
BARRIER ANALYSIS Providers may still be relying on clinical findings alone to diagnose strep throat. Guidelines recommend confirmation of streptococcal cause of pharyngitis via throat culture or rapid antigen detection. If rapid antigen detection is negative, a throat culture should be obtained. Parental pressure may also be a contributing factor. Parents want their children to feel better soon and often do not understand that sore throat can also be caused by a virus that cannot be treated with antibiotics. Literature also indicates that Medi-Cal insured parents are more likely to express strong expectations for antibiotics, which may be driven by such socioeconomic indicators such as childcare (*Pediatrics* Volume 136, number 2, August 2015). **NEXT STEPS** Continue provider education using evidence based articles and focus on those clinics that require the most improvement. Continue to provide lists of member who have been prescribed an antibiotic inappropriately. Provide links to educational material that providers can give to parents such as those from the CDC and AWARE (Alliance Working for Antibiotic Resistance Education). Provider feedback performance reports and the newly revised HEDIS report cards will be disseminated to clinics on a bi-monthly basis and rates discussed during the HEDIS results reviews.					

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
DHCS	Appropriate Treatment for Children with Upper Respiratory Infection - percentage of children 3 months – 18 years of age who were diagnosed with an upper respiratory infection (URI) and **were not dispensed** an antibiotic prescription.	Meet or exceed NCQA 90th Percentile	Q4 2016	Provide provider performance feedback by means of 2015 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI

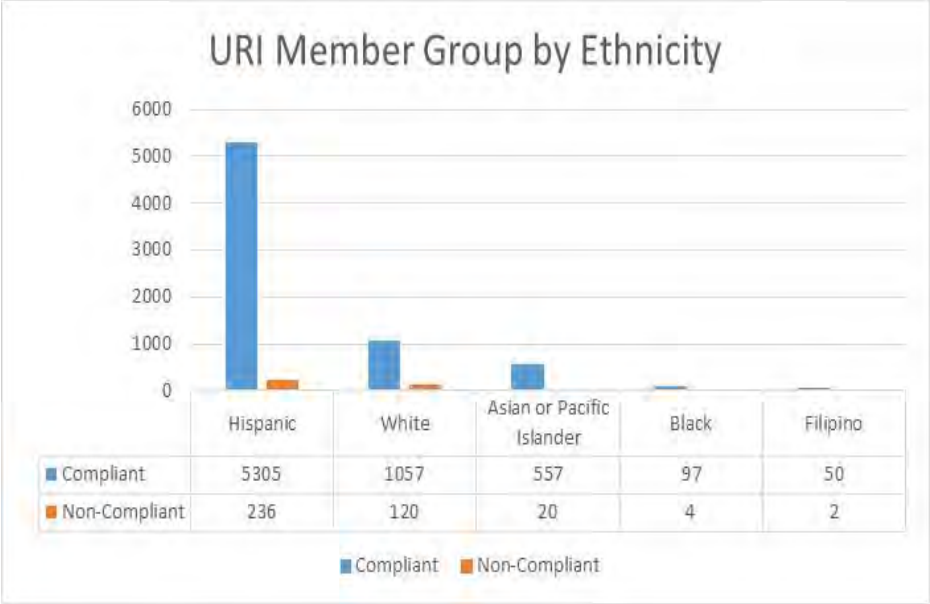
EVALUATION OF 2016 WORK PLANAAB

RESULTS (Quantitative Analysis) Goal Not Met

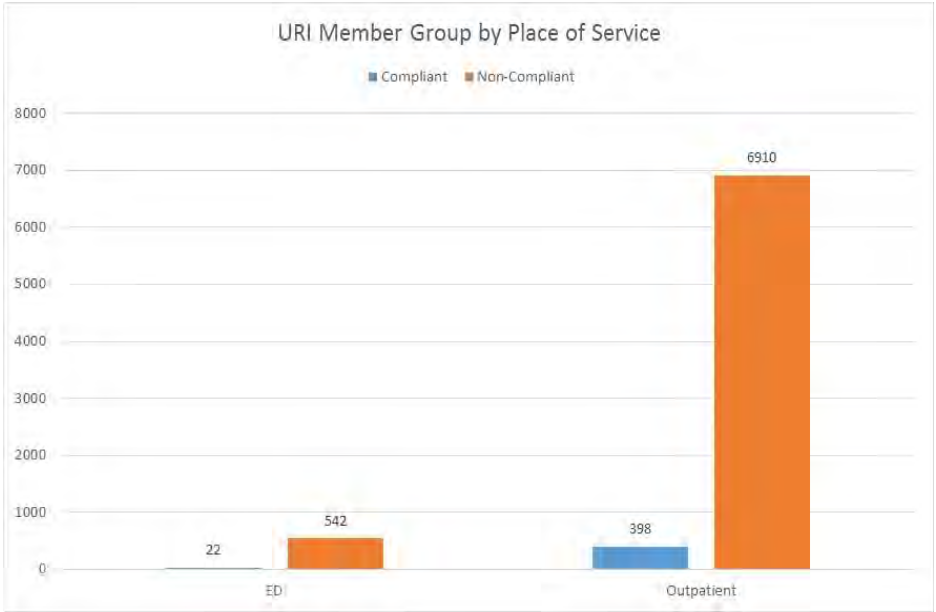
							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	**Domain of Care**	**2014**	**2015**	**2016**	**2015-16 Rate Difference**	**Current NCQA Percentile Ranking**	10th	25th	50th	75th	90th
Effectiveness of Care: Respiratory Conditions											
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Q	92.67	94.82	94.80	↓ -.02	75th	76.23	84.92	89.39	93.38	96.08

RESULTS (Quantitative Analysis)

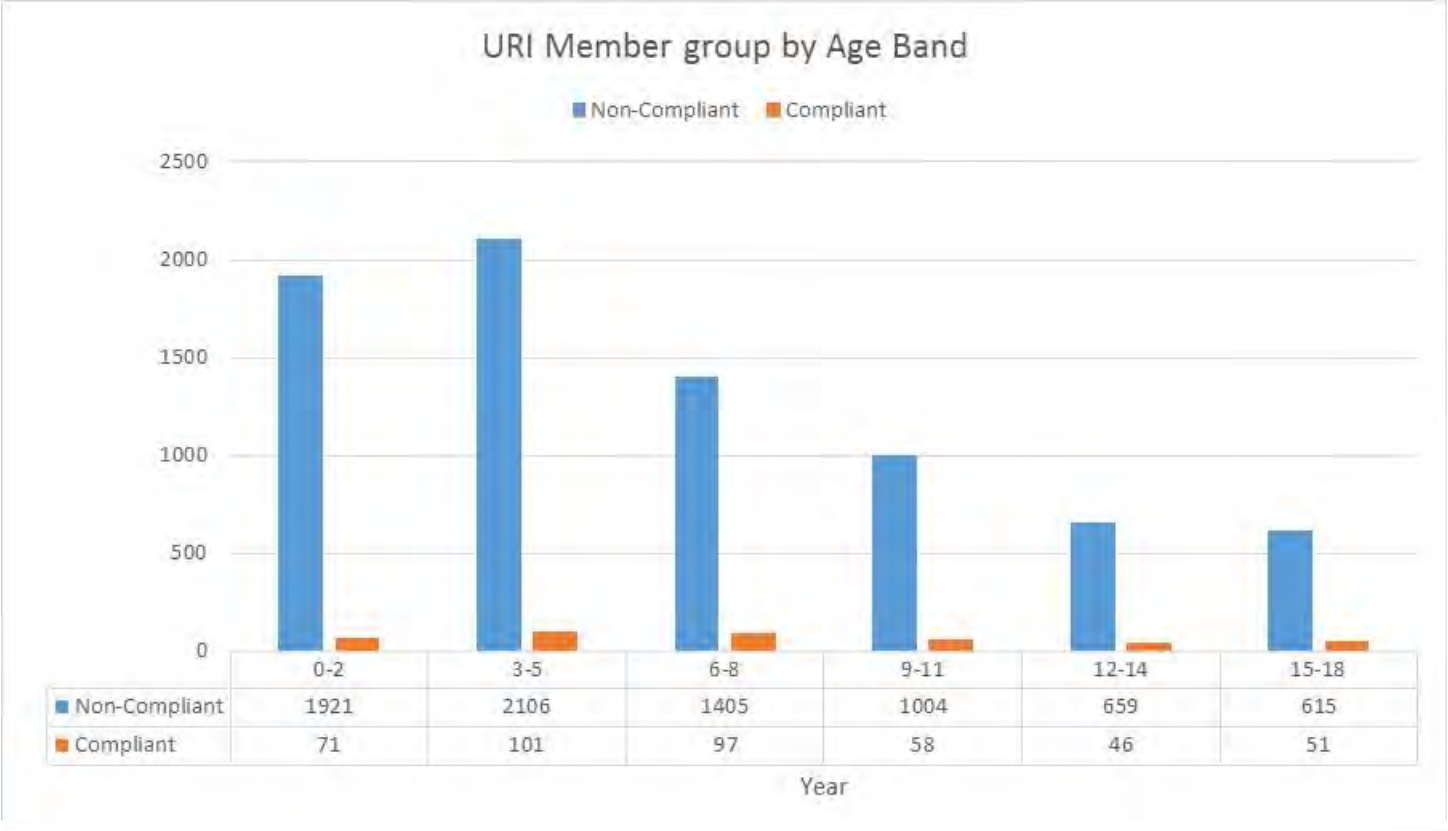
Graph #1



Graph #2



Graph #3



RESULTS (Qualitative Analysis) The rate for this measure fell .02% points from the previous year and fell short of the NCQA 90th Percentile by 1.28% points. Disparities analysis showed that Hispanic and white children were most non-compliant. Graph #2 shows that most inappropriate dispensing of antibiotics events was in the outpatient setting (6910) versus the ED setting (542).

BARRIER ANALYSIS

Parental pressure may be a contributing factor. Parents want their children to feel better soon and often do not understand that URIs are caused by a virus and will not resolve with the use of an antibiotic.

NEXT STEPS

Continue educating providers using evidence based articles of the importance of not prescribing antibiotics unless necessary. Continue to provide lists of members who have been prescribed an antibiotic inappropriately. Provide links to educational material that providers can give to parents such as those from the CDC and AWARE (Alliance Working for Antibiotic Resistance Education).

Also, newly revised provider feedback performance reports and HEDIS report cards will be disseminated to clinics on a bi-monthly basis and rates discussed during the HEDIS results reviews.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
DHCS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis - percentage of adults 18 – 64 years of age with a diagnosis of acute bronchitis **who were not dispensed** an antibiotic prescription.	Meet or exceed NCQA 50th Percentile	Q4 2016	Provide provider performance feedback by means of 2015 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI

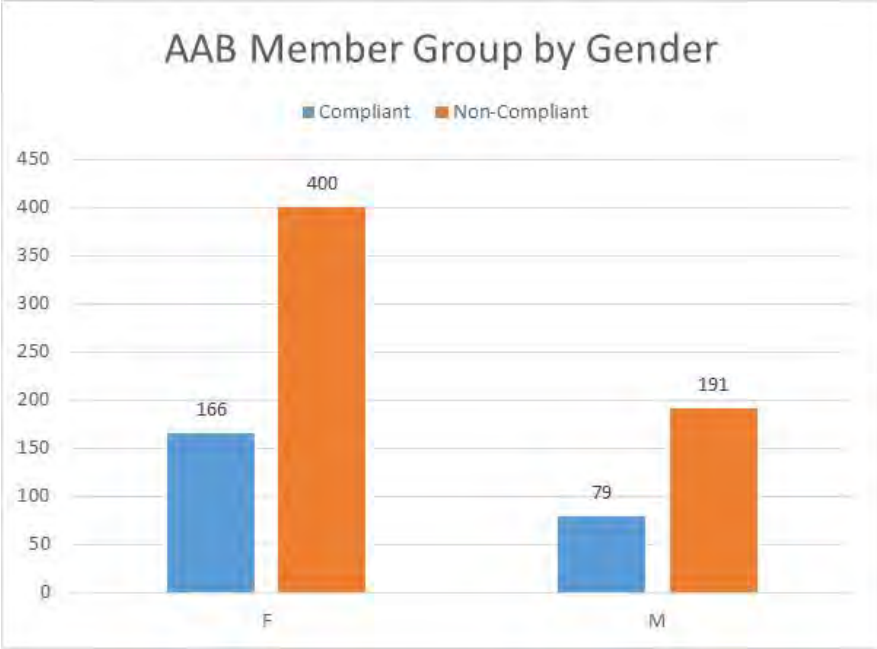
EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis) Goal Met Rate increase from MY 2015 of 3.69% points put us into the NCQA 50th Percentile

							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	**Domain of Care**	**2014**	**2015**	**2016**	**2015-16 Rate Difference**	**Current NCQA Percentile Ranking**	10th	25th	50th	75th	90th
Utilization											
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Q	21.15	25.58	29.27	↑ 3.69	50th	19.47	22.13	26.26	32.33	38.7

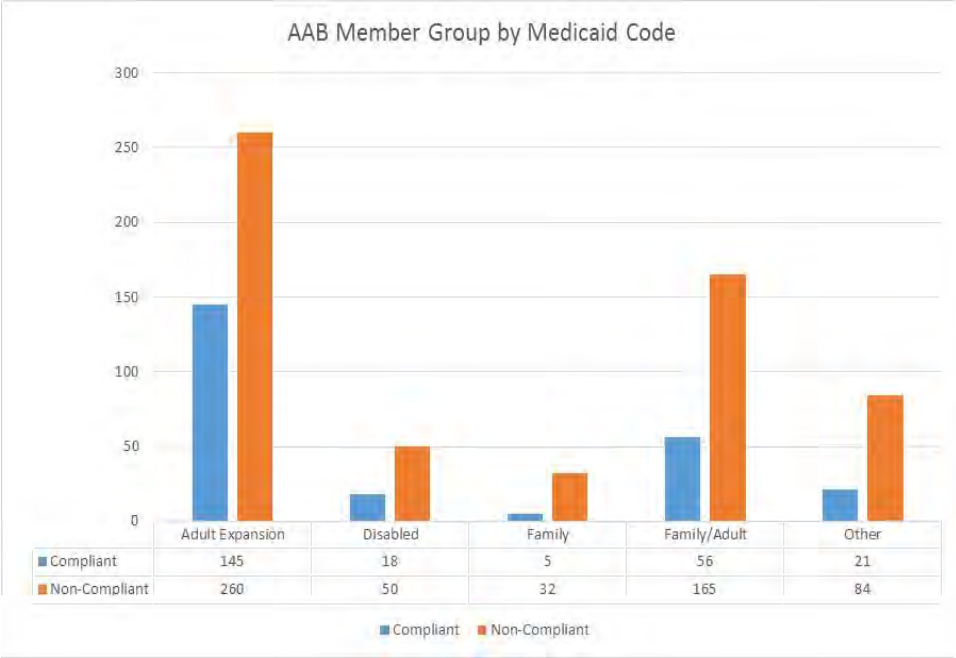
RESULTS (Quantitative Analysis)

Graph 1: Avoidance of Antibiotic with Acute Bronchitis by Gender

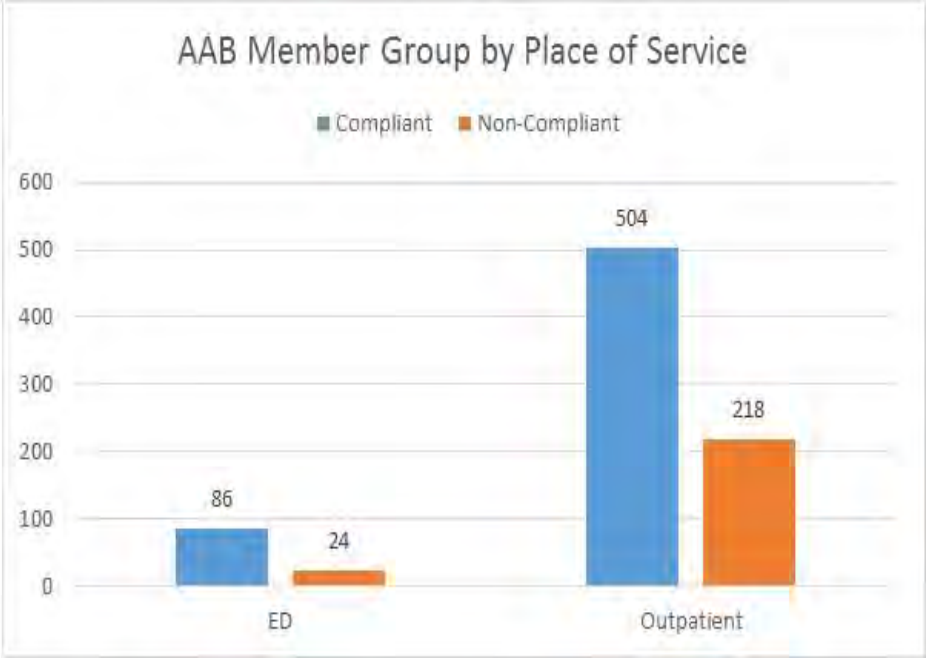


Graph 2: Avoidance of Antibiotic with Acute Bronchitis by ethnicity

Graph #3



Graph #4



RESULTS (Qualitative Analysis)

Disparities analysis by gender and ethnicity (Graphs 1 & 2) indicate that white and Hispanic females were the highest recipients of inappropriately dispensed antibiotics.

Barrier Analysis

Member expectations to receive an antibiotic may be a contributing factor. 90% of bronchitis infections are caused by viruses and will not resolve by use of antibiotics. However, member misunderstanding of when antibiotics work can contribute to the expectation of being prescribed antibiotics.

Next Steps

Continue to provide provider resources from the CDC and AWARE (Alliance Working for Antibiotic Resistance Education) and discussion during HEDIS results review. These resources can provide member educational materials that providers can share with their members. Provide education via use of evidenced based articles. Also, newly revised provider feedback performance reports and HEDIS report cards will be disseminated to clinics and rates discussed during the HEDIS results reviews.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
DHCS	Ambulatory Care- Summarizes Utilization of Ambulatory Care Outpatient Visits – per 1,000 Member Months	Meet Medi-Cal Managed Care Performance Dashboard Rate	Q4 2016	Adult and child member letters for appointment reminders/engage members to see their PCP Meet with clinics to discuss results of clinic rates	QI

EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis) Partially Met The most recent Medi-Cal Managed Care Performance Dashboard rate for outpatient visits is 690/1000 so, while our rate went up by 6.17/1000 visits we are still 437.78 short, but we are moving in the right direction. For ED visits the MCMCPD rate is 42/1000 and we were lower by 3.21/1000 and lower than last year's rate by 2.26/1000.

2017 NCQA Percentile Ranking

HEDIS Measure/Data Element	2014	2015	2016	2015-16 Rate Difference
Effectiveness of Care: Respiratory Conditions				
Ambulatory Care	Visits/1000	Visits/1000	Visits/1000	
Outpatient Visits	209.28	246.05	252.22	↑6.17/1000
ED Visits	39.21	41.05	38.79	↓ -2.26/1000

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					

RESULTS (Qualitative Analysis)

While our rates for 2016 did not meet the most recent Medi-Cal Managed Care Performance Dashboard rate our numbers for both Outpatient & ED Visits are improving

BARRIER ANALYSIS

For outpatient visits - In 2016 there was a texting campaign that encouraged members to contact their providers and schedule and complete appointments. We had well-child exam member incentive program to get members in to see their providers and also the addition of a clinic system which brought in an additional 9 clinic sites. These additional interventions considerably contributed to the increase in the Ambulatory Outpatient Visit rate.

For ED visits –GCHP Eligible population increased which increased the outpatient visits but decreased ED visits. Also, there was a change to counting ED visits in that those resulting in an inpatient admit within the same day or one day later are now excluded from being counted as an ED visit. Because of these 2 scenarios, there likely was a decline for this measure.

NEXT STEPS

Provider feedback performance reports and the newly revised HEDIS report cards will be disseminated to clinics on a bi-monthly basis and rates discussed during the HEDIS results reviews.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
Quality Improvement Projects					
DHCS	External PIP: Improve the rates for Childhood Immunization Status (CIS) Combo 3 HEDIS measure	Increase rates at Las Islas Family Medical Group from 67.66% to 77.66%	June 30, 2017	Submit Modules as directed by DHCS for approval • Modules 3,4 and 5 submit separately Report 3 month PDSA cycle results to QIC and DHCS/HSAG	QI

EVALUATION OF 2016 WORK PLAN

							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	**Domain of Care**	**2014**	**2015**	**2016**	**2015-16 Rate Difference**	**Current NCQA Percentile Ranking**	10th	25th	50th	75th	90th
Effectiveness of Care: Prevention and Screening											
Childhood Immunization Status											
Combination #3	Q, A, T	69.97	75.43	64.96	↓ **-10.47**	25th	57.84	64.30	71.06	75.60	79.81

RESULTS (Quantitative Analysis)

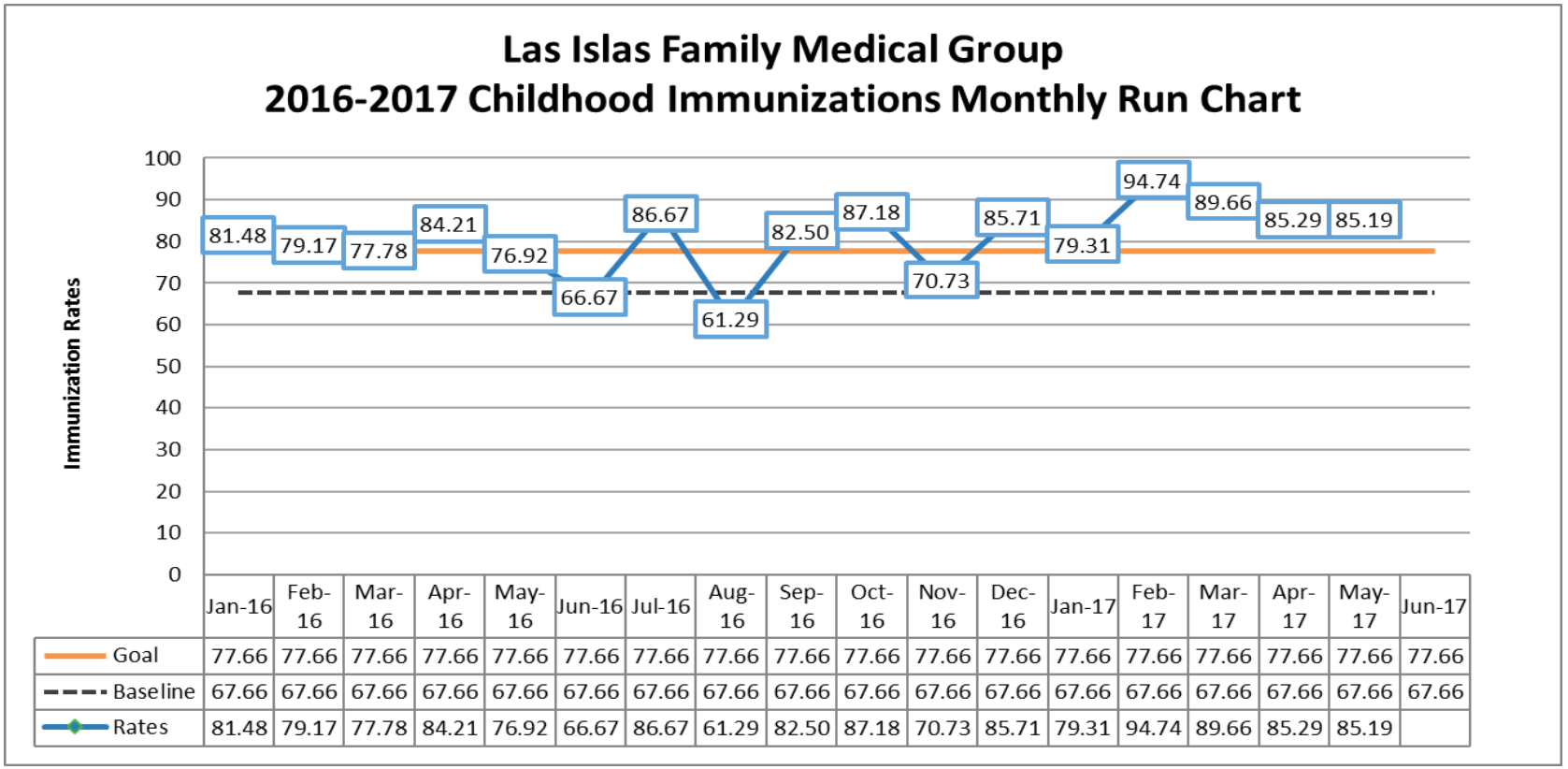
Note: This improvement project is still in-progress and the final quantitative analysis is pending completion of the Plan-Do-Study-Act on June 30, 2017.

Status of Module Submissions to HSAG/DHCS	HSAG Due Date	GCHP Submission Date
Module 3: Intervention Determination and Process Mapping	02/29/16	02/29/2016
Module 4: Plan section	06/01/16	06/01/16
Module 4: Preliminary PDSA Results to HSAG and DHCS	09/16/16	09/16/16
Module 4: Do-Study-Act sections	08/15/17	PIP Still In-Progress
Module 5: PIP Conclusion	08/15/17	PIP Still In-Progress
HSAG's Feedback to GCHP on PIP	10/31/17	N/A

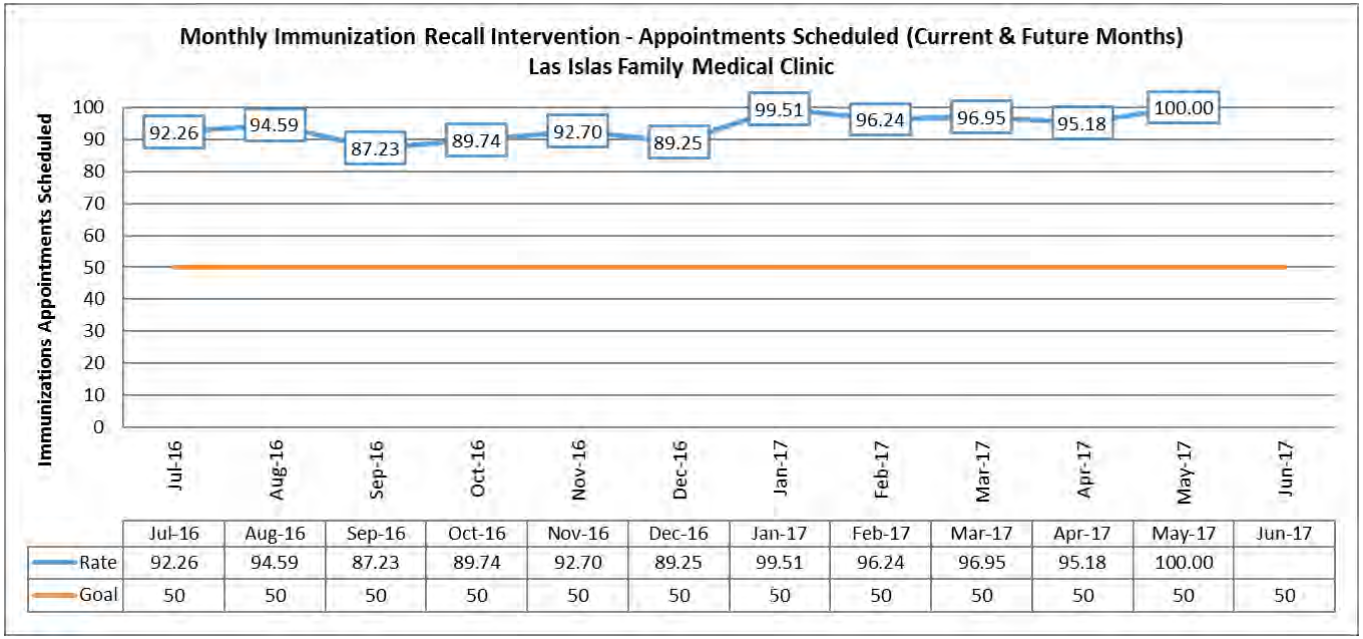
2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					

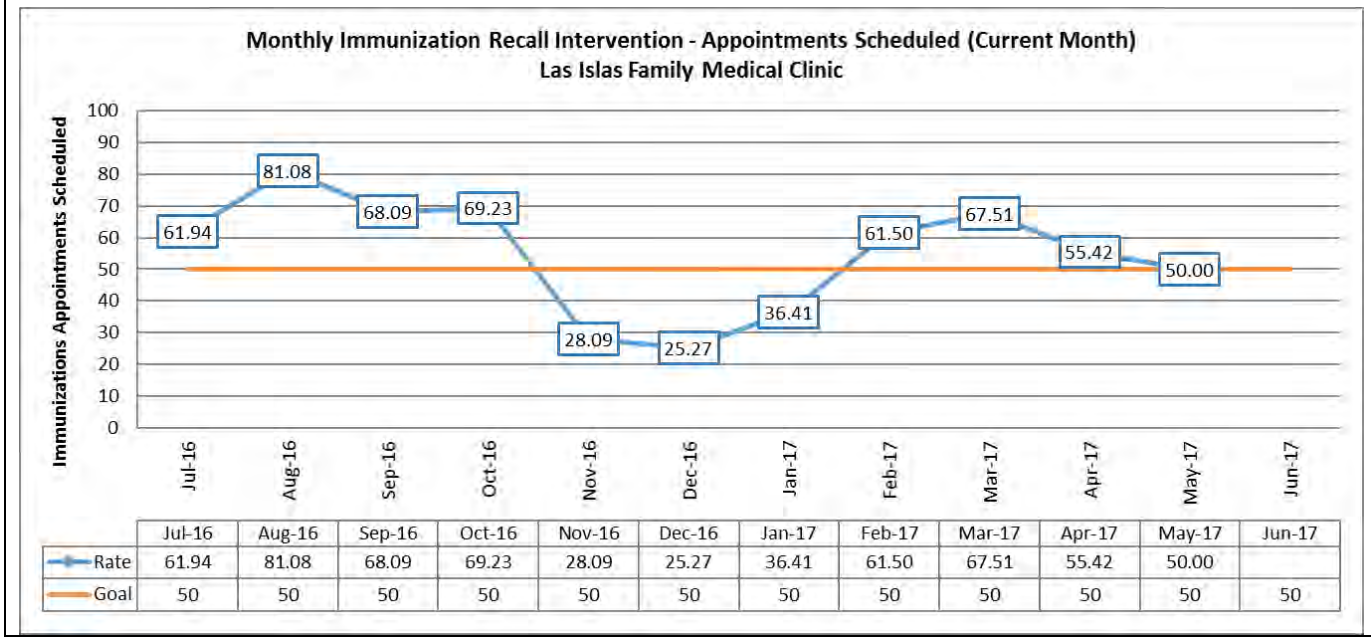
Child Immunization PIP Updates to Quality Improvement Committee
03/18/16
06/28/16
09/27/16
12/13/16
03/28/17



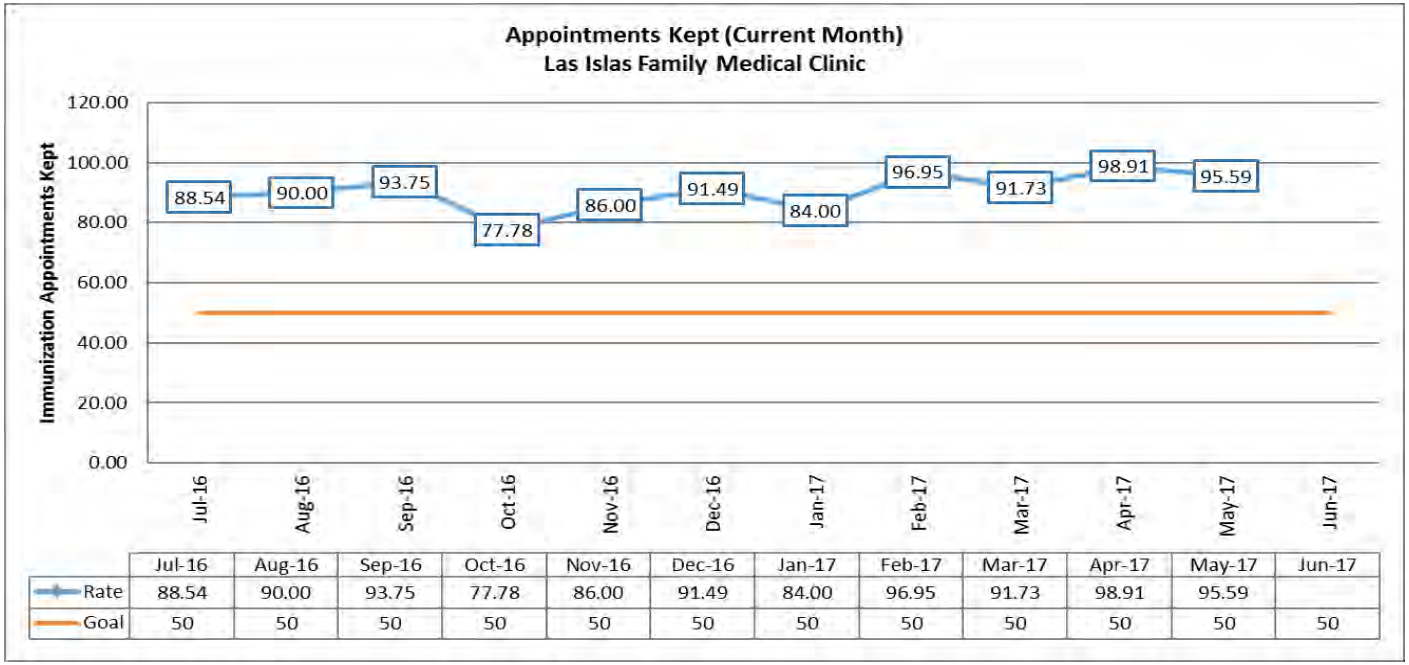
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Goal	77.66	77.66	77.66	77.66	77.66	77.66	77.66	77.66	77.66	77.66	77.66	77.66	77.66	77.66	77.66	77.66	77.66	77.66
Baseline	67.66	67.66	67.66	67.66	67.66	67.66	67.66	67.66	67.66	67.66	67.66	67.66	67.66	67.66	67.66	67.66	67.66	67.66
Rates	81.48	79.17	77.78	84.21	76.92	66.67	86.67	61.29	82.50	87.18	70.73	85.71	79.31	94.74	89.66	85.29	85.19	



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Rate	92.26	94.59	87.23	89.74	92.70	89.25	99.51	96.24	96.95	95.18	100.00	
Goal	50	50	50	50	50	50	50	50	50	50	50	50



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Rate	61.94	81.08	68.09	69.23	28.09	25.27	36.41	61.50	67.51	55.42	50.00	
Goal	50	50	50	50	50	50	50	50	50	50	50	50



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Rate	88.54	90.00	93.75	77.78	86.00	91.49	84.00	96.95	91.73	98.91	95.59	
Goal	50	50	50	50	50	50	50	50	50	50	50	50

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					

PRELIMINARY RESULTS (Qualitative Analysis)

Note: This improvement project is still in-progress and the final qualitative analysis is pending completion of the Plan-Do-Study-Act on June 30, 2017.

- To implement the scheduling outreach project for this study, the clinic had to assigned one full-time staff person.
- The clinic reported that many parents preferred to schedule their child's immunizations appointments at the clinic's weekend clinic because the parents did not have to take time off work.
- The clinic identified some pediatricians were not giving all immunizations at one appointment but "splitting" them and sometimes the parents were not aware of were not informed that they needed to return to the clinic to complete the remining appointments. The clinic trained the medical assistants to schedule the child for a follow-up appointment or to notify the parents to utilize the walk-in clinic to complete the remaining immunizations.
- All medical assistants have adopted the process of printing immunization reports and notifying providers if any immunizations are needed – no compliant from staff on extra work.

PRELIMINARY BARRIER ANALYSIS

Note: This improvement project is still in-progress and the final barrier analysis is pending completion of the Plan-Do-Study-Act on June 30, 2017.

- The clinic cannot administer immunizations to children assigned to the clinic because some parent(s) takes their child to another clinic and do not contact the health plan to change PCP assignment.
- The CAIR 2.0 Upgrade that began in October 2016 created some technical issues that made it more difficult for the clinic to manage the immunization status of their patients. Most of these issues were resolved by March 2017, but some of the issues the clinic encountered included:
  - Duplicate CAIR IDs
  - Duplicate flu vaccines
  - Reports printing in PDF only
  - ACIP guidelines not included – these were included in CAIR 1.0 guidelines assisted clinic with identify when immunization were due.
- Clinic's EMR not sending immunization data to CAIR – still needs to be manually entered
- Difficulty accessing parents by phone
- Coordinating appointments with provider and parent schedule.
- No show appointments

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
DHCS	Internal PIP: Increase rates of developmental screenings	Increase rates at Sierra Vista Family Medical Clinic from 45.82% to 55.82%.	June 30, 2017	Submit Modules as directed by DHCS for approval • Modules 1 & 2 • Modules 3, 4, and 5 submit separately Report 3 month PDSA cycle results to QIC and DHCS/HSAG	QI Help Me Grow Ventura

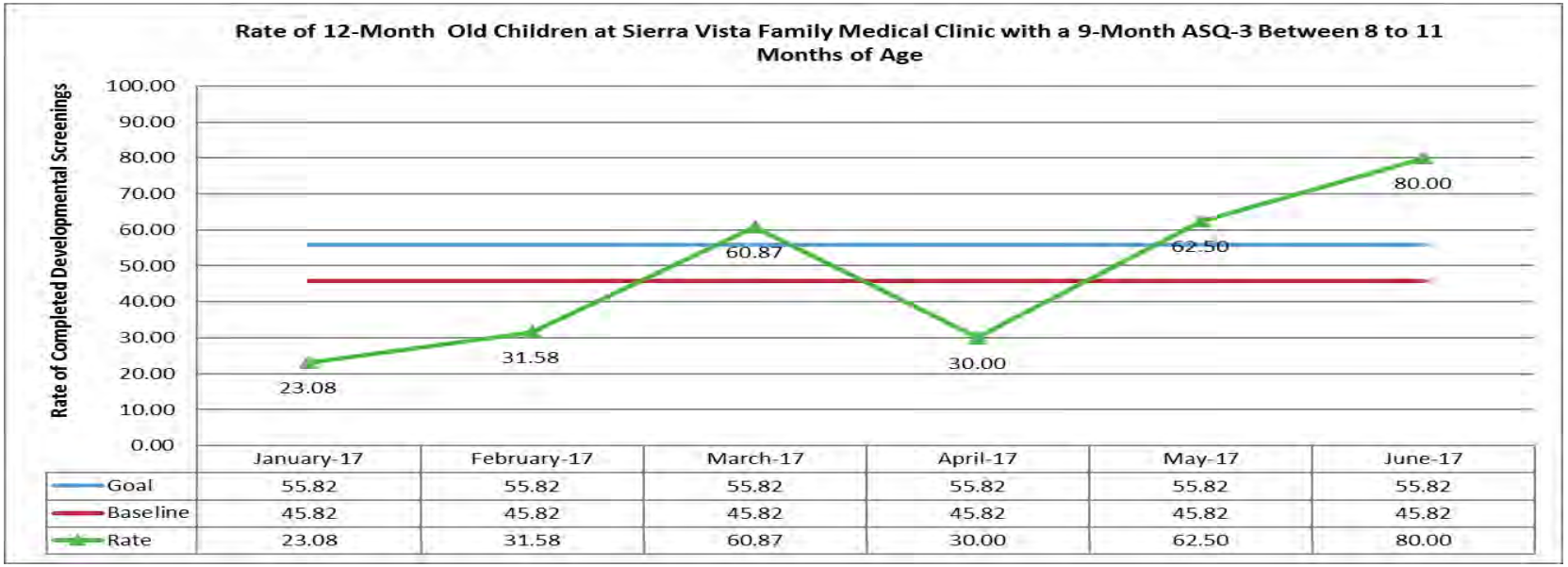
EVALUATION OF 2016 WORK PLAN

PRELIMINARY RESULTS (Quantitative Analysis)

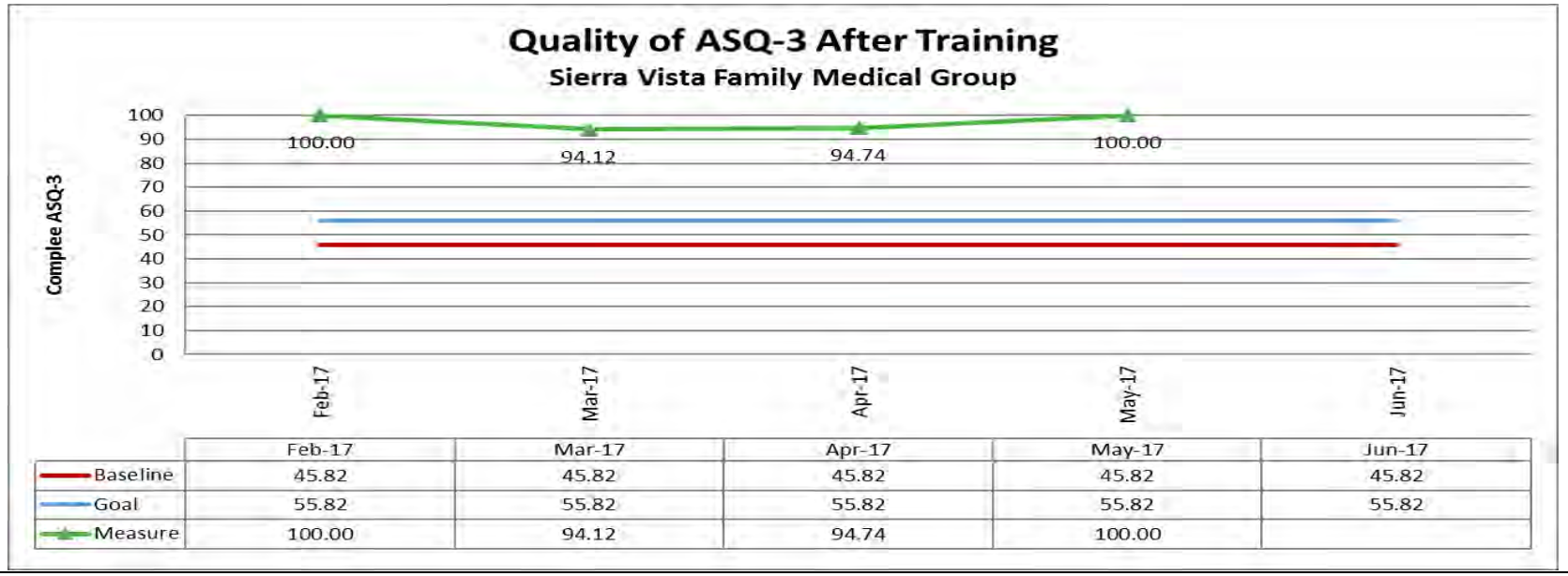
Note: This improvement project is still in-progress and the final quantitative analysis is pending completion of the Plan-Do-Study-Act on June 30, 2017.

Status of Module Submissions to HSAG/DHCS	HSAG Due Date	GCHP Submission Date
Module 1: PIP Initiation	12/9/16	12/9/16
Module 2: SMART AIM Data Collection Plan	12/9/16	12/9/16
Module 3: Intervention Determination and Process Mapping	01/31/17	01/31/17
Module 4: Plan section	03/17/17	03/03/17
Module 4: Preliminary PDSA Results to HSAG and DHCS	Pending HSAG	Pending HSAG
Module 4: Do-Study-Act sections	08/15/17	PIP Still In-Progress
Module 5: PIP Conclusion	08/15/17	PIP Still In-Progress
HSAG's Feedback to GCHP on PIP	10/31/17	N/A

Child Developmental Screening PIP Updates to Quality Improvement Committee
09/27/16
12/13/16
03/28/17



	January-17	February-17	March-17	April-17	May-17	June-17
Goal	55.82	55.82	55.82	55.82	55.82	55.82
Baseline	45.82	45.82	45.82	45.82	45.82	45.82
Rate	23.08	31.58	60.87	30.00	62.50	80.00



	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Baseline	45.82	45.82	45.82	45.82	45.82
Goal	55.82	55.82	55.82	55.82	55.82
Measure	100.00	94.12	94.74	100.00	

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					
PRELIMINARY RESULTS (Qualitative Analysis) Note: This improvement project is still in-progress and the final qualitative analysis is pending completion of the Plan-Do-Study-Act on June 30, 2017. • The clinic's initial goal for this five-month study was to complete a 9-month ASQ-3 on all 8 to 11-month-old children that had an office visit. However, during the first month into the study, the clinic staff reported it was very difficult to complete the ASQ-3 when the office visit was directed on treating a child's acute/chronic condition and the physician and parent did not have time to answer the ASQ-3 questionnaire. For the remaining four months of the study, the focus was redirected to give ASQ-3 forms to children during their well-child exams. • One pediatrician stated it was difficult for the clinic to identify which children needed well-child exams and stated that it was the health plan's responsibility to notify their members to schedule their annual preventive care exams. • The clinic staff reported that the training provided from Help Me Grow on the ASQ-3 form helped increase the utilization of ASQ-3 forms. • The clinicians reported that completed the ASQ-3 was not as difficult as they had perceived.					
PRELIMINARY BARRIER ANALYSIS Note: This improvement project is still in-progress and the final barrier analysis is pending completion of the Plan-Do-Study-Act on June 30, 2017. • The clinic cannot complete well-child exam with ASQ-3 to children assigned to the clinic because some parent(s) takes their child to another clinic and do not contact the health plan to change PCP assignment. • One of the planned process improvement for this study was to transition the distribution of questionnaires given to the parent from the back-office staff to the front office liaison. The purpose for this transition was to give parents more time to complete the questionnaire and the purpose of creating a new role, the front office liaison, was to help parents complete the forms and answer any questions. However, due to staffing and office space limitations, the clinic has not been able to implement this change.					
Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
GCHP	Internal PIP collaborative with Ventura County Public Health (VCPH): Increase rates of perinatal 4Ps Plus Perinatal Substance Use Screening and linkage to services	Metric TBD	TBD	VCPH conduct training on 4Ps Plus VCPH to track rates and report to GCHP	QI VCPH
EVALUATION OF 2016 WORK PLAN					
RESULTS (Quantitative Analysis) This improvement project was canceled due to the unavailability of VCPH resources.					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
DHCS	IP: Cervical Cancer Screening	Meet or exceed DHCS MPL	Q4 2016	Implement alternative method of engaging members: Text program Provider performance feedback by means of 2015 HEDIS report cards Provide bi-annual member lists of members who have not received services Provide performance feedback reports at least twice to clinics	QI

EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis) Goal Met Our rate for Cervical Cancer Screenings increased by 3.89 % over the 2015 rate of 50.61. This resulted in the measure moving from below the MPL in 2015 to above the MPL for 2016.

							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	**Domain of Care**	**2014**	**2015**	**2016**	**2015-16 Rate Difference**	**Current NCQA Percentile Ranking**	10th	25th	50th	75th	90th
Effectiveness of Care: Prevention and Screening											
Cervical Cancer Screening	Q, A	61.77	50.61	54.50	↑ 3.89	25th	41.12	48.26	55.92	63.70	69.89

Plan-Do-Study-Act #1: Bundled Telephonic Member Outreach Program

Intervention: The Quality Improvement and Health Education/Cultural Linguistics Departments collaborated to test if a bundled telephonic member outreach program, which consists of a member mailer (Pap test reminder letter/educational material) followed by a telephone call, to verify receipt of the letters and assist with scheduling appointments, will engage women to complete their cervical cancer screenings.

Goal: We almost me our 5% goal of increasing cervical cancer screening in women enrolled at Mandalay Bay Women's and Children's Medical Group from 23.36% (25/107) to 28.36% (31/107) by December 31, 2016.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee

Objective: Improve Quality and Safety of Clinical Care Services (cont.)

Rates Before and After Intervention

A	B	C	D	E	F	G	Rate Change
Clinic	**Enrolled at Clinic (111- 4 Who Lost Coverage) = 107**	**Exams Before Intervention**		**Exams After Intervention**	**Rate Comparison**		
		Claims	**Medical Record Review**	**Medical Record Review**	**Rate Before Intervention (C+D)/B**	**New Rate After Intervention (C+D+E)/B**	
Mandalay Bay	107	20	5	5	23.36	28.03	+4.67

Results of Outreach and Medical Record Review Validation

Telephonic Outreach Stats		**Medical Record Review Validation of CCS Exams**		
Call Stats	**Count**	**CCS Exams Completed**	**CCS Before Intervention**	**CCS After Intervention**
Members on Call List	91			
Member Who Lost Medicaid Benefits and Not Called	4			
Eligible Members Called	87			
Unreachable Members	60			
Reachable Members	27			
Second CCS Packets Mailed	6			

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					
Outreach Outcome for Members with CCS Exams		10			
Already Scheduled Appt.		4	3	1	
Preferred to Scheduled Appt.		1	0	1	
Requested Assistance		2	0	2	
Concerns on Medicaid Eligibility		1	0	1	
No Answer		1	1	0	
Number Disconnected		1	1	0	
Total Exams		**10**	**5**	**5**	

RESULTS (Qualitative Analysis)

Unreachable Members

- 69% (60/87) of the eligible members on the call list were unreachable by telephone.
- Only 27 of the 143 documented call attempts resulted in direct contact with the members.
- 116 call attempts resulted in leaving a message, no answer or a disconnected number.
- Members with disconnected numbers or wrong numbers had only one call attempt.
- 20 members contacted stated they had or planned to have a CCS exam but only 10 CCS exams were found during the medical record review.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					

BARRIER ANALYSIS

- Unreachable Members
- Clinic's Resistance to Scheduling Appointments
- Members' Hesitation with Verifying Member Information via Telephone
- Underutilization of the Outbound Call Spreadsheet
- Outreach Started During Holiday Season
- Member Outreach Incomplete

NEXT STEPS for PDSA #2:
We will continue the Bundled Telephonic Member Outreach Program for PDSA #2 with a new clinic: Conejo Valley Medical Group.

Lessons Learned from PDSA #1:

- Continue 2nd and 3rd call attempts for members with disconnected numbers because the phone may become reconnected.
- Look at available resources to find other phone numbers for members who have disconnected numbers, wrong numbers or no numbers.
- Review progress and data collected from outbound calls more frequently to ensure outreach program is progressing as planned.

Modifications to PDSA#2:

- Revise the data collection tool to improve the data collection process.
- Contact the targeted clinic prior to beginning the telephone calls and establish a clinic contact for scheduling appointments.
- Identify resources for searching addition phone numbers for members who have disconnected or wrong numbers.
- Schedule more frequent QI-HE meetings to review data and review progress of improvement project.

RESULTS (Quantitative Analysis) Goal Not Met

Plan-Do-Study-Act #2: Bundled Telephonic Member Outreach Program
Intervention: The Quality Improvement and Health Education/Cultural Linguistics Departments collaborated to test if a bundled telephonic member outreach program, which consists of a member mailer (Pap test reminder letter/educational material) followed by a telephone call, to verify receipt of the letters and assist with scheduling appointments, will engage women to complete their cervical cancer screenings.
Goal: We did not meet our goal of increasing cervical screenings in women enrolled at Conejo Valley Medical Group by 5.0%, from 52.85% (982/1858) to 57.85% (1075/1858).

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					

Rates Before and After Intervention

A	B	C	D	E	F	G	Rate Change
Clinic	**Enrolled at Clinic (1963) – Excluded TAH (14) MI (91)**	**Exams Before Intervention**		**Exams After Intervention**	**Rate Comparison**		
		Claims	**Medical Record Review**	**Medical Record Review**	**Rate Before Intervention (C+D)/B**	**New Rate After Intervention (C+D+E)/B**	
Conejo Valley	1858	857	125	63	52.85	56.24	+3.39

Telephonic Outreach Stats

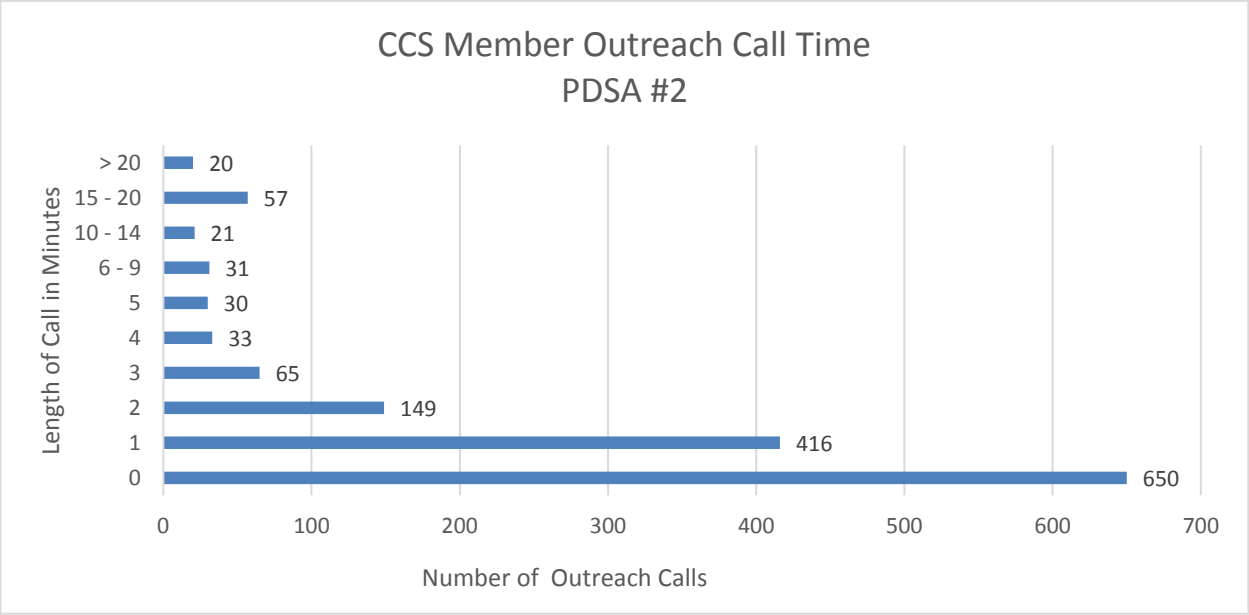
Outreach Stats	Counts
Members on Original Call List	1106
Members Excluded: Medi-Cal Ineligible	91
Members Called	1015
Total Calls Made	1472
CCS Packets Returned as Undeliverable	0
CCS Packets Re-Mailed Due to Unable to Reach (251) Due to Original Not Received (11)	262

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					

Call Outcome

Call Outcome Stats	Counts
Already Scheduled Appointment	61
CCS Exam Completed Within Last	220
Assisted with Scheduling CCS Exam	20
Member Will Schedule Appointment	55
Member Not Interested	169
No Answer	309
Left Message	424
Number Disconnected	154
Wrong Number	55

Call-Time Status



Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					

Medical Record Reviews Outcome

MRR Stats	Counts
Records Reviewed	1106
Women with CCS Exams Before Intervention	125
Women with CCS Exams After Intervention	63
Women Excluded due to documentation of Total Abdominal Hysterectomy (TAH)	14
Women Who Refused CCS Exam in Physician's Office	8

RESULTS (Qualitative Analysis)

BARRIER ANALYSIS

- Unreachable members.
- Clinic's resistance to scheduling appointments.
- Members' hesitation with verifying member information via telephone.
- Outreach calls are time-intensive – Multiple call attempts are needed to contact members.
- Language-line calls are time-intensive.
- Limited appointment availability for Medi-Cal patients.
- Discussing Pap exams too personal for some members
- Missing claims/encounter/clinical data results falsely identifying members as non-compliant.

NEXT STEPS

Lessons Learned:

- Telephonic outreach is a time intensive process and direct contact with members does not increase member engagement with completing cervical cancer screening exams.
- Some of the challenges with direct outreach to members include inability to reach all members and members disinterest and/or hesitation with discussing cervical cancer screenings. Additionally, some women expressed that this was a sensitive or personal topic.

Modification to Intervention:

- We will discontinue the telephonic outreach program
- We will continue the annual CCS mailers that consist of the cervical cancer screening letter and educational material.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
DHCS	IP: Well Child Visits in Third, Fourth, Fifth and Sixth Years	Increase rates by 5% over previous measurement year	Q4 2016	Continue member incentive program to engage members Provide provider performance feedback by means of 2015 HEDIS report cards Provide bi-annual member lists with members who have not received services Provider education of required periodicity of exams and required components of exams HEDIS results visits with clinics	QI

EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis) Goal Met

							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	**Domain of Care**	**2014**	**2015**	**2016**	**2015-16 Rate Difference**	**Current NCQA Percentile Ranking**	10th	25th	50th	75th	90th
Utilization											
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life		64.11	64.72	66.18	↑ 1.46	25th	60.64	64.72	71.42	77.57	82.97

Plan-Do-Study-Act #1: Provider Outreach Project (Performance Feedback Reports)

Intervention: This is a provider/clinic-level intervention to test if Performance Feedback Reports, which list children who have not had their well-child exams, will help clinics schedule appointments and ultimately increase the rate of well-child exams.

Goal: We surpassed our goal of increasing well-child exams by 5% for children, 3 to 6 years of age, who are enrolled at the following two low performing Ventura County Medical Center (VCMC) clinics:

Las Posas Family Medical Group – Increase rate from 40.17% (92/229) to 45.17 (104/229) by December 31, 2016

West Ventura Medical Clinic – Increase rate from 52.04% (153/294) to 57.04% (168/294) by December 31, 2016

Rates Before and After Intervention

A	B	C	D	E	F	G	Rate Change
Clinic	**Sample**	**Exams Before Intervention**		**Exams After Intervention**	**Rate Comparison**		
		Claims	**Medical Record Review**	**Medical Record Review**	**Rate Before Intervention (C+D)/B**	**New Rate After Intervention (C+D+E)/B**	
Las Posas	**229**	**46**	**46**	**30**	**40.17**	**53.28**	**+13.11**
West Ventura	**294**	**98**	**55**	**42**	**52.04**	**66.33**	**+14.29**

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					

Results of Medical Record Reviews

Clinic	Exams Before Intervention	Exams After Intervention	No Exams	Reason for No Exams
Las Posas Family Medical Group	46	30	107	No Visit in 2016 – 34 Acute/Urgent Care Visits – 50 Not Registered with PCP – 15
West Ventura Medical Clinic	55	42	99	No Visits in 2016 – 41 Acute/Urgent Care Visits – 36 No Registered with PCP – 27 Well-Child Exam Missing Documentation - 3

RESULTS (Qualitative Analysis) While the rate for this measure improved 1.46% over the previous year; we missed our goal by 3.54%.

Plan-Do-Study-Act #1: Provider Outreach Project (Performance Feedback Reports)

- **Varied Clinic Receptiveness to Reports**
  - West Ventura Medical Clinic: The manager seemed more engaged and provided feedback to the QI Department that their clinic had reviewed the reports and were scheduling well-child exams. The manager also requested Performance Feedback Reports for two other clinics she managed.
  - Las Posas Family Medical Group: The manager only confirmed receipt of the reports but didn't provide additional feedback.

- **Ease of Generating Performance Feedback Reports**
  The performance feedback reports are easily generated by exporting a W34 compliance reports from the HEDIS software and importing it into an Access database to create custom reports. However, this is a manual process that requires multiple steps. The health plan's new HEDIS software offers more diverse reporting capabilities that may allow the QI Department to generate these clinic-level and member-level gap analysis reports directly from the HEDIS software.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					

BARRIER ANALYSIS

- **Distribution of Performance Feedback Reports to Clinic Contacts**

Relying on a primary contact at VCMC to distribute the Performance Feedback Reports to the clinics was a barrier in getting the reports to the clinics timely so they could begin their member outreach to schedule well-child exams. Although VCMC's administration had requested this method of distribution, both Gold Coast Health Plan and VCMC will need to determine a more reliable method of delivering reports to the clinics.

- **Limited Outreach to Clinics**

DHCS's PDSA Cycle Feedback on September 30, 2016, suggested to make the intervention more active by:

- Establishing a direct clinic contact and schedule ongoing communication
- Provide a concrete list of actionable opportunities and a specific timeframe with a deadline
- Conduct a WebEx conference call with the appropriate provider staff to review the care gap report ad help clarify the purpose and urgency of the activity

The QI Department established direct clinic contacts and offered WebEx conference calls. However, due to limited staff and resources, the QI Department could not establish more ongoing communications with the clinics and this may be difficult to maintain if this intervention is expanded to multiple clinics.

- **Missing Claims Data Creates False Negatives on Performance Feedback Reports**

The primary data sources for the Performance Feedback Reports are claims/encounter and supplemental data. Due to untimely submission of some claims data from providers, the reports may include children who have had a well-child exam. This barrier may be unavoidable since claims submission is process initiated at the provider-level; however, to minimize the effects of claims lag, GCHP continues to promote providers to submit claims timely.

NEXT STEPS

For PDSA #2, we will continue to study the effectiveness of Performance Feedback Repots with two new VCMC clinics:

Academic Family Medical Group
Magnolia Family Medical Group

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee

Objective: Improve Quality and Safety of Clinical Care Services (cont.)

RESULTS (Quantitative Analysis) Goal Not Met

Plan-Do-Study-Act #2: Provider Outreach Project (Performance Feedback Reports)

Intervention: This is a provider/clinic-level intervention to test if Performance Feedback Reports, which list children who have not had their well-child exams, will help clinics schedule appointments and ultimately increase the rate of well-child exams.

Goal: We almost our goal of increasing well-child exams by 10% for children, 3 to 6 years of age, who are enrolled at the following two low performing Ventura County Medical Center (VCMC) clinics:

Academic Family Medical Center - Increase rate from 56.22% (140/249) to 66.22% (165/249)

Magnolia Family Medical Clinic – Increase rate from 61.28% (334/545) to 71.28% (389/545)

Rates Before and After Intervention

A	B	C	D	E	F	G	Rate Change
Clinic	**Sample**	**Exams Before Intervention**		**Exams After Intervention**	**Rate Comparison**		
		Claims	**Medical Record Review**	**Medical Record Review**	**Rate Before Intervention (C+D)/B**	**New Rate After Intervention (C+D+E)/B**	
AFMC	249	114	26	21	56.22	64.66	+8.44
MFMC	545	274	60	39	61.28	68.44	+7.16

Results of Medical Record Reviews

Clinic	Exams Before Intervention	Exams After Intervention	No Exams	Reason for No Exams
Academic Family Medical Center	26	21	87	No Visit in 2017 – 59 Acute/Urgent Care Visits – 27 Well-Child Exam Missing Documentation – 1

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services (cont.)					
Magnolia Family Medical Clinic	60	39	172	No Visits in 2017 – 133 Acute/Urgent Care Visits – 39	

RESULTS (Qualitative Analysis)

Varied clinic receptiveness to outreach from health plan:

- Clinic #1 responded immediately and included clinic staff in discussing the performance feedback reports and strategies to schedule well-child exams
- Clinic #2 was difficult to reach and preferred minimal contact with the clinic

Both clinic appreciated the usefulness of the performance feedback report to facilitated scheduling well-child exams.

BARRIER ANALYSIS

- Missing claims/encounter/clinical data results falsely identifying members as non-compliant.
- Missed opportunities to complete or schedule well-child exams while the child is at the clinic.
- Children with no office visits or outreach to schedule exams in 2017
- Difficulty reaching clinic to provide support and education on the performance feedback reports
- Availability of staff can affect how much time a clinic can allocate to member outreach for scheduling preventive care exams.

NEXT STEPS

Although we did not meet out 10% goal for each clinic, we will adopt this intervention and expand it to other clinics because the results of both PDSA #1 and PDSA #2 demonstrated that (1) Performance Feedback Reports helped clinics schedule well-child exams and (2) the clinic's expressed that this was a very helpful report. The expanded outreach to the clinics conducted by the QI RN in PDSA #2 demonstrated the value of having a designated contact within the Quality Improvement Department to build relationships with the clinics and to provide education on the benefits of utilizing the Performance Feedback Report and the HEDIS measures.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
GCHP	Opioid Use Improvement Strategy	Develop strategy	Q4 2016	Formulary Edits Provider education Benefit alternatives	Pharmacy

EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis) Unable to measure. No quantitative analysis is available at this time. The first formulary edits were placed January 1, 2017 and not enough time has elapsed to allow for a review of effectiveness.

RESULTS (Qualitative Analysis) The following formulary edits were implemented: removal of certain high dose products, removal of Oycontin and the addition of alternative opioids with reduction addiction potential (Nucynta).

BARRIER ANALYSIS Some of the formulary edits have not yet been implemented due to PBM programming issues. These programming issues are being reviewed and assessed for work-arounds or other ways to implement.

Next Steps

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality of Nonclinical Services					
NCQA NET 2 DHCS	**Primary Care Access** Members are offered: • Non-urgent primary care within 10 business days of request • Urgent care within 24hours **Specialty Care Access** Members are offered: • Non-urgent specialty care appointment within 15 business days • Non-urgent ancillary services within 15 business days	Standards met for minimum of 90% of providers	Q4 2016	Monitor performance and complaints relating to appointments Report quarterly performance to QIC Develop and implement corrective action plans when timely access standards not met Conduct survey	Network Operations Grievances and Appeals

EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis) Goal Met

Primary Care access prior survey results

1. Non-Urgent primary care within 10 days of request: 90.2% Met criteria
2. Urgent care within 24 hours: 100%. Met criteria. However it is important to keep in mind that this number is based on the DMHC standard of 48 hours

Specialty Care Access:

1. Non-urgent specialty care appointment within 15 business days: 51.6% Did not meet standard
2. Non-urgent ancillary services within 15 business days 76.5% did not meet standard

Efforts initiated to identify these specialty providers and discuss findings and alternatives. In addition, the Network Operations department has under taken an aggressive strategy to enhance our specialty network concentrating on key specialty areas where we have limited providers and access has been impacted. The results of this effort has resulted in a threefold increase in network specialists.

The results achieved in this appointment availability survey shows an improvement from the last one. We saw increases in the following:

- PCP within 10 days went up 5.9%
- Urgent care with 24hrs went 6.7%
- 4% reduction on the ancillary within 15 days

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee

Objective: Improve Quality of Nonclinical Services (cont.)

- Slight reduction of 3.1% on the specialist side.

We did not specifically target the providers who did not meet standards but worked globally through our site visit policy and joint operation meeting to make some improvements

Grievances:

Total of 5 Access to Care grievances were received in 2016, none were related to Primary Care Access and 1 was related to Specialty Care Access.

RESULTS (Qualitative Analysis)

Primary and Specialty Access surveys are in process of development. Initial focus was to do our own survey, but we re-assessed this to retain SPH and tailor the survey to our specs. Information has been provided by key departments, based on key additional question, which we will vet with SPH to determine pricing. The goal is to do this survey by no later than the end of FY 2017.

Grievances:

There were 5 Access to Care grievances received in 2016 and there were 27 Access of Care grievances received in 2015, these totals reflect a decrease in Access to Care grievances. In 2015 out of the 27 Access to Care grievances received, 4 were for Primary Care Access and 4 were for Specialty Care Access.

BARRIER ANALYSIS No barriers identified due to the reduction in these types of grievances.

NEXT STEPS: Customize questions with SPH and complete survey by end Q4 2017. Continue to monitor grievances.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality of Nonclinical Services					
DHCS	After Hours Availability • Members are able to reach a provider after hours	Standards met for 90 % of providers	Q4 2016 Q3 2016	Monitor performance and complaints relating to after-hours availability Report quarterly performance to QIC Develop and implement corrective action plans when timely access standards not met Conduct survey	Network Operations Grievances and Appeals

EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis) Goal Not Met

954 PCP/Specialist Providers surveyed. Over all approximately 18% of the surveyed providers did not meet After-Hours standards.

Person or type of recording equipment reached after hours;

- Recording or Auto Attendant: 72.2% met the after-hours standards
- Live Person: 70.7%
  - The PCP portion yielded 74.7% met the after-hours standards
    - 25.3% did not meet standards
  - For Specialists 82.7%
    - 17.3% did not meet standards

No grievances were received related to after hours availability.

RESULTS (Qualitative Analysis) This year's results produced a higher portion of PCP and Specialists completed surveys. However, results yielded from 2013/2014 After-Hours is incomparable due to the variances in questioning and answers obtained. Between the chosen vendor SPH Analytics' results and GCHP 2013/14 After-Hours self-reported results, the amount of providers surveyed in current survey exceeded 2013/14 (i.e. 111).

BARRIER ANALYSIS Variance in questions and answers

NEXT STEPS: A plan to educate/correct those who did not meet timely access After-Hours standard is in development.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality of Nonclinical Services					
Practitioner Availability: Cultural Needs & Preferences					
NCQA NET 1 DHCS	Availability of Practitioners	Ratios: 1 PCP 1:2000 Total Physicians 1: 1200 Physician Supervision to Non-Physician Practitioner Ratio Nurse Practitioners 1:4 Physician Assistants 1:4 Network maintained PCP located within 30 minutes or 10 miles	Q4 2016	Conduct bi-annual ratio analysis and annual Quest Analytics analysis for primary care and high volume specialties Identify gaps and implement corrective action plan Monitor progress towards action plans to maintain or improve GeoAccess standards Report bi-annual ratio analysis and annual GeoAccess findings to QIC	Network Operations

EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis) Goal Met

- Ratio of Members to PCPs 1:848
- Ratio of Members to Total Physicians 1:217
- Network maintained 99.8% of members within 30 minutes or 10 miles to PCP
- Nurse Practitioners to PCP Physicians 1:2
- Physician Assistants to PCP Physicians 1:3
- All Mid-levels to Total Physicians 1:5

RESULTS (Qualitative Analysis) Availability of PCP practitioners continues to maintain within standards as well as specialists. Growth in high-volume specialties were targeted in the last year and all standards met within the quarter with the exception of Mid-levels to Total Physician which are falling slightly short at 1:5, however based upon a membership ratio perspective (i.e. 1:1200) the ratio would be 1:845.

BARRIER ANALYSIS None identified

NEXT STEPS Adequacy of Mid-levels to Total Physicians in the network will be part of GeoAccess quarterly report for monitoring and discussed with providers.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality of Nonclinical Services					
NCQA NET 1 DHCS	Practitioner Availability: Cultural and Linguistics Needs & Preferences: Assess the cultural, ethnic and linguistic needs of our members	Complete Annual Assessment	Q4 2016	Analyze the demographic needs of our members to identify opportunities for improvement	Member Services Network Operations

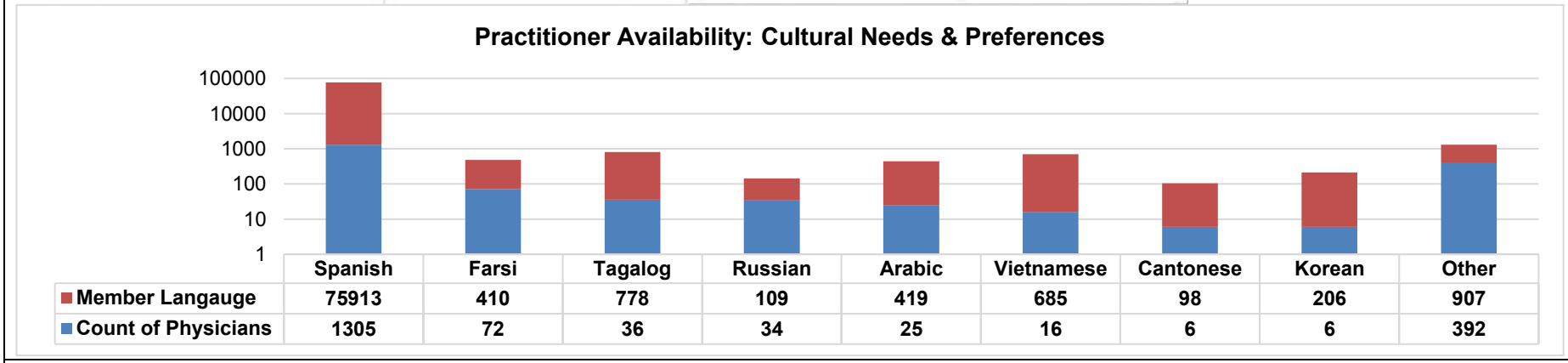
EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis)

Membership Data 2016

M_ETHNICITY	Count
American Indian/Alaskan Native	542
Asian/Pacific Islander	22,223
Black/African American	3,583
Caucasian/White	51,646
Hispanic/Latino	101,389
Not Available/Unknown	16,155
Other	13,392
Total	208,930

PRIMARY_LANGUAGE	Count
Arabic	419
Armenian	60
Cantonese	98
English	127,478
Farsi	410
Hmong	4
Korean	206
Russian	109
Spanish	75,913
Tagalog	778
Vietnamese	685
Not Available/Unknown	1,863
Other	907
Total	208,930



2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality of Nonclinical Services (cont.)					

RESULTS (Qualitative Analysis)

Other than English, Spanish is the most prevalent language spoken.

27% Hispanic/Latino in comparison to total membership

57% of Hispanic/Latino members to 43% of Physicians who report language fluency in Spanish

Further analysis needed to encompass Asian/Pacific Islander preferred languages and other ethnicities to primary language

BARRIER ANALYSIS

- Physician's to report ethnicity is voluntary
- Network Operations does not maintain physician/professional ethnicity
- Physician proficiency in language is currently not measured
- Collaborate with Member Services, Health Education/Cultural & Linguistics, QI Credentialing and other key departments to evaluate the methodology and/or actions required for such reporting
- Potentially recruit, credential and contract with practitioners who speak a language that reflects members' linguistic needs.
- Potentially recruit, credential and contract with practitioners with similar cultural and ethnic background as underrepresented members.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality of Nonclinical Services					
NCQA NET 1 DHCS	Assess the provider network and adjust the availability of providers within the network, if necessary, to meet membership needs and preferences	Complete Annual Assessment	Q4 2016	Monitor how effectively the practitioner network meets the needs and preferences of our members	Network Operations
EVALUATION OF 2016 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Not Met No assessment done to identify practitioner ethnicity to meet the needs and preferences of members					
RESULTS (Qualitative Analysis) NA					
BARRIER ANALYSIS • Physician's to report ethnicity is voluntary • Collaborate with QI Credentialing, Member Services, Health Ed/Cultural & Linguistics, and other key departments to work out the methodology for such reporting • Potentially recruit, credential and contract with practitioners who speak a language that reflects members' linguistic needs. • Potentially recruit, credential and contract with practitioners with similar cultural and ethnic background as underrepresented members.					
	Provider Satisfaction Survey	Complete Survey	Q4 2016	Analyze results and identify opportunities for improvement Develop and implement interventions as needed to improve rates	Network Operations
EVALUATION OF 2016 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Not Met					
RESULTS (Qualitative Analysis) NA					
BARRIER ANALYSIS The prior Provider, Satisfaction Survey done in late 2016 was determined to be of limited use given the poor response rate we received from primary care and specialty providers. **NEXT STEPS** We are working with a vendor to assist us in finalizing a Provider Satisfaction Survey, slated to go out the beginning of the 2nd qtr of CY 2017.					

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Patient Safety					
DHCS	Complete Initial and Tri-annual Facility Site Reviews Complete Interim Reviews	100%	Year End 2016	Monitor FSR database Submit bi-annual reports to DHCS	FSR Nurse QI
EVALUATION OF 2016 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Met					
RESULTS (Qualitative Analysis) All site reviews completed for 2016 and bi-annual reports submitted to DHCS.					
BARRIER ANALYSIS Goal Met, no barriers presently identified.					
DHCS	Complete Physical Accessibility Site Reviews	100%	Year End 2016	Compile reports for high volume/ancillary specialists Submit report to State Complete PARs for new provider sites	FSR Nurse QI
EVALUATION OF 2016 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Met					
RESULTS (Qualitative Analysis) All PARs completed for 2016. Reports completed and submitted to DHCS.					
BARRIER ANALYSIS Goal Met, no barriers presently identified.					
NCQA CR 5 & 6 DHCS	Improve Safe Clinical Practice	Tracking	Ongoing	Monitor site visit results from practitioner credentialing Monitor member complaints involving clinical quality of care concerns (safety)	Credentialing/ Peer Review Grievances and Appeals
EVALUATION OF 2016 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Met					
RESULTS (Qualitative Analysis) No site visits were conducted in 2016 as no grievances were submitted to QI that would trigger a site visit.					
BARRIER ANALYSIS Goal Met, no barriers presently identified. Grievances will continue to be monitored and site visits completed within 30 days as needed.					

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Member Experience: CAHPS, Complaints/Grievances TBD					
NCQA QI 4 DHCS	Conduct annual assessment of complaints and grievances. Conduct Six Month Member Access and Satisfaction Survey results to identify opportunities for improvement	Increase rates by 5% over previous year : Your Overall Appointment Experience Adult: 2015 - 68.6% Child: 2015 – 57.9% Ease of Accessing Care Adult: 2015 - 85.9% Child: 2015 - 89.1%	Q4 2016	Provider Interventions: • Review 2015 Member Access and Satisfaction Survey final results with clinics • Provider access survey Q2 2016; follow up with providers not meeting standards Customer Service Interventions: • Monitor results/reports of after call survey performed by call center; follow up if issues identified Monitor complaints and grievances	QI Network Operations Operations Grievances and Appeals

EVALUATION OF 2016 WORK PLAN

RESULTS (Quantitative Analysis) Call Center: The after-call survey of the call center was completed.

Member Access and Satisfaction Survey: Summary Rate Scores: Goal Partially Met

Composite	Summary Rate Definition	Summary Rate Scores 2016	Summary Rate Scores 2015
Your Overall Appointment Experience	Excellent/Very good	67.2%	64.7%
Ease of Accessing the Care You Need	Strongly Agree/Agree	88.4%	87.1%

Adult vs. Child:

Adult vs. Child (Database)	Summary Rate Definition	Adult		Child	
Attribute		Valid n	2016 SRS*	Valid n	2016 SRS*
Your Overall Appointment Experience			68.5%		64.3%
Ease of Accessing the Care You Need			87.3%		90.9%

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Member Experience: CAHPS, Complaints/Grievances TBD					

RESULTS (Qualitative Analysis) Call Center: Changes to the call center Interactive Voice Response System (IVRS) were completed in August 2016. Results of the survey show a 13% improvement on the satisfaction of using the IVRS. In 2016, 6% of the callers expressed their dissatisfaction with the IVRS in comparison to 19% in 2015.

Member Access and Satisfaction Survey: Our vendor conducted this survey from July to December 2016. Surveys were in English and Spanish. There were 1371 total respondents.

The following topics were covered by the survey:

- Your Overall Appointment Experience

This composite addresses the type of appointment, how many days between making appointment and seeing provider, wait time past scheduled appointment time, and rating of overall quality of care and services provided by health care provider.

- Ease of Accessing the Care You Need

This composite addresses the availability of timely appointments, ease of scheduling appointment, and access to someone in doctor's office during regular office hours. The survey also asked about the convenience of the location, office hours, and the ease of getting care, tests and treatments needed. In addition the survey asked if the clerks and receptionists were helpful, courteous and respectful. Finally, the survey covered if the doctor's explained things in an understandable way, showed respect to what the member had to say, spent enough time with the member, and met cultural and language needs.

Results: There was an improvement of 2.5% in the aggregate score for overall appointment experience from 2015 to 2016. Ease of accessing the care you need saw a slight improvement in the aggregate score of 1.3% from 2015 to 2016. However, the scores missed the goal of 5% improvement.

Adult: Your overall appointment experience score for adults decreased by 0.01% while the score for ease of accessing care increased by 1.4%.

Child: Your overall appointment experience score for children increased 6.4% while the ease of accessing care increased by 1.8%.

BARRIER ANALYSIS None identified as this is the first year comparison. Last year's rate was the baseline.

Next Steps: Meeting with Network Operations to discuss results of survey and next steps.

2016 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Health Plan Quality					
NCQA QI 1 DHCS	●Update QI Program Description ●Complete 2015 QI Program Evaluation ●Develop and Implement 2016 QI Program Work Plan	100%	April 2016 April 2016 April 2016	1. Review and revise annual QI Program Description, Work Plan and Evaluation 2. Obtain approval of 2016 QI Program and Work Plan and Evaluation of 2015 QI Program 3. Evaluate the adequacy of resources, committee structure, practitioner participation and leadership involvement in the QI Program in order to restructure or change the QI Program for subsequent year as necessary	Chief Medical Officer QI Director Quality Improvement Committee
EVALUATION OF 2016 WORK PLAN					
RESULTS (Quantitative Analysis) Goal met. QI Program Description and Work Plan approved at QIC on March 29, 2016; Work Plan and Work Plan Evaluation revised and approved June 28, 2016 and at Ventura County Medi-Cal Managed Care Commission meeting on April 25, 2016; revision approved August 22, 2016.					
RESULTS (Qualitative Analysis) NA					
BARRIER ANALYSIS Goal Met, no barriers presently identified.					
NCQA QI 10 DHCS	Completion of Delegation Oversight Delegated Activities • Credentialing • QI • UM • Members' Rights • Claims	100%	Q4 2016	1. Complete audits 2. Issue CAPs as applicable 3. Follow-up on CAPs as applicable 4. Report to Compliance Committee and QIC	Compliance
EVALUATION OF 2016 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Met.					
RESULTS (Qualitative Analysis) Delegation oversight audits were completed. A delay in audits on UM, QI, Member Rights for GCHP MBHO was a result of staff attrition. However, 100% of audits were completed.					
BARRIER ANALYSIS Goal Met, no barriers presently identified.					
Monitoring via use of Dashboard					

GOLD COAST HEALTH PLAN
2017 QUALITY IMPROVEMENT PROGRAM

I. MISSION AND PURPOSE

Mission
Gold Coast Health Plan's mission is 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, Gold Coast Health Plan's Quality Improvement Program will strive to continuously improve the care and quality of service for its members in partnership with its contracted provider network as exhibited by its dedication to the concept of measurement and re-measurement, and documenting strong actions taken and results.

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

Values
The QI Program supports the organizations 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 of GCHP community to achieve 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

Purpose
The purpose of the Gold Coast Health Plan (GCHP) Quality Improvement (QI) Program is to achieve high quality and optimal clinical outcomes in all departmental programs reflecting the State mission to preserve and improve the health of all Californians. The QI Program provides the framework for Gold Coast to continually monitor, evaluate and improve the quality of care, safety and services provided to all members, practitioners/providers and external/internal customers. The program provides an ongoing evaluation process that lends itself to improving identified opportunities for under/over utilization of services. Core values of the program include maintaining respect and diversity for members, providers and employees.

To accomplish this GCHP's QI Program aligns its efforts with the current version of the Department of Health Care Services (DHCS) Strategy for Quality Improvement in Health Care.

This foundation for a quality strategy is anchored in three linked goals of the "Triple Aim": improve health; enhance quality of health care services, including the patient experience; and reduce DHCS per-capita health program costs.

The QI Program consists of the following elements:

A. QI Program Description
B. Annual QI Program Evaluation
C. Annual QI Work Plan
D. Quality Improvement Activities
E. QI Committee Structure
F. Policies and Procedures

II. 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 Program. The VCMMCC is ultimately accountable for the quality of care and services provided to Members but will delegate supervision, coordination, and operation of the program to the Chief Executive Officer and Quality Improvement Department under the supervision of the Chief Medical Officer and its QI Committee. The VCMMCC will approve the overall QI Plan, Work Plan and QI annual report; the CMO will be responsible for the day-to-day oversight of the QI Program. The VCMMCC will receive operational information through regular reports from the CMO and/or the Health Services Department in conjunction with the operations of its various Committees as described below.

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

1. Medical Advisory Committee (MAC)
2. Pharmacy & Therapeutics (P&T) Committee
3. Utilization Management (UM) Committee
4. Health Education (HE) & Cultural Linguistics (CL) Committee
5. Credentials Committee
6. Network Management Committee
7. Member Services Committee
8. Grievance & Appeals (G&A) Committee

To further support the community involvement and achieve Plan's QI goals and objectives, the VCMMCC organized two committees reporting directly to them: the Provider Advisory and Member/Consumer Advisory.

A chart depicting the complete VCMMCC organizational structure is provided on the following pages. In addition, an organizational chart is attached depicting the key reporting relationships and discharge of QI Program activities by GCHP staff position and title. Specific roles and responsibilities are delineated in the following sections.

The VCMMCC approved delegation of quality activities to GCHP. The Quality Improvement Program is under the direct oversight of the Health Plan Chief Medical Officer, who, through the Quality Improvement Committee, will guide and oversee all activities in place to continuously monitor plan quality initiatives. The VCMMCC 's quality improvement role will continue to include the approval of the QI Program and QI Work Plan annually. In addition, the VCMMCC will receive regular updates to the QI Work plan for review and comment.

Membership

GCHP is governed by the eleven (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 county healthcare agency and consumer advocates.

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

III. PROGRAM SCOPE

The scope of the Quality Improvement Program will ensure the non-discriminatory quality and availability of all medically necessary, covered clinical care and services for Plan Members with limited English proficiency, diverse cultural and ethnic backgrounds, and disabilities and regardless of race, color, national origin, creed, ancestry, religion, age, marital status, gender, health status, sexual orientation or gender identity. All covered services are required to be provided in a culturally and linguistically appropriate manner. The monitoring, evaluation and prioritization of issues reflects the population served. Provisions will be made for cultural and linguistic appropriateness based on the annual Group Needs Assessment (GNA). The *scope* of the QI process encompasses the following:

1. Quality and safety of clinical care services including, but not limited to:

- Preventive services
- Chronic disease management
- Prenatal care
- Family planning services
- Behavioral health care services
- Medication management
- Coordination and Continuity of Care

2. Quality of nonclinical services including, but not limited to:

- Accessibility
- Availability
- Member satisfaction surveys

- Grievance process
- Cultural and Linguistic Services

3. Patient safety initiatives including, but not limited to:

- Facility site reviews
- Credentialing of practitioners
- Peer review
- Sentinel event monitoring
- Health Education

4. A QI focus which represents

- All care settings
- All types of services
- All demographic groups

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, utilization management, credentialing/recredentialing and grievance and appeals. GCHP retains accountability for ensuring the function is being performed according to expectation and standards. 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 the Plan 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 Plan'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. Corrective action plans are implemented based upon areas of non-compliance. Delegated entities are required to submit at least semi-annually reports to GCHP according to the reporting schedule specified in the delegation agreement. Audit results and outcomes of corrective action plans are reported to QIC.

IV. QI PROGRAM GOALS, OBJECTIVES AND METHODOLOGY

The QI Program goals include:

- Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of 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
- Identify opportunities and make improvements based on measurement, validation and interpretation of data
- Provide oversight of delegated entities to ensure compliance with Gold Coast standards as well as State and Federal regulatory requirements

The Program Objectives include the following:

- To integrate the QI Program with other operational functions of GCHP
- To conduct an annual evaluation of the QI Program
- To establish and conduct an annual review of quality and performance improvement projects (PIPs) related to significant aspects of clinical and non-clinical services
- To identify opportunities for improvement through analysis of information collected from Healthcare Effectiveness Data and Information Set (HEDIS®) and utilization management patterns of care
- 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 service are delivered

GCHP addresses the needs of our members with complex as well as non-complex health needs through our Care Management Program. GCHP offers case management programs for the coordination of health care and for continuity of care. Through the provision of care coordination, targeted education and resource management GCHP promotes member wellness, autonomy, and appropriate use of services and financial resources. Members are referred to the case management program by self-referral, referrals by caregivers, providers, internal departments; hospitals and GCHP discharge planners, community agencies, as well as review of data and utilization patterns. For additional information, refer to the Care Management Program Description.

GCHP's Utilization Management (UM) Program is integrated with the QI Program to ensure continuous quality improvement. UM activities are outlined in the Utilization Management Program Description. 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, cost effective, medically appropriate healthcare services. The UM Program Description defines how UM decisions are made in a fair and consistent manner. The UM Program Description is

approved by the UMC and the program evaluation is reported to the QIC. For additional information, refer to the UM Program Description.

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 as appropriate. UM and QI Committees work together resolve cross-related issues or problems.

GCHP's Disease Management (DM) Program aims to improve the quality of care and the health outcomes of GCHP members and their families. The program achieves this objective by educating the member and by enhancing the member's ability to self-manage his or her condition or illness. The DM Program uses a population health approach with a patient centered medical home model to improve the clinical and quality management outcomes of our members with chronic conditions. GCHP's DM Program is developed from evidence-based clinical practice guidelines. GCHP's DM Program includes Asthma and Diabetes. These conditions were selected based upon common chronic conditions experienced by GCHP members. For additional information refer to the DM Program Description.

Inclusion and Diversity
GCHP assigns all Members to PCPs, without regard to race, color, ethnicity, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or gender identity. All contracted providers are required to render services to all Members assigned or referred to them. They may 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 access to covered services that are delivered in a manner that meets their needs GCHP accomplishes this is a variety of way such as:

- Review of member complaints and grievances
- Provision of language assistance services to assist providers to provide linguistically appropriate medical care to Limited English Proficient members
- Conducting a Group Needs Assessment every 5 years
- Provision of a Culturally Competency Training Program for both providers and GCHP staff
- Conducting surveys of members to determine if culture and language needs are met by providers
- Seniors and Persons with Disabilities (SPD) Cultural Sensitivity Training for providers and staff
- Assessment of provider linguistic capabilities
- Assessment of GCHP staff language capabilities

Performance Improvement Methodology

GCHP utilizes the Institute for Health Care Improvement (IHI) Model for Improvement. Staff is encouraged to achieve improvement continuously by using the "Rapid Cycle

Small Test of Change Methodology."

GCHP uses the "Plan-Do-Study-Act Cycle" (PDSA) to implement and test the effectiveness of changes. This model focuses on identifying improvement opportunities and changes, and measuring improvements. The PDSA cycle guides the test of a change to determine if the change is an improvement.

V. PROGRAM ORGANIZATION, OVERSIGHT AND EVALUATION

CHIEF MEDICAL OFFICER

The Chief Executive Officer has appointed the Chief Medical Officer (CMO) as the designated physician to support the QI Program by providing day to day oversight and management of quality improvement activities.

The Chief Medical Officer has the overall responsibility for the clinical direction of GCHP's QI Program. The Chief Medical Officer ensures that the QI Program is adequate to monitor the full scope of clinical services rendered, and that identified problems are resolved and corrective actions are initiated when necessary and appropriate.

The Chief Medical Officer serves on the QIC, CPR, P&T, UM/CM, NMC and MAC Committees. The Chief Medical Officer works directly with all GCHP department heads and executive team members. Further, as Chief Medical Officer and a member of the Quality Improvement Committee, the Chief Medical Officer annually oversees the approval of the clinical appropriateness of the Quality Improvement Program.

The Chief Medical Officer reports to and is supervised by the Chief Executive Officer. The Chief Medical Officer's job description also specifies that the Chief Medical Officer has the ability and responsibility to inform the Chief Executive Officer, and if necessary the Commission, if at any time the Chief Medical Officer believes his/her clinical decision-making ability is being adversely hindered by administrative or fiscal consideration.

ASSOCIATE CHIEF MEDICAL OFFICER

The Associate Chief Medical Officer assists in the functions of the Health Services Department by collaborating with the Chief Medical Officer, Health Services Staff, Quality Improvement Department, Grievance and Appeals Department, and other GCHP staff. This collaboration allows the ACMO to oversee and carry out utilization management decisions, resolve clinical complaints and appeals and monitor clinical quality improvement programs. Key performance and quality of care indicators and criteria are established and reported to the QIC by the ACMO. The ACMO also serves on committees as directed by the CMO including the QIC, CPR, P&T, UM/CM and MAC.

DIRECTOR OF QUALITY IMPROVEMENT

The QI Director is a California licensed Registered Nurse. The QI Director is responsible for working with sub-committee chairs and appropriate departments to ensure all quality monitors; analysis and improvement initiatives are in place. The Director works with the QIC, subcommittees and leadership to educate all health plan staff on the importance and role in quality improvement, communication, analysis and reporting. The Director is a mentor for all department heads and works with them to implement processes that will create both efficient and quality services.

The Director reports to the CMO and ensures that he/she is updated on any deficiencies and proposed improvement activities.

Specific roles and responsibilities include but are not limited to:

- Ensuring that the annual Quality Improvement plan and work plan are created and reviewed by all appropriate areas
- Working with all appropriate departments in the creation of the annual QI review and analysis of results
- Ensuring QIC approval of all QI documents annually
- Guiding the collection of HEDIS data as mandated by contractual requirement and assisting in the development of activities to improve care
- Ensuring that appropriate principles of data collection and analysis are used by all departments when looking for improvement opportunities

- Providing educational opportunities for QI staff and other staff members key to improving care and service to better target improvement initiative

The QI Director oversees staff consisting of an adequate number of Registered Nurses with the requirement to fulfill QI responsibilities, and other staff that includes a QI Manager, QI Project Manager, Senior Quality Improvement HEDIS® Analyst, a QI Data Analyst, a Credentialing Coordinator and the QI Specialist.

QI PROGRAM EVALUATION

The QI Program is evaluated annually. This includes a review and revision of the QI Program Description, evaluation of the prior year's QI Work Plan, and the development of the current year's QI Work Plan to ensure ongoing performance improvement.

An written evaluation of the QI Program is completed annually. The evaluation is reviewed and approved by the QIC and VCMMCC and includes at least the following:

- A description of completed and ongoing QI activities that addresses quality and safety of clinical care provided to GCHP members, including trended measures and an analysis of barriers to success.
- A description of completed and ongoing QI 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 QI Program (structure, communication, resources, practitioner participation), including progress toward influencing network-wide safe clinical practices and addressing the cultural and linguistic needs of GCHP members.
- Recommendation for changes to the QI Program to make it more effective.

VI. ANNUAL WORK PLAN

The Annual QI Work Plan serves as the roadmap for the QI Program and lists measurable objectives for key indicators and includes interventions to improve performance. The QI Work Plan is developed largely from recommendations from the annual QI Program Evaluation. Areas of significant focus include partially resolved and unresolved activities from the previous year. These activities include clinical and service improvement activities that have the greatest potential impact on quality of care, service and patient safety. The work plan also reflects the contractual requirements of GCHP.

At a minimum, the QI Work Plan includes a clear description of the monitoring and improvement activities, the specific timeframe and responsible parties for conducting the activities. Activities and outcomes are compared to predetermined goals. Improvement activities identified during the year and other changes may be made to the QI Work Plan as presented to the QIC and VCMMCC for approval on an ongoing basis. The QIC oversees the prioritization and implementation of clinical and non-clinical Work Plan initiatives. The QI Work Plan is assessed and updated at a minimum, semi-annually, and is included as part of the Annual QI Program Evaluation.

GCHP views this as a living document that reflects ongoing progress on QI 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 medical services.

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

- Access and Availability Studies;
- Initial Health Assessment monitoring; and
- GeoAccess Studies

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

- Consumer Assessment of Healthcare Providers and Systems (CAHPS);
- Member Grievance Review
- Provider Satisfaction Survey; and
- Focus Groups

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

- HEDIS;
- Coordination of Care Studies
- Facility Site Reviews; and
- Potential Quality Issue Investigation

Quality Improvement activities that evaluate GCHP's ability to serve a culturally and linguistically diverse membership include the following:

- Annual provider language study;
- Annual cultural and linguistic study;
- Ongoing monitoring of interpreter service and use
- Ongoing monitoring of grievances; and
- Conduct focus groups to determine how to meet needs of diverse members

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

- Credentialing and Recredentialing activities; and
- Peer Review Activities

Communication and Feedback

Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, mailings and announcements. Providers are educated regarding quality improvement initiatives via on-site quality visits, provider newsletter, Provider Operations Bulletin and the GCHP

website. Specific HEDIS® performance feedback is communicated to providers via a HEDIS® report card and listings of members who need specific services.

VII. PROGRAM RESOURCES DEDICATED TO QUALITY IMPROVEMENT

QI Program Resources- Multidisciplinary Staff
Resources for the QI 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 case management, disease management, utilization management and other clinical process improvement measures and outcomes is provided by Health Services and QI staff.

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

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

Credentialing and peer review functions are supported by QI staff.

The quality improvement staff assists the 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 include but are not limited to the following:

- Assist in creating the annual QI Plan document
- Assist in coordination of HEDIS® data collection and analysis of results
- Work with other departments to gather information for the annual QI Review
- Assist in developing activities for the annual QI work plan
- Assist the QI Director as required
- Credential and recredential providers and facilities

OTHER QI RESOURCES

Staff from other departments will contribute to the QI process. They will continue to identify areas for improvement. Department staff will be deployed to assist in creating and implementing quality improvement initiatives.

QI Program Resources- Program and Tools
GCHP has dedicated resources to the acquisition of programs and tools that promote high quality 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 our website

QI Tools, Resources and 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®), Quality Compass
- *Government issues 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)
- *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)

QI Program Resources- Data, Information and Analytics Support
GCHP's QI Program monitors and evaluates performance and information from many different sources throughout the organization including but not limited to:

- Enrollment data, 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.)
- Case management and disease management reports to assess support of members with complex or chronic medical and behavioral health conditions, and to evaluate coordination of care across the care spectrum
- Complaint and appeal data, including investigational data (type of complaints, timeliness and/or appropriateness of resolution)
- Ongoing tracking and trending of quality of care or serious reportable event 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
- HEDIS® data to assess the effectiveness of clinical care and services

VIII. QUALITY COMMITTEES AND SUBCOMMITTEES

1. Quality Improvement Committee (QIC)

QIC Charter:

The QIC is the principal organizational unit that will have delegated authority to monitor, evaluate and report to the VCMMCC on all component elements of the GCHP's Quality Improvement System outlined in this Plan. The Committee shall have a minimum of 8 voting members and be chaired by the by the GCHP Chief Medical Officer (CMO) and facilitated by the Director, Quality Improvement. Membership will consist of the chairs of the 8 QI Subcommittees and at least one Commissioner and at least one practicing physician in the community. The Committee shall meet at least quarterly. Ad hoc committees, however, will meet on an as-needed basis. The Committee will critically examine and make recommendations on all quality functions of GCHP described in this policy and by California and Federal regulatory authorities as appropriate.

It is the responsibility of the QIC and its subcommittees to assure that QI 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 all Plan committees and makes recommendations on their implementation. The VCMMCC is updated quarterly or as frequently to demonstrate follow-up on all finding and required action by the Chair of the QIC or designee via a report which may include QIC minutes, information packet, data dashboard, or other communication mechanism. All of the Plan's Committees are required to maintain confidentiality and avoid conflict of interest.

An annual QI Report is submitted to the VCMMCC addressing:

A. Quality improvement activities such as:
   i. Utilization Reports
   ii. Review of the quality of services rendered
   iii. HEDIS results
   iv. Quality Improvement Projects- status and/or results
   v. Satisfaction Survey Results
   vi. Collaborative initiatives- status and/or results

B. Success in improving patient care, and outcomes, 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 QI Plan including recommendations for revision identified as a result of the Review.

QIC Objectives:

- Ensure communication process is in place to adequately track action items and work plan and enable horizontal and lateral communication as well as closing the loop when issues are resolved.
- Ensure QIC members can have a candid discussion about barriers to achieve quality goals and objectives, and to facilitate the removal of such barriers.

QIC Responsibilities:

- Facilitate data-driven indicator development for monitoring Access, Care and Service and Quality Improvement Projects interventions.
- Review quarterly committee meeting minutes, action item logs and reports regarding monitoring of health plan functions and activities. Suggest interventions or corrective actions that adhere to the rapid cycle improvement methodologies.
- Oversee the annual review, analysis and evaluation for achievement of goals and effectiveness of the QI Program, quality improvement policies and procedure and QI Work Plan for presentation.
- Recommend policy changes or implementation of new policies to GCHP's Administration and Commission.

QIC Membership:

- Chief Medical Officer (Chair)
- Director of Quality Improvement
- Director of Health Education & Cultural Linguistics
- Associate Chief Medical Officer
- Director of Operations
- Quality Improvement Staff (as needed)
- Director of Network Operations
- Director of Pharmacy
- Director of Compliance
- Director, Health Services
- Practitioner Representatives
- CEO, Ex Officio
- Manager, Member Services

QIC Reporting Structure:

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

Meeting Frequency:

The QIC meets at a minimum quarterly.

2. Medical Advisory Committee (MAC)

Purpose:

The purpose of the MAC is to:

- Offer input to GCHP regarding issues related to the delivery of medical care to the GCHP membership
- Provide input regarding issues of concern to the physician community
- Provide guidance on quality of care concerns
- Offer input on local medical care practices that may affect Health Plan Operations

Function:

The Committee may include, but is not limited to, the following:

- Clinical Care Guidelines
- Preventive Care Guidelines
- Provider Grievance Process
- Provider Satisfaction Issues
- Provider Materials
- Quality Improvement Activities
- Provider Access Standards
- Provider Contracting Issues
- Clinical Service Delivery
- Utilization Data
- HEDIS Measures

Feedback from the MAC is relayed to the QIC as well as other QI committees where data may be relevant to process improvements.

Membership:

Membership is comprised of physicians representing the contracted provider community for GCHP's programs. The Chief Medical Officer will serve as Chairman and will ensure that the membership has adequate specialty representation.

Meeting Frequency:

The committee meets at a minimum on a quarterly basis.

3. Member Services Committee (MSC)

MSC Charter:

The MSC oversees those processes that assist GCHP's 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 have an understanding of 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.
- Ensure members have access to information on languages spoken in physician offices to better aid them in the selection of a primary care physician.
- 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 CAHP survey to identify service indicators for improvement.
- Ensure GCHP's Member Rights and Responsibilities policy is distributed 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:

- Director of Operations
- Director of Network Operations
- Manager of Member Services (Chair)
- Manager of Grievance and Appeals or designee
- Quality Improvement Representative
- Director of Health Services
- Director of Health Education & Cultural Linguistics or designee
- Director of Communications (Ad Hoc)
- Compliance Specialist

Meeting Frequency:

The MSC meets quarterly at a minimum.

4. Grievance and Appeals Committee (G&A)

G&A Charter:

The Grievance and Appeal Committee monitors expressions of dissatisfaction from members. Information gathered is used to improve the delivery of service and care to Gold Coast members.

G&A 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 grievances and appeals to the correct area for resolution
- Ensure that issues needing intervention are routed to the appropriate area for discussion and intervention

G&A Committee Membership:

- Manager of Grievance and Appeals (Chair)
- Sr. Grievance and Appeals Specialist
- Associate Chief Medical Officer
- Director of Network Operations or Designee
- Manager of Member Services or Designee
- Director of Quality Improvement or Designee
- Director of Health Services or Designee
- Compliance Specialist
- Director of Operations
- Director of Health Education & Cultural Linguistics or designee
- Director of Pharmacy

Meeting Frequency:

The committee meets quarterly.

5. Utilization Management Committee (UM)

Committee Charter:

The UM Committee is charged with reviewing and approving clinical policies, clinical initiatives and programs before implementation. This committee reports to the QIC quarterly. It is responsible for annually providing input on GCHP's clinical strategies, such as clinical guidelines, utilization management criteria, disease and case management protocols, and the implementation of new medical technologies.

UM Responsibilities:

Responsibilities include but are not limited to the following:

- Annual review and approval of the UM and CM 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 Inter Rater Reliability Test results of UM staff involved in decision–making (RN's and MD's) and take appropriate actions for staff that fall below acceptable mark
- Interfaces with other GCHP committees for trends, patterns, corrective actions and outcomes of reviews

Membership:

- Associate Chief Medical Officer (Chair)
- Director of Health Services
- Trainer Health Services
- Manager of Case Management
- Manager of Utilization Management
- Director of Pharmacy
- Lead UM Nurse/Trainer
- MD Reviewers
- Delegation Oversight RN
- Director of Quality Improvement
- Chief Medical Officer

Meeting Frequency:

The UM/CM Committee meets quarterly at a minimum.

6. Health Education & Cultural Linguistics Committee (HE/CL)

Purpose:

The purpose of the HE/CL committee is to assess the cultural and language needs of the Plan population. The 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 committee will assist in developing cultural sensitivity training and ensure that those that serve the population are appropriately trained.

Functions:

- Ensure the Group Needs Assessment (GNA) is completed to determine a baseline for serving education and cultural /language needs.
- Work with other areas and the CMO to prioritize health education needs.
- Ensure opportunities are available to educate members on disease process, preventive care, plan processes and all other areas essential to good member health.
- Assist providers in educating Plan members.
- Ensure written materials are at a reading level consistent with Plan membership needs and are no greater than the sixth grade reading level.
- Educate Plan staff on specific cultural barriers that might hinder the delivery of optimal health care.
- As needed, the Health Education and Cultural Linguistic Committees will meet separately to review specific program goals and objectives. Members for the Health Education Committee will consist of the same membership as the Cultural and Linguistic Committee with expectation of:

Membership:

- Director of Health Education & Cultural Linguistics (Chair)
- Chief Medical Officer
- Associate Chief Medical Officer
- Director of Health Services or designee
- Manager of Case Management or designee
- Director of Communications
- Manager of Member Services or designee
- Director of Network Operations or designee
- Quality Improvement Representative
- Cultural and Linguistic Specialist
- Health Education Specialist/Health Navigator Lead

Meeting Frequency:

The committee meets at a minimum bi-annually.

7. Credentials/Peer Review (CPR) Committee

Purpose:

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

Functions:

Credentialing Responsibilities:

- Provide guidance and comments on GCHP's provider credentialing process
- Review and make decisions for initial credentialing and re-credentialing for participation in GCHP's provider network
- Review the provider credentialing policy annually and make recommendations for change

Peer Review Responsibilities:

- Review results of provider profiling when available and suggest methods to feed information back to network providers
- Review member and provider clinical complaints, grievances, and issues involving clinical quality of care concerns and determine corrective action when necessary

Membership:

The Committee will consist of seven to nine (7-9) physicians and the CMO who will be the chairperson. To assure due process in the performance of peer review investigations, the Chief Medical Officer 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.

8. Pharmacy & Therapeutics (P&T) Committee

Purpose:

The P&T Committee serves as the oversight committee to GCHP for the development and implementation of a plan-wide medication management program. The P&T Committee is for the development of a formulary to ensure optimal efficacy, safety, and cost-effectiveness of drug therapy.

Function:

- Maintenance of a drug formulary based on an objective evaluation of efficacy, safety and cost-effectiveness of medications that is reviewed and updated at least quarterly
- Assess, review and determine formulary status for all new drugs approved by the FDA and all drugs added to the Medi-Cal Fee For Service List of Contract Drugs
- Review and approve all matters pertaining to the use of medication, including development of prescribing guidelines and protocols and procedures to promote high quality and cost-effective drug therapy
- Provide oversight of the prior authorization process to ensure that medications are reviewed consistently according to the approved guidelines
- Review and evaluation of analyses including but not limited to population demographics, morbidities, health risks, and provider-specific and plan-wide utilization patterns for enrolled members
- Any other issues related to pharmacy quality and usage

Membership:

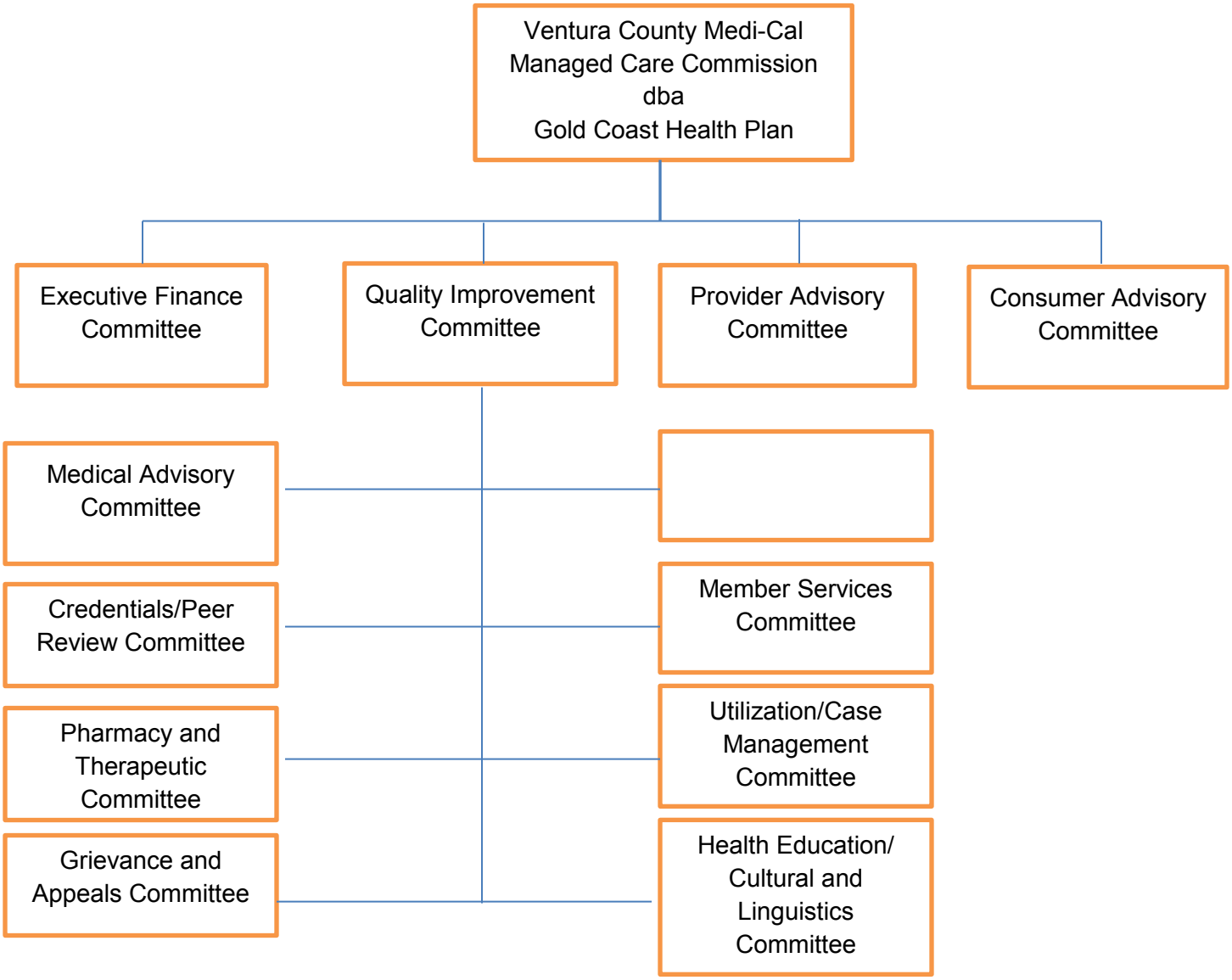
The P&T Committee members include but are not limited to GCHP's Chief Medical Officer (Chair), PBM representative, GCHP's Director of Pharmacy Services, physicians, and representatives of a variety of clinical specialties.

Meeting Frequency:

The committee meets quarterly.

IX. GOLD COAST HEALTH PLAN COMMITTEE ORGANIZATIONAL CHART

The following organizational chart shows the key GCHP committees that advise the Ventura County Medi-Cal Managed Care Commission and their reporting relationships:



X. QUALITY COMMITTEE MEETINGS FOR CALENDAR YEAR 2016

Tuesday, March 28, 2017

Tuesday, June 27, 2017

Tuesday, September 26, 2017

Tuesday, December 12, 2017

Location – Bell Canyon Conference Room

AVAILABILITY OF QI Program TO PRACTITIONERS AND MEMBERS

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

REFERENCES

- Gold Coast Health Plan Quality Improvement System Policy QI-002 Gold Coast Health Plan Utilization Management Program Description
- Gold Coast Health Plan Care Management Program Description
- Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 13-005
- HEDIS® National Committee for Quality Assurance
- DHCS Quality Strategy
- National Quality Strategy
- 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(b) (1)

UTILIZATION MANAGEMENT AND CARE MANAGEMENT PROGRAM DESCRIPTION IN A SEPARATE DOCUMENT.
The 2017 Quality Improvement Program Description and Work Plan were approved by the Quality Improvement Committee on XX, 2017.

The 2017 Quality Improvement Program Description and Work Plan were approved by Ventura County Medi-Cal Managed Care Commission (VCMMCC) on XX, 2017.

2017 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
NCQA MED 2	Diabetes Clinical Practice Guideline (CPG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant CPGs Distribute if necessary	Q4 2017	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of each of the CPGs Distribute guidelines to appropriate practitioners	MAC
NCQA MED 2	Asthma Clinical Practice Guidelines (CPG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant CPGs Distribute if necessary	Q4 2017	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of each of the CPGs Distribute guidelines to appropriate practitioners	MAC
NCQA MED 2	Preventive Health Guideline (PHG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant PHGs Distribute if necessary	Q4 2017	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of two PHGs Distribute guidelines to appropriate practitioners	MAC
Advance Prevention					
DHCS	Increase percentage of members who smoke who report being counseled to quit in prior 6 months	90%	Q4 2017	Measure during IHA monitoring Educate providers based on results of IHA monitoring Audit and provide feedback	QI
DHCS	Increase percentage of members who smoke who report a provider discussed tobacco cessation medication in the prior 6 months	90%	Q4 2017	Measure during IHA monitoring Educate providers based on results of IHA monitoring Audit and provide feedback	QI
DHCS	Increase rates of Initial Health Assessment (IHA)	90%	Q4 2017	Measure during medical record reviews for IHA and provide performance feedback at time of completion of record review Educate providers of requirements and components of IHA Audit and provide feedback Article in POB regarding requirements of IHA, including outreach requirements	QI

2017 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
HEDIS® Measures					
DHCS	Postpartum Care – Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	Increase rates by 5% over previous measurement year	Q4 2017	Continue Member education mailings to compliment member incentive forms HE to continue to promote incentive during outreach events Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Continue member incentive program to engage members; partner with CPSP staff at clinics and Ventura County Public Health to help promote	QI
DHCS	Childhood Immunization Status Combo 3 – Percentage of two year old children who receive a specific group of vaccines (DTap, IV, MMR, HiB, HepB, VZV and PCV) on or before their 2nd birthday	Increase rates by 5% over previous measurement year	Q4 2017	Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Educate Providers on trending of rates via Provider Update	QI
DHCS	Immunizations for Adolescents (Combo 1) – percentage of adolescents 13 years of age who received a meningococcal vaccine on or between the member's 11th and 13th birthday and Tdap or Td on or between the member's 10th and 13th birthdays (Combo1)	Increase rates by 5% over previous measurement year	Q4 2017	Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports	QI
DHCS	Children and Adolescents' Access to Primary Care Practitioners – percentage of members 12 months – 19 years of age who had a visit with a PCP	Meet or exceed DHCS MPL	Q4 2017	CAP P4P Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports	QI Network Operations QI
DHCS	Counseling for Nutrition and Physical Activity for Children and Adolescents – percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling	Meet or exceed DHCS MPL	Q4 2017	Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Provider Operations Bulletin article Meet with clinics to discuss rates	QI

2017 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
Over/Under Utilization					
DHCS	Appropriate Testing for Children with Pharyngitis - percentage of children 2 – 18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic **and received a group A strep test.**	Meet or exceed NCQA 25th percentile; 2016 rate of 59.46 remains below the NCQA 25th percentile	Q4 2017	Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI
DHCS	Appropriate Treatment for Children with Upper Respiratory Infection - percentage of children 3 months – 18 years of age who were diagnosed with an upper respiratory infection (URI) and **were not dispensed** an antibiotic prescription.	Meet or exceed NCQA 90th Percentile	Q4 2017	Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI
DHCS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis - percentage of adults 18 – 64 years of age with a diagnosis of acute bronchitis **who were not dispensed** an antibiotic prescription.	Meet or exceed NCQA 50th Percentile	Q4 2017	Provide provider performance feedback by means of 2016 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI
DHCS	Ambulatory Care- Summarizes Utilization of Ambulatory Care Outpatient Visits – per 1,000 Member Months	Meet Medi-Cal Managed Care Performance Dashboard Rate	Q4 2017	Adult and child member letters for appointment reminders/engage members to see their PCP Meet with clinics to discuss results of clinic rates	QI

2017 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
Quality Improvement Projects					
DHCS	Health Disparity PIPTBD			Submit Modules as directed by DHCS for approval • Modules 3,4 and 5 submit separately Report 3 month PDSA cycle results to QIC and DHCS/HSAG	QI
DHCS	PIP: TBD			Submit Modules as directed by DHCS for approval • Modules 1 & 2 • Modules 3, 4, and 5 submit separately Report 3 month PDSA cycle results to QIC and DHCS/HSAG	QI
DHCS	IP: Annual Monitoring for Patients on Persistent Medication	Meet or exceed DHCS MPL	Q4 2017	Provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Educate providers via Provider Update Audit and feedback	QI
					QI
DHCS	IP: Comprehensive Diabetes Care • Blood Pressure Control	Meet or exceed DHCS MPL	Q4 2017	Ensure aggressive management of medical records retrieval of HEDIS vendor Member educational mailing with health education materials	QI
DHCS	IP: Comprehensive Diabetes Care • HbA1c Adequate Control (<8.0%) • HbA1c Poor Control (<9.0%)	Meet or exceed DHCS MPL	Q4 2017	Ensure aggressive management of medical records retrieval of HEDIS vendor Collaborate with DM program to close care gaps and provide health coaching Bi-monthly prospective HEDIS report cards and performance feedback reports Member educational mailing	QI
DHCS	IP: Controlling Blood Pressure	Meet or exceed DHCS MPL	Q4 2017	Ensure aggressive management of medical records retrieval of HEDIS vendor Member educational mailing with health education materials	
GCHP	Opioid Use Improvement Strategy	Develop strategy	Q4 2017	Formulary Edits Provider education	Pharmacy

2017 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality of Nonclinical Services					
NCQA NET 2 DHCS	**Primary Care Access** Members are offered: • Non-urgent primary care within 10 business days of request • Urgent care within 48 hours **Specialty Care Access** Members are offered: • Non-urgent specialty care appointment within 15 business days • Non-urgent ancillary services within 15 business days	Standards met for minimum of 90% of providers	Q4 2017	Monitor performance and complaints relating to appointments Report quarterly performance to QIC Develop and implement corrective action plans when timely access standards not met Conduct survey	Grievances and Appeals Network Operations
DHCS	After Hours Availability • Members are able to reach a provider after hours	Standards met for 90 % of providers	Q4 2017 Q3 2017	Monitor performance and complaints relating to after-hours availability Report quarterly performance to QIC Develop and implement corrective action plans when timely access standards not met Conduct survey	Network Operations Grievances and Appeals
NCQA NET 1 DHCS	Availability of Practitioners	Ratios: 1 PCP 1:2000 Total Physicians 1: 1200 Physician Supervision to Non-Physician Practitioner Ratio Nurse Practitioners 1:4 Physician Assistants 1:4 Network maintained PCP located within 30 minutes or 10 miles	Q4 2017	Conduct bi-annual ratio analysis and annual Quest Analytics analysis for primary care and high volume specialties Identify gaps and implement corrective action plan Monitor progress towards action plans to maintain or improve GeoAccess standards Report bi-annual ratio analysis and annual GeoAccess findings to QIC	Network Operations

2017 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality of Nonclinical Services					
Practitioner Availability: Cultural Needs & Preferences					
NCQA NET 1 DHCS	Practitioner Availability: Cultural and Linguistics Needs & Preferences: Assess the cultural, ethnic and linguistic needs of our members	Complete Annual Assessment	Q4 2017	Analyze the demographic needs of our members to identify opportunities for improvement	Member Services Network Operations
NCQA NET 1 DHCS	Assess the provider network and adjust the availability of providers within the network, if necessary, to meet membership needs and preferences	Complete Annual Assessment	Q4 2017	Monitor how effectively the practitioner network meets the needs and preferences of our members	Network Operations
	Provider Satisfaction Survey	Complete Survey	Q4 2017	Analyze results and identify opportunities for improvement Develop and implement interventions as needed to improve rates	Network Operations
Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Patient Safety					
DHCS	Complete Initial and Tri-annual Facility Site Reviews Complete Interim Reviews	100%	Year End 2017	Monitor FSR database Submit bi-annual reports to DHCS	FSR Nurse QI
DHCS	Complete Physical Accessibility Site Reviews	100%	Year End 2017	Compile reports for high volume/ancillary specialists Submit report to State Complete PARs for new provider sites	FSR Nurse QI
NCQA MED 4 DHCS	Improve Safe Clinical Practice	Tracking	Ongoing	Monitor site visit results from practitioner credentialing Monitor member complaints involving clinical quality of care concerns (safety)	Credentialing/ Peer Review Grievances and Appeals

2017 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Member Experience: CAHPS, Complaints/Grievances TBD					
NCQA QI 4 DHCS	Conduct annual assessment of complaints and grievances. Conduct Six Month Member Access and Satisfaction Survey results to identify opportunities for improvement Call Center Monitoring	Increase rates by 5% over previous year : Your Overall Appointment Experience Adult: 2015 - 68.6% Child: 2015 – 57.9% Ease of Accessing Care Adult: 2015 - 85.9% Child: 2015 - 89.1% ASA: 30 seconds or less Abandonment Rate : 5% or less	Q4 2017 July to Dec 2017	Provider Interventions: • Review 2016 Member Access and Satisfaction Survey final results with clinics • Provider access survey Q2 2016; follow up with providers not meeting standards Conduct Six Month Member Access and Satisfaction Survey Provide results to Network Operations Monitor complaints and grievances Customer Service Interventions: • Monitor results/reports of after call survey performed by call center; follow up if issues identified • Monitor Average Speed of Answer (ASA and Abandonment Rate	Network Operations QI Grievances and Appeals Member Services

2017 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Health Plan Quality					
NCQA QI 1 DHCS	●Update QI Program Description ●Complete 2015 QI Program Evaluation ●Develop and Implement 2016 QI Program Work Plan	100%	June 2017	1. Review and revise annual QI Program Description, Work Plan and Evaluation 2. Obtain approval of 2016 QI Program and Work Plan and Evaluation of 2015 QI Program 3. Evaluate the adequacy of resources, committee structure, practitioner participation and leadership involvement in the QI Program in order to restructure or change the QI Program for subsequent year as necessary	Chief Medical Officer QI Director Quality Improvement Committee
NCQA CR 8, QI 10, UM 13, RR 5 DHCS	Completion of Delegation Oversight Delegated Activities • Credentialing • QI • UM • Members' Rights • Claims	100%	Q4 2017	1. Complete audits 2. Issue CAPs as applicable 3. Follow-up on CAPs as applicable 4. Report to Compliance Committee and QIC	Compliance
Monitoring via use of Dashboard					

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: August 21, 2017

SUBJECT: Chief Executive Officer Update

ORGANIZATIONAL CHANGES

I am pleased to announce that **Dr. Nancy Wharfield** has accepted the position of Chief Medical Officer replacing retired **Dr. Albert Reeves**. Dr. Wharfield was previously the Associate Chief Medical Officer for GCHP. **Kathy Neal, RN, DNP**, is replacing the retiring **Vickie Lemmon, RN, MSN**. Kathy is joining GCHP from Central California Alliance for Health where she was Chief Health Services. Vickie is retiring after 44 years as an RN and after 3.5 years at GCHP. She was an outstanding leader for our health services team. **Melissa Scrymgeour** has expanded responsibilities including oversight of government affairs and external relations function and the clerk of the commission. Her new title is Chief Administrative Officer.

CONGRESSWOMAN JULIA BROWNLEY VISITS GOLD COAST HEALTH PLAN

We were honored to host Congresswoman Julia Brownley on Aug 11, 2017. Congresswoman Brownley was able to meet our leadership team and hear a little about the services we provide to the community. She also visited our Health Education and Members Services team to learn more about their initiatives. Finally, she was able to briefly sit in during a Child Health and Disability Program (CHDP) meeting.

Congresswoman Brownley and GCHP leadership team

COMMUNITY HEALTH INVESTMENTS APPRECIATION EVENT

On July 19, 2017, GCHP hosted an appreciation event for the awardees of this year's Community Health Investment grants.

The event allowed agency leaders to meet with the GCHP team and other agency leaders to share ideas for collaboration and support.

We awarded grants to 16 agencies worth a total of $1.5 million.

GCHP and leaders of community agencies receiving grants

AMERICASHEALTH PLAN KICKOFF MEETING

On August 10, leadership from GCHP and AHP met to kickoff planning and negotiations for a potential plan-to-plan pilot. Ruth Watson is the project lead with support from Margaret Tatar from HMA. Guidelines for the pilot and a tentative timeline was established. Follow up meetings by subgroups will be weekly or as needed.

DELAY DECISION – CMS DUAL ELIGIBLE SPECIAL NEEDS PLAN

There are a number of significant projects and activities currently affecting GCHP and our ability to implement all regulatory and contractual requirements and to maintain day-to-day operations. As a result, the team is deferring to a later date any decision around implementation of a dual eligible special needs plan (D-SNP). Under the original timeline, work would need to begin immediately in preparation for a January 2020 go-live.

LEGISLATIVE UPDATE

Legislative Advocacy in Washington, DC

At the end of June, Gold Coast Health Plan's (GCHP) Manager of Government and External Relations participated in the Association of Community Affiliated Plans' (ACAP) Legislative Advocacy "Fly-In". This event is held tri-annually to allow ACAP member plans to meet with members of Congress and their staff to discuss federal legislation and policies that may impact the Medicaid/Medi-Cal program.

June's "Fly-In" was held during a crucial time when the U.S. Senate was expected to vote on the Better Care Reconciliation Act (BCRA). Under the BCRA, states would be provided a choice of per-capita or block grants as their funding mechanism. By 2024, the enhanced match for the Expansion population would begin being phased out. Per the Congressional Budget Office, over 15 million people would lose Medicaid coverage by 2026. According to the State of California's Department of Health Care Services, California could have lost more than $30 billion annually in additional health costs by 2027, forcing officials to consider drastic reductions in Medi-Cal, including reducing or ending coverage for more than 3.8 million individuals enrolled under the Affordable Care Act's (ACA) Medicaid expansion. In Ventura County, 55,000 Expansion members could have lost their coverage.

For the reasons stated above, ACAP along with its member plans met tirelessly with members of Congress to advocate for the Medicaid program and its beneficiaries. GCHP staff met with staff from the offices of House Representatives Julia Brownley and Steve Knight.

The BCRA was ultimately defeated on July 28, 2017.

California Legislative Summary

Before the Legislature went to recess there was a lot of momentum around SB 562, the universal health care bill. SB 562 would establish a single-payer health care system to be administered through a new, independent state entity "Healthy California" providing no-cost coverage to all California residents. According to the Senate Appropriations Committee, the annual cost would be approximately $400 billion annually, it is projected the funding would come from a combination of existing federal, state, and local funds including a 15 percent payroll tax. SB 562 moved out of the Senate; however, it was held in the Assembly because it did not address serious issues, such as financing, delivery of care, and cost controls. Because this is the first year of a two-year legislative session, this action does not mean SB 562 is dead. The Government Relations team will continue to monitor SB 562 and provide updates as needed. Attached is a legislative bills summary table.

Gold Coast Health Plan's Priority Tracking Legislative Bills Table

BILL NUMBER	SUMMARY	STATUS
AB 391 (Chiu)	**Medi-Cal: Asthma Preventive Services** Would require DHCS to seek an amendment to its Medicaid state plan to include qualified asthma preventive service providers.	7/12/17: Senate Appropriations Committee
AB 428 (Ridley-Thomas)	**Brown Act; Quorum for local plan meetings** Would continue to allow a quorum where health authority members call in to meeting, provided other requirements are met.	7/31/17: Chaptered by the Secretary of State.
AB 447 (Gray)	**Medi-Cal: Covered benefits: glucose monitors** Would add continuous glucose monitors that are medically necessary as a Medi-Cal benefit.	7/10/17: Senate Appropriations Committee
AB 1074 (Maienschein)	**Health Care Coverage: Autism** Revises 'behavioral health treatment' services to modify current supervisorial requirements.	7/12/17: Senate Appropriations Committee
AB 1092 (Cooley)	**Medi-Cal Eyeglasses** Restores eyeglass coverage of one pair every two years to ages 21 older.	6/15/17: Referred to Senate Health and Appropriations Committees
AB 1316 (Quirk)	**Public Health: Childhood Lead Poisoning: Prevention** Would require the standard of care to be that all children be screened for blood lead levels.	7/6/17: Senate Committee on appropriations

Gold Coast Health Plan's Priority Tracking Legislative Bills Table

BILL NUMBER	SUMMARY	STATUS
AB 1534 (Nazarian)	**HIV Specialists** Requires every health care service plan contract that is issued, amended, or renewed on or after January 1, 2018 to permit an HIV specialist to be an eligible primary care provider, if the provider requests primary care provider status and meets the health care service plan's eligibility criteria for all specialists seeking primary care provider status.	6/26/17: Senate Appropriations Committee
SB 171 (Hernandez)	**Spot bill for Mega Reg Implementation** Mega Reg provisions for Network adequacy, Medical Loss Ratio, and public hospital financing reform.	7/11/17: Assembly Appropriations Committee
SB 199 (Hernandez)	**Health Care Cost, Quality Database** This bill requires the California Health and Human Services Agency (CHHSA) to convene an advisory committee to make recommendations related to a statewide health care cost, quality, and equity atlas.	7/19/17: Assembly Appropriations Committee
SB 223 (Atkins)	**Health Care Language Assistance Services** Would require specified documents be translated into threshold languages identified by the needs assessment. Would also require written notice be made available in the top 15 languages spoken by limited-English-proficient individuals.	6/28/17: Assembly Appropriations Committee
SB 743 (Hernandez)	**Family Planning Providers** This bill prohibits Medi-Cal managed care plans from restricting an enrollee's choice of a family planning services provider, even if they are out-of-network, and requires Medi-Cal managed care plans to reimburse out-of-network providers at the applicable fee-for-service rate.	7/19/17: Assembly Appropriations Committee

COMPLIANCE

Audits and Investigations (A&I) conducted the annual onsite medical audit during the weeks of June 5, 2017 through June 16, 2017. Gold Coast Health Plan (GCHP) is anticipating a draft report tentatively slated for August 2017. Staff will keep the commission apprised as GCHP receives information.

On March 17, 2017, DHCS issued GCHP a CAP relative to the Provider Network 274 File, which is a new requirement for provider network data reporting. GCHP staff has been working diligently with DHCS during the entire process. On July 21, 2017 DHCS issued GCHP a letter (please see attached) indicating the Plan has achieved compliance, however because the Plan did not meet the initial deadlines for three months, financial sanctions will be applied. The financial sanction is $25,000.00.

GCHP continues to meet all regulatory contract submission requirements. GCHP submitted all required initial Final Rule deliverables on May 12, 2017 to DHCS. DHCS is currently reviewing the material submitted and has provided feedback to GCHP on most deliverables. For items that required follow up staff has incorporated the additional information and sent the deliverables back to DHCS for review and approval. The majority of the deliverables have been approved. All regulatory agency inquiries and requests are processed timely. Compliance staff is actively engaged in sustaining contract compliance.

An audit was conducted on Conduent and because of poor quality prep and lack of material to review; compliance failed Conduent on the audit and issued a CAP. Compliance staff conducted a second audit on Conduent the week of April 24, 2017 through April 27, 2017. A CAP was issued to Conduent on June 16, 2017. A response from Conduent was received and the CAP is still open. Staff is working with Conduent to ensure compliance is achieved.

GCHP MBHO remains under a CAP, for claims processing and financial sanctions are currently in place. GCHP Vision provider is also under a CAP. GCHP delegation oversight staff is working with each delegate on achieving compliance to address the deficiencies identified and ultimately close out the CAPs issued.

The compliance dashboard is attached for reference and includes information on but is not limited to staff trainings, fraud referrals, HIPAA breaches, delegate audits.

DHCS
JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

July 19, 2017

Dale Villani, CEO
Gold Coast Health Plan
711 E. Daily Dr., Suite 106
Camarillo, CA, 93010

Dear Mr. Villani:

NOTICE OF INTENT TO IMPOSE MONETARY SANCTIONS FOR FAILURE TO COMPLY WITH CORRECTIVE ACTION PLAN

The Department of Health Care Services (DHCS) informed Medi-Cal Managed Care Plans (MCPs) of the transition to report provider network data in the 274 provider network data file in August 2015. DHCS and MCPs began testing MCP reporting of provider network data submissions in the 274 provider network data file in March 2016. On January 13, 2017, DHCS informed Gold Coast Health Plan of the requirement to complete testing and submit January and February 2017 provider network data in the 274 provider network data file by March 10, 2017. The 274 provider network data file is required to be submitted through the Post Adjudicated Claims and Encounters System. DHCS also informed all MCPs that failure to meet the March 10, 2017, deadline would result in the imposition of a Corrective Action Plan (CAP).

On March 17, 2017, DHCS imposed a CAP on Gold Coast Health Plan for failure to meet its contractual obligations for reporting provider network data through the 274 provider network data file. The CAP further advised Gold Coast Health Plan that its failure to submit provider data in the 274 provider network data file for the months of January through April 2017 by May 10, 2017, could result in monetary sanctions.

Under the authority of Title 22, California Code of Regulations, Section 53872, DHCS is imposing monetary sanctions in the amount of $25,000 for Gold Coast Health Plan failure to submit 274 provider network data files for the months of March through May 2017 by the May 10, 2017, deadline. The sanction amount represents a sanction of $5,000 for the first month of non-compliance and $10,000 for the second and third month of non-compliance. On June 8, 2017, Gold Coast Health Plan submitted all provider network 274 files for the months of January through May 2017. DHCS reviewed all submitted files and confirmed that Gold Coast Health Plan has corrected the deficiencies that necessitated the CAP.

Additionally, DHCS reserves its right to claim liquidated damages to the extent that Gold Coast Health Plan's provider network data reporting deficiencies result in a requirement to repay federal financial participation to the Centers for Medicare & Medicaid Services.

If you have any questions, please contact Sarah Brooks at Sarah.Brooks@dhcs.ca.gov or (916) 440-7800.

Sincerely,

Jennifer Kent
Director

Enclosure

Notice of Appeal Rights

This decision will be final unless Gold Coast Health Plan files a written appeal within 15 days from the date of service of this notice addressed as follows:

The Honorable Sharon Stevenson
Chief Administrative Law Judge
Office of Administrative Hearings and Appeals
Department of Health Care Services
1029 J Street, Suite 200
Sacramento, CA 95814

A copy of the appeal should also be sent to the Department of Health Care Services, Office of Legal Services, addressed as follows:

Jared Goldman
Assistant Deputy Director and Chief Counsel
Department of Health Care Services
1501 Capitol Avenue, MS 1101
P.O. Box 997413
Sacramento, CA 95899-7413

COMPLIANCE REPORT 2017

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
Hotline A confidential telephone and web-based process to collect info on compliance, ethics, and FWA	Referrals *one referral can be sent to multiple referral agencies*	5	1	7	14	9	13	16						65
Hotline Referral *FWA	Department of Health Care Services Program Integrity Unit / A&I	0	0	0	3	1	0	0						4
Hotline Referral *FWA	Department of Justice	0	0	0	0	0	0	0						0
Hotline Referral	Internal Department (i.e. Grievance & Appeals, Customer Services etc.)	5	1	7	11	8	13	16						61
Hotline Referral	External Agency (i.e. HSA)	0	0	0	0	0	0	0						0
Hotline Referral	Other * Legal, HR, DHCS (Division outside of PIU i.e. eligibility, note to reporter), etc.	0	0	0	0	0	0	0						0
Delegation Oversight	Delegated Entities	8	8	8	8	8	8	0						8
The committee's function is to ensure that delegated activities of subcontracted entities are in compliance with standards set forth from GCHP contract with DHCS and all applicable regulations	Reporting Requirements Reviewed **	71	83	68	81	75	73	85						536
	Audits conducted	5	1	0	1	0	0	0						7
Delegation Oversight	Letters of Non-Compliance	0	0	1	0	0	0	0						1
Delegation Oversight	Corrective Action Plan(s) Issued to Delegates	0	1	1	1	0	0	0						3
Audits	Total	0	0	0	0	0	0	0						0
External regulatory entities evaluate GCHP compliance with contractual obligations.	Medical Loss Ratio Evaluation performed by DMHC via interagency agreement with DHCS	0	0	0	0	0	0	0						0
	DHCS Facility Site Review & Medical Records Review *Audit was conducted in 2013*	0	0	0	0	0	0	0						0
	HEDIS Compliance Audit (HSAG)	0	0	0	0	0	0	0						0
	DHCS Member Rights and Program Integrity Monitoring Review *Review was conducted in 2012*	0	0	0	0	0	0	0						0
	DHCS Medical Audit	0	0	0	0	0	0	0						0
Fraud, Waste & Abuse	Total Investigations	5	1	0	14	8	13	16						57
The Fraud Waste and Abuse Prevention process is intended to prevent, detect, investigate, report and resolve suspected and /or actual FWA in GCHP daily operations and interactions, whether internal or external.	Investigations of Providers	0	0	0	1	0	0	3						4
	Investigations of Members	5	1	0	1	5	13	10						35
	Investigations of Other Entities	0	0	0	1	4	0	2						7
	Fulfillment of DHCS/DOJ or other agency Claims Detail report Requests	0	0	0	0	0	0	0						0

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
HIPAA	Referrals	6	2	4	2	3	2	5						24
Appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of health information and ensure compliance with HIPAA regulatory requirements.	State Notification	6	2	4	2	3	2	5						24
	Federal Notification	0	3	0	0	0	0	0						3
	Member Notification	2	0	0	0	0	1	1						4
	HIPAA Internal Audits Conducted	0	0	1	0	0	0	1						2
Training	**Training Sessions**	12	2	0	3	1	2	2						72
Staff are informed of the GCHP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	Fraud, Waste & Abuse Prevention (Individual Training)	2	2	0	1	1	2	2						10
	Fraud, Waste & Abuse Prevention (Member Orientations)	6	6	6	6	6	6	6						42
	Code of Conduct	2	2	0	1	1	2	2						10
	HIPAA (Individual Training)	2	2	0	1	1	2	2						10
	HIPAA (Department Training)	0	0	0	0	0	0	0						0

** Reporting Requirements are defined by functions delegated and contract terms. Revised contracts, amendments or new requirements form DHCS may require additional requirements from subcontractors as a result the number is fluid

** Audits- Please note multiple audits have been conducted on the Plan, however many occurred in 2012 and 2013 and will be visible on the annual comparison dashboard

** This report is intended to provide a high level overview of certain components of the compliance department and does not include/reflect functions the department is responsible for on a daily basis.

^ The large aggregates for the month of November and December represent the yearly training of full time employees and new coming Commissioners.

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Anne Freese, PharmD, Director of Pharmacy

DATE: August 21, 2017

SUBJECT: Implementation of New PBM: OptumRx

SUMMARY:

Gold Coast Health Plan (GCHP or the Plan) contracts with a Pharmacy Benefits Manager (PBM) in order to provide pharmacy benefit services to its members. The commission entered into a new contract with OptumRx (ORx) to be the PBM effective June 1, 2017.

BACKGROUND:

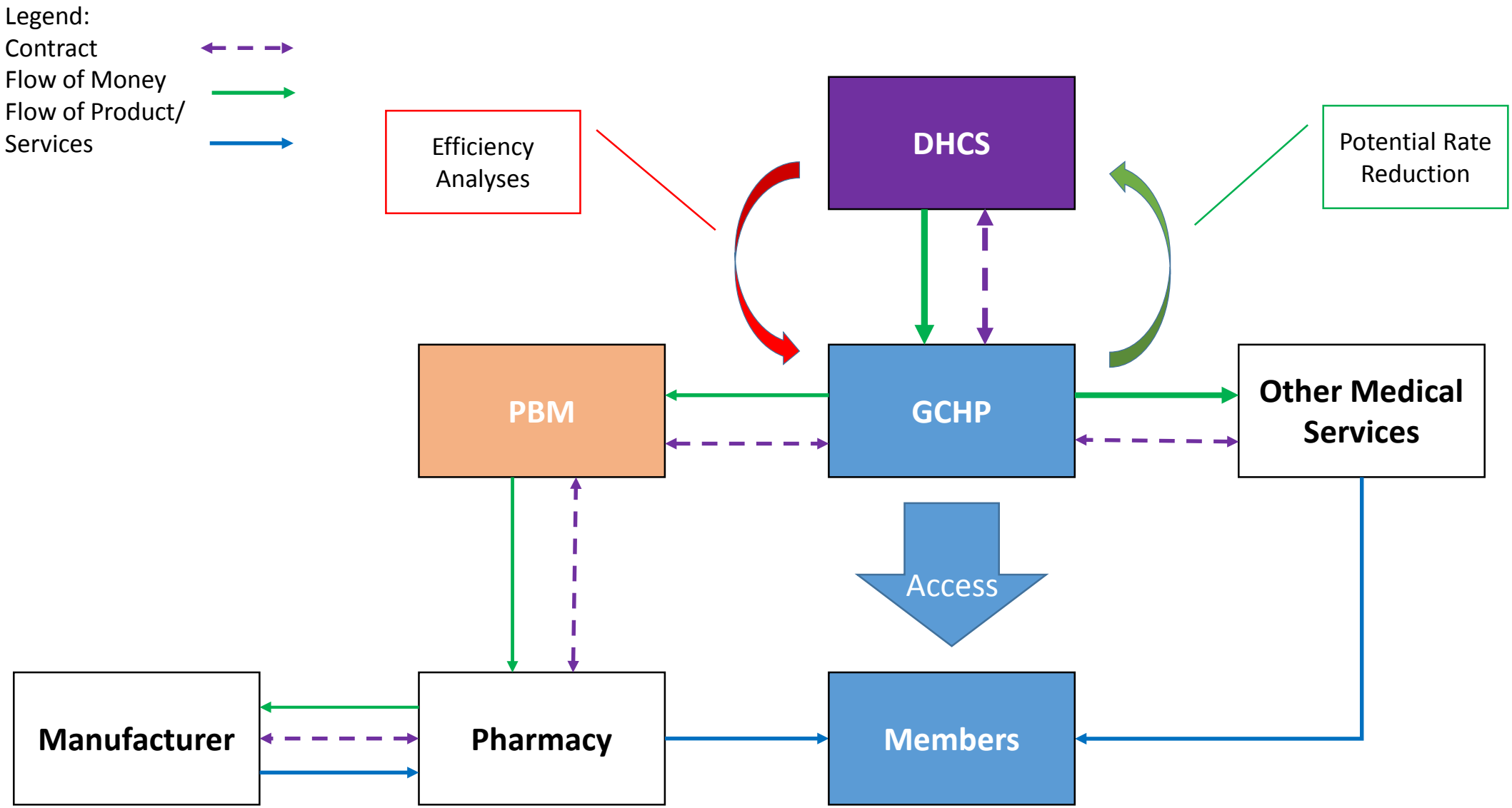
GCHP worked diligently with ORx on plan specifications to build out GHCP's pharmacy benefit within ORx's systems. This has been a detailed, complex and arduous process to ensure that the benefit is built to the same specifications as with the prior PBM.

DISCUSSION:

ORx's claim system went live for GCHP on June 1. At that time, GCHP and ORx conducted daily check-in calls to verify reports of identify issues and ensure that the benefit and systems were working properly. Through July 31, OptumRx has paid over 200,000 prescriptions claims for GCHP members.

There are several outstanding issues and verbal updates will be provided on the following items:

- Kaiser pharmacies
- 340B eligible drugs claims
- Pharmacy reimbursement (see attached graphic)


Legend:
Contract
Flow of Money
Flow of Product/
Services
Efficiency
Analyses
DHCS
Potential Rate
Reduction
PBM
GCHP
Other Medical
Services
Access
Manufacturer
Pharmacy
Members

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: August 21, 2017

SUBJECT: Chief Operating Officer Update

OPERATIONS UPDATE

Membership Update – (July 2017)

Gold Coast Health Plan (GCHP) membership is a product of Ventura County residents who are eligible for Medi-Cal and who choose to sign up for our plan. Membership is fluid, as people must re-determine each year, move in and out of the county or move to Medi-Cal fee for service.

As of July 1, 2017, Gold Coast Health Plan's (GCHP's) total membership was 200,903. The Plan experienced a net loss of 552 members over the previous month. We attribute the loss to the following potential impacts:

- Lack of redeterminations;
- Movement of members out of the county;
- Increases to income rendering member ineligible for plan participation.

In August 2017, Gold Coast Health Plan's (GCHP's) total membership is 202,670. The Plan gained 1,767 members over the previous month. We attribute the loss to the following potential impacts:

- Increase in the county's population;;
- Increase to Medi-Cal enrollees who enrolled with the Plan.

AB 85 Auto Assignment- State Assembly Bill (AB 85) requires that the Plan assign 50% of those new Adult Expansion (AE) members who have not chosen a PCP within 30-days of enrollment to the County Public Hospital System, VCMC. In the month of June, GCHP assigned 577 members to VCMC, while in the month of July; GCHP assigned 519 members to VCMC, while the remaining 519 members were assigned to providers in compliance with the VCMMCC Auto Assignment policy. VCMC has 31,404 AE members assigned as of July 1, 2017. VCMC's target enrollment, as established by DHCS, is 65,765 and is currently at 47.75% of the target.

FY 16-17 Monthly Adult Expansion (AE) Membership Lookback (by aid code)

	L1	M1	7U	7W	7S	Total
Aug 17	447	56,028	58	14	87	56,634
Jul 17	464	55,407	80	30	94	56,075
Jun 17	484	55,462	83	31	91	56,151
May 17	505	55,331	92	35	113	56,076
Apr 17	520	55,333	94	44	163	56,154
Mar 17	560	55,539	100	48	210	56,457
Feb 17	590	55,667	113	55	243	56,668
Jan 17	646	55,551	141	50	203	56,591
Dec 16	695	55,820	521	123	240	57,399
Nov 16	770	55,567	1,057	216	314	57,924
Oct 16	919	55,103	1,227	254	374	57,877
Sep 16	1,015	54,740	1,370	280	336	57,741
Aug 16	1,162	54,237	1,470	307	361	57,537

Member Orientation Meetings

Eighty-five (85) total members (65 English, 20 Spanish) attended Member Orientation meetings between January and July 2017. Of the 85 members, 52 indicated they learned about the meeting because of the informational flyer included in each new member packet. Other methods of notification included:

- Website
- TCRC
- HSA

Claims Update

Claims Inventory represents the number of claim received but not adjudicated. Claims Inventory for May was 200,595 and June is 183,581. This equates to a Days Receipt on Hand (DROH) of 4.55 days in May and 3.04 days for June compared to a DROH maximum goal of 5 days with June reflecting a decrease over the previous month. GCHP received approximately 8,345 claims per day in June.

FY 2016-2017 Monthly Claims Receipts

Month	Total Monthly Claims Received	Average Daily Claims Receipts
April 2017	164,613	8,231
March 2017	208,407	9,061
February 2017	171,343	9,018
January 2017	168,660	8,433
December 2016	190,686	9,080
November 2016	170,209	8,510
October 2016	209,638	9,983
September 2016	159,446	7,593
August 2016	180,049	7,828
July 2016	166,955	8,347

Claims Processing Results – Conduent has several Service Level Agreements (SLAs) in place with GCHP to ensure that claims processed meet the minimum state and generally accepted service levels for claim processing. GCHP measures three (3) SLAs for claim processing:

- **Claims Turnaround Time (TAT) -** The number of days needed to process a claim from date of receipt to date of determination. The target is determination of 90% of original clean claims processed within 30 calendar days of receipt.
- **Financial Claims Processing Accuracy-** Percentage of correct payments against the total payments made in a month. The target is ≥ 98%
- **Procedural Claims Processing Accuracy-** The number of claims without any procedural errors (non-financial) against the total number of claims processed. The target is ≥ 97%.

Conduent met the Claim Turnaround Time target in the months of May and June.

Conduent also met the remaining claims targets for May and June.

Monthly SLA Performance

Month: June		
Service Level Agreement	**Expected Outcome**	**Actual Outcome**
Claim Turnaround Time	90%	97.2%
Financial Claims Processing Accuracy	98%	99.62%
Procedural Claim Processing Accuracy	97%	99.99%

Claim Denials – remain at 14.45% of total volume for both months, which is within industry norms.

Top Claim Denial Reasons:

- Service is included in Monthly Capitation per contract with provider
- Duplicate line item
- Primary Carrier EOB Required
- Charges incurred after term date
- Denied base on system edit
- Services are the financial responsibility of Clinicas

Encounter Data Quality Summary – GCHP collects monthly encounter data, which we submit to DHCS. These data are used in calculating the rates GCHP

Call Center Results – Conduent is responsible for taking level one calls from members and providers. The volumes reported reflect only Conduent call data. Additional calls are taken by the GCHP member services team which includes calls routed from Conduent considered escalated or second level calls, calls from providers and members directly to the GCHP member services team and any calls to members or providers requesting a call be by the GCHP member services team. Conduent has three (3) call queues: provider, member (English), member (Spanish).

GCHP monitors and reports on two (2) specific areas that help identify the Conduent Call Center work effort:

- **Call Volume** – Call volume measures the number of calls taken in a month's time. May's call volume was 11,775 whereas June call volume was 11,572. These remain consistent over previous months.

- **Average Call Length** – Call length measures the amount of time a call center representative spends on a call with a member or provider. Call length is a function of the call type and may be shorter or longer depending on the type of call and type of caller. GCHP measures the average call length only as an indicator of how long the call center representatives are spending with our callers. May and June average call length was approximately 7 minutes per call.

GCHP currently has three (3) SLAs that measure Conduent's call center efficacy on a monthly basis. Conduent met all targets in the month of April.

- **Average Speed to Answer (ASA) –** The number of seconds a caller waits in a queue until the call is answered by a call center representative.

GCHP received seven total clinical appeals in May; three appeals were upheld two appeal was overturned and two were withdrawn. There were two State Fair Hearing cases in May and both were denied.

Monthly Member Grievances

Type of Member Grievances	Number of Grievances
Accessibility	2
Benefits	1
Denials/Refusals	1
Quality of Care	8
Quality of Service	3
Total Member Grievances	**15**

In June, GCHP received 19 member grievances and 253 provider-claim payment grievances.

The 19 member grievances equate to 0.09 grievances per 1,000 members.

GCHP received 12 Quality of Care member grievances, which consisted of the following issues:

- Delay of Care
- Inappropriate Provider Care

GCHP received seven total clinical appeals in June; four appeals were upheld and two were withdrawn. There were two State Fair Hearing cases in June. One withdrawn and one approved

Monthly Member Grievances

Type of Member Grievances	Number of Grievances
Accessibility	2
Benefits	2
Billing	2
Quality of Care	12
Quality of Service	1
Total Member Grievances	**19**

Conduent Contract Negotiations:

Gold Coast Health Plan and Conduent Health Administration have agreed to terms for a new contract beginning July 1, 2017 and ending June 30, 2019. The terms of the contract delineate services in detail, which the previous contract lacked. The new contract outlines increased SLAs, greater liability limits and Conduent responsibility for cyber liability issues should they arise. Additional details can be found in the staff report included in this month's Commission Packet.

Appendix A: 2016 through FY 2015-2016 Monthly Membership Lookback

Monthly Membership Lookback (by aid code)

	L1	M1	7U	7W	7S
Jul 16	1,261	53,767	1,593	346	397
Jun 16	1,349	53,864	1,703	386	424
May 16	1,407	52,898	1,820	433	478
Apr 16	1,596	51,769	1,910	462	549
Mar 16	1,800	50,648	2,015	510	620
Feb 16	1,873	50,185	2,110	549	579
Jan 16	1,953	49,653	2,205	608	736

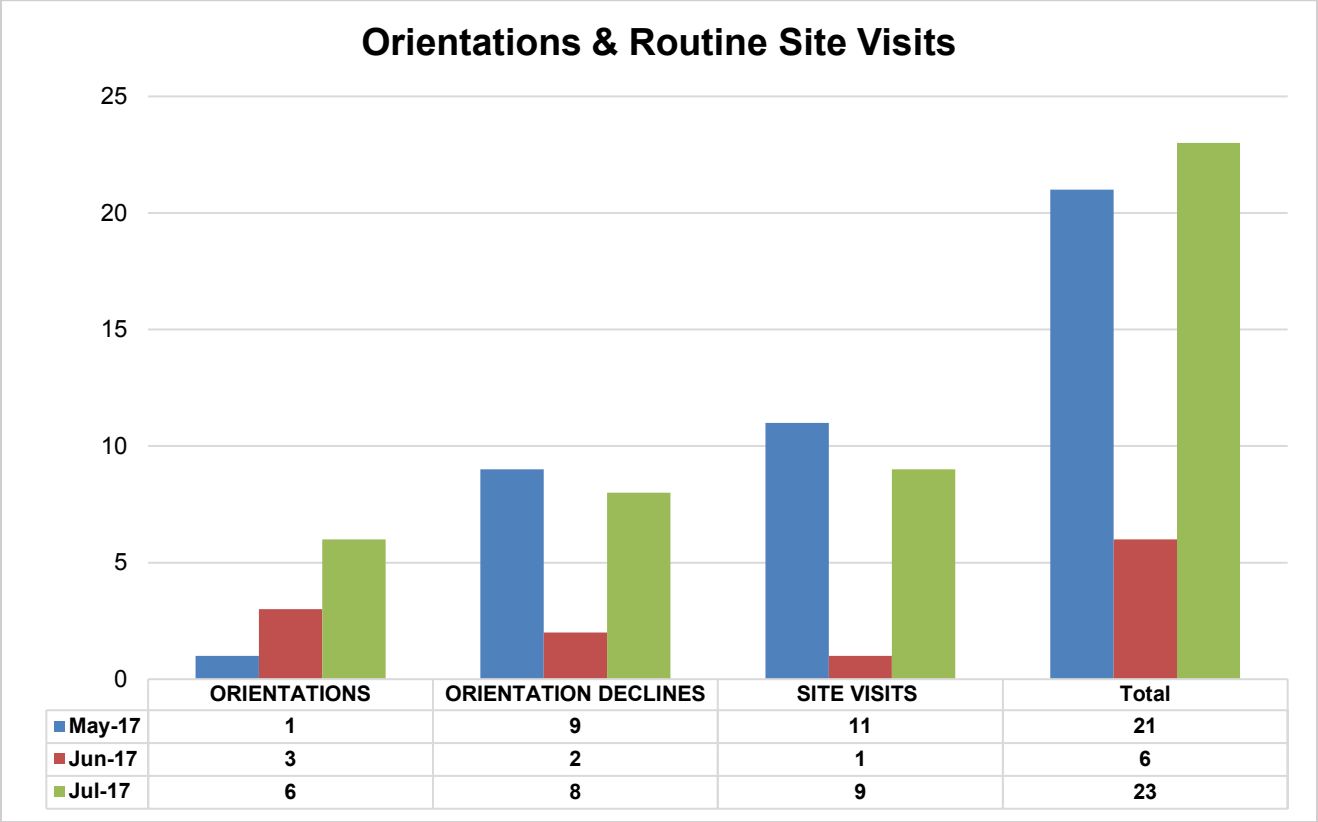
Appendix B: 2015 through FY 2015-2016 Monthly Claims Receipts

Monthly Claims Receipts

Month	Total Monthly Claims Received	Average Daily Claims Receipts
June 2016	177,246	8,057
May 2016	157,434	7,497
April 2016	162,287	7,728
March 2016	193,881	8,429
February 2016	176,656	8,833
January 2016	154,770	8,146
December 2015	170,897	7,768
November 2015	142,247	7,902
October 2015	156,109	7,095
September 2015	164,510	7,834
August 2015	152,840	7,278
July 2015	162,237	7,374

NETWORK UPDATE JULY 2017

Provider Site Visit Results



	ORIENTATIONS	ORIENTATION DECLINES	SITE VISITS	Total
May-17	1	9	11	21
Jun-17	3	2	1	6
Jul-17	6	8	9	23

- Orientations: 10 new provider orientations were conducted by GCHP Provider Relations Staff over the last 3 months. This figure is up approximately 40% due to staffing re-allocation of resources, which were previously dominated by the MCPDIP 274 project.

- 19 Physicians declined orientation during this reporting period due to their joining an established contracted group with GCHP. Established groups such as delegated providers have participated in previous orientations; they are familiar with GCHP policies and procedures and have the staff and capability to perform the orientation function on their own.

- Site Visits: 20 provider site visits were completed by Network Operations- Provider Relations staff. The goal for the Provider Relations team is to complete 20 site visits per Provider Relations Specialists per month ie. A total of 40 visits per month. These figures are down for this 3-month period due to two factors: loss of a Provider Relations Specialists who moved to Colorado and the other a result of the “all hands on deck”. We approach utilized to address the AB 274 project. As of the last report, Network Operations was is in the process of

interviewing candidates for this replacement position. We have just re-filled and hired for the vacant provider relations position, which will serve to increase our orientation and provider site visit numbers.

KEY PROJECTS:

1. **MANAGED CARE PROVIDER DATA IMPROVEMENT PROJECT (MCPDIP) 274- UPDATE**

- GCHP is in live production mode, no longer testing as of June
- July's 274 File was successfully accepted by the state
- 5/26: Recommendation to DHCS leadership that Gold Coast HP passed Phase 4 testing to remove CAP. Awaiting confirmation of formal letter notification.
- Business process preparation and discussions around data readiness currently taking place. Data Readiness process to take place on monthly basis.
  - 7/20: POB outlining impact to provider community via phone calls, e-mails and site visits to providers to ensure existing information is accurate
- Extract of provider data for 274-creation takes place as soon as vendor files are received.

2. **SB 137 PROVIDER DIRECTORIES**

- 8/3: Approval from the state of current directory received

- Final Rule deliverable #8
  - Minimum 12 font throughout the directory
  - 18 font tag line
- 6/30 directory submission including excel spreadsheet

- Completed action plan for remaining FR #8 deliverables
  - Obtaining after hour call hours
  - Obtaining URL information

3. **PROVIDER NETWORK DATA BASE & CREDENTIALING SYSTEM RFP**

- Completed RFP requirements
- RFP sent out 6 vendors last month- one vendor has declined to participate
- RFP's due 8/11

PROVIDER ADDS & TERMINATIONS- July 2017

Provider Adds: 42

- PCPs & Mid-levels: 14
- Specialists: 10
  - Hospitalists: 4
  - Oral-Maxillofacial: 2
  - Orthopedics: 1
  - Pathology:1
  - Pulmonology: 1
  - Cardio-Thoracic Surgery:1
- Ancillary: 18
  - Hospice: 1
  - Occupational Therapy: 2
  - Physical Therapy: 6
  - Radiology: 7
  - Speech Therapy: 2

Provider Terms: 32

• Cardio-Thoracic: 1	**Impact:** None. 22 individual cardio-thoracic surgeons Contracted.
• DME: 1	**Impact:** None**.** 42 DME providers contracted
• Hospice: 1	**Impact:** None. 16 Hospice providers contracted
• Hospitalist: 18	**Impact:** None. Terms due to provider clean-up under 274. All out of area.
• PCP's and Mid-Levels: 8	**Impact:** Small. Terms mainly due to provider clean-up Under 274. 168 FP's, 48 peds and 35 IM PCP's remain Actively contracted. # excludes mid-levels
• Radiology: 3	**Impact:** None: Terms due to provider clean-up under 274.

NEW HIRES:

Contract Manager position filled 7/10/2017. This was part of a departmental re-engineering initiative. This new role addressed a resource gap as we strive to keep up with new regulations regarding provider adequacy. While a new position it is a neutral addition from an FTE standpoint.

Incumbent: Vicki Wrighster

Key Responsibilities: Negotiating contracts that are cost effective, improving and developing policies and procedures and using a collaborative approach to contract implementation so that contracts are easier to operationalize by both providers and internal stakeholders.
Provider Relations Manager position filled 8/7/2017.

Incumbent: Jacob Hubbard

Key Responsibilities: Internal and external staff and provider education and training, provider site visits, triage of provider issues and resolution and provider roster management.

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, Chief Medical Officer

DATE: August 21, 2017

SUBJECT: Chief Medical Officer Update

HEALTH SERVICES UPDATE

Utilization data in the Health Services monthly update to the Commission is based on paid claims compiled by date of service and is lagged by 3 months to allow for partial run out of claims data. Claims data is complete at approximately 6 months. While incomplete, a 3 month lagged snapshot allows us to see an estimate of utilization without waiting for a more complete 6-month report. Administrative days are included in these calculations. Dual eligible members, Skilled Nursing Facility (SNF), and Long Term Care (LTC) data is not included in this presentation.

UTILIZATION SUMMARY

Inpatient utilization metrics through April 2017 are similar to CY 2016.

Bed days/1000 members have declined by about 43% from Plan's inception in 2011 through CY2016. Bed days/1000 for 2017 YTD are 225 compared with 210 for CY2016. For April 2017, Adult Expansion members utilized the greatest number of bed days (40%) followed closely by SPD (38%) and Family members (21%).

Bed days/1000 for SPD members were 1005 for YTD 2017 compared with 1006 for CY 2016. While the rate of bed days for SPD members is high, it does not have a strong effect on the overall plan rate of bed days per 1,000 members because SPD is such a small portion of our membership (5%).

Bed days/1000 Benchmark: The 2016 Managed Care Public Payer Digest report a bed days/1000 benchmark of 400. (Bed days/1000 are not reported on the Medi-Cal Managed Care Dashboard).

Average length of stay for CY2016 was 4.2. Average length of stay for YTD 2017 was 4.5.

Average length of stay Benchmark: The 2016 Managed Care Public Payer Digest reports an average length of stay benchmark of 4.75. (Average length of stay is not reported on the Medi-Cal Managed Care Dashboard).

Admits/1000 decreased about 10% from CY2015 to CY2016 (59 v. 53). Admits/1000 for YTD 2017 are 50.5.

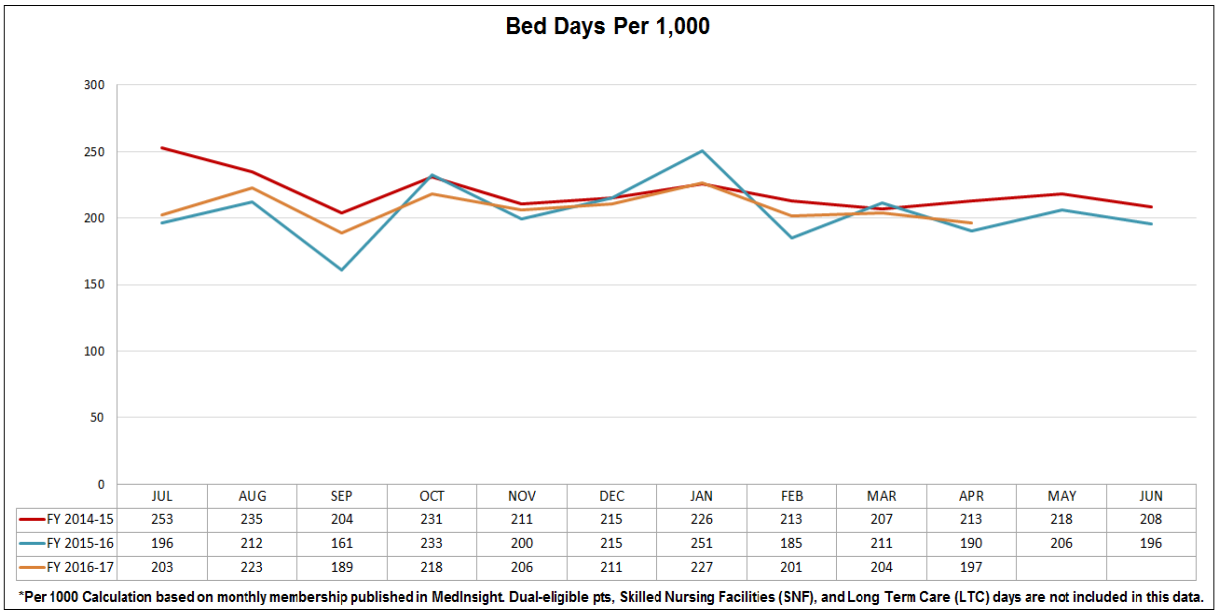
Admits/1000 for SPD members for CY 2016 was 184.2 compared with 194.1 for YTD 2017.

Admits/1000 Benchmark: The September 2016 DHCS Medi-Cal Managed Dashboard reports a benchmark of 120 admissions/1000 members. This variation between GCHP and DCHS may be explained by the relative youth of GCHP SPD members versus DHCS SPD members. (Only 33% of GCHP SPD members are age 40 – 64 years versus 42% for the DHCS SPD population.)

ED utilization/1000 decreased by about 10% from CY 2012 through CY2016 (494 to 442). ED utilization typically peaks in January or February each year. ED utilization/1000 for YTD 2017 is 477 compared with 448 for CY 2016. The family aid code group continues to utilize about half of all ED visits (48% followed by AE members at 32%.

ED utilization for SPD members is 839/1000 members for YTD 2017 compared with 802 for CY 2016.

ED Benchmark: The September 17, 2015 DHCS Medi-Cal Managed Care Performance Dashboard reported 36 ER visits / 1000 member months statewide for all managed care plans for October 2013 – September 2014. GCHP ER utilization / 1000 member months for the same period was 38. The March 2017 Medi-Cal Managed Care Performance Dashboard reported SPD ED utilization to be 1065/1000 members.



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2014-15	253	235	204	231	211	215	226	213	207	213	218	208
FY 2015-16	196	212	161	233	200	215	251	185	211	190	206	196
FY 2016-17	203	223	189	218	206	211	227	201	204	197		

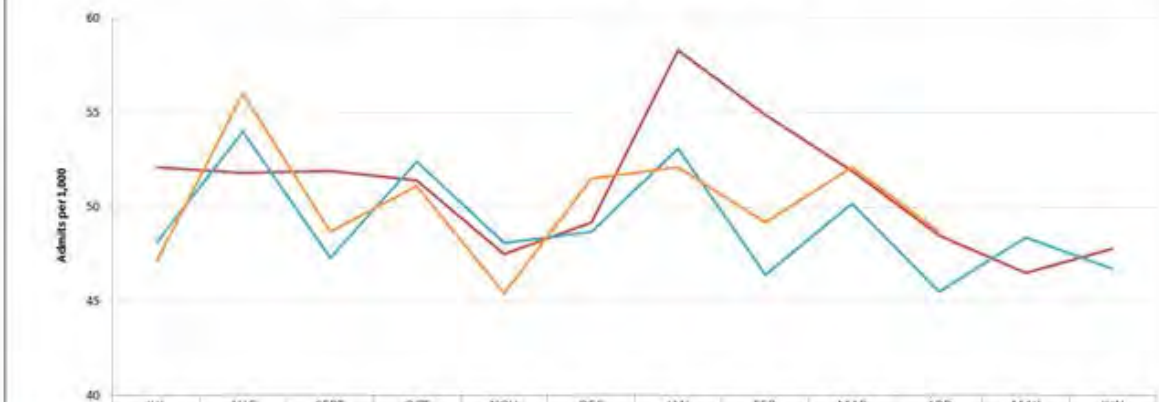
*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.

Average Length of Stay

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2014-15	4.9	4.5	3.9	4.6	4.5	4.4	4.6	4.5	4.0	4.4	4.7	4.4
FY 2015-16	4.1	3.9	3.4	4.4	4.1	4.4	4.7	4.0	4.2	4.2	4.3	4.2
FY 2016-17	4.3	4.0	3.9	4.3	4.5	4.1	4.4	4.1	3.9			

*Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.

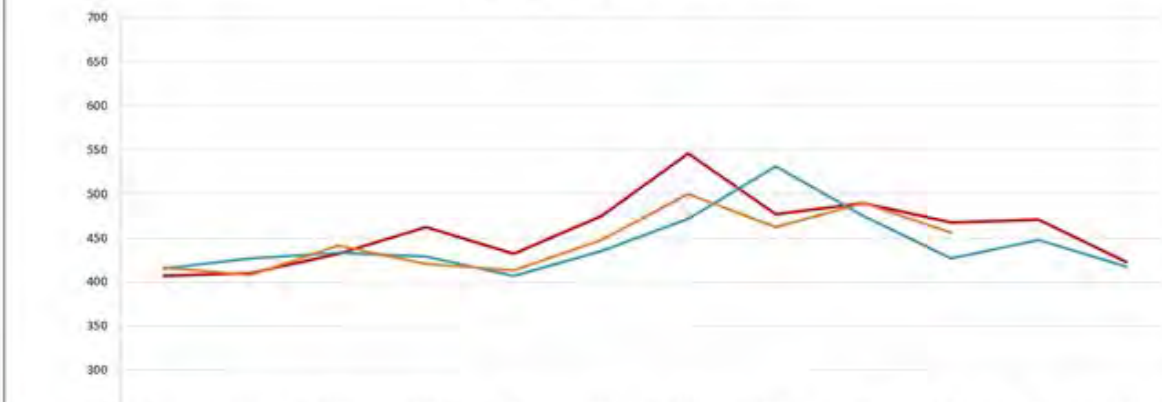
Acute Inpatient Admissions/1000 Members



	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2014-15	52	52	52	51	48	49	58	55	52	49	47	48
FY 2015-16	48	54	47	52	48	49	53	46	50	46	48	47
FY 2016-17	47	56	49	51	45	52	52	49	52	49		

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.
*Data from MedInsight: 06/12/2017

ER Utilization Per 1,000

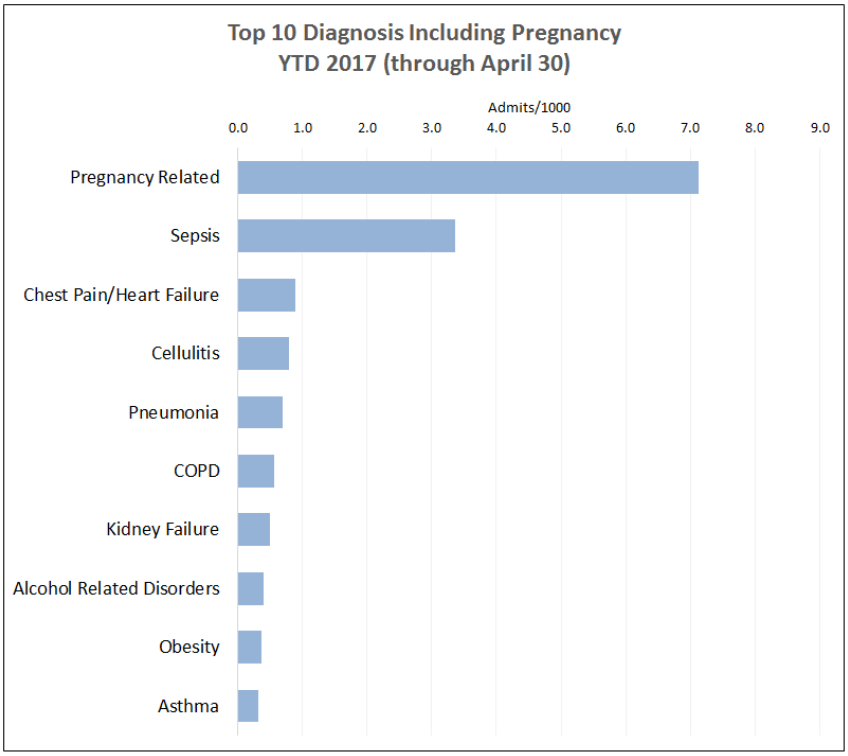


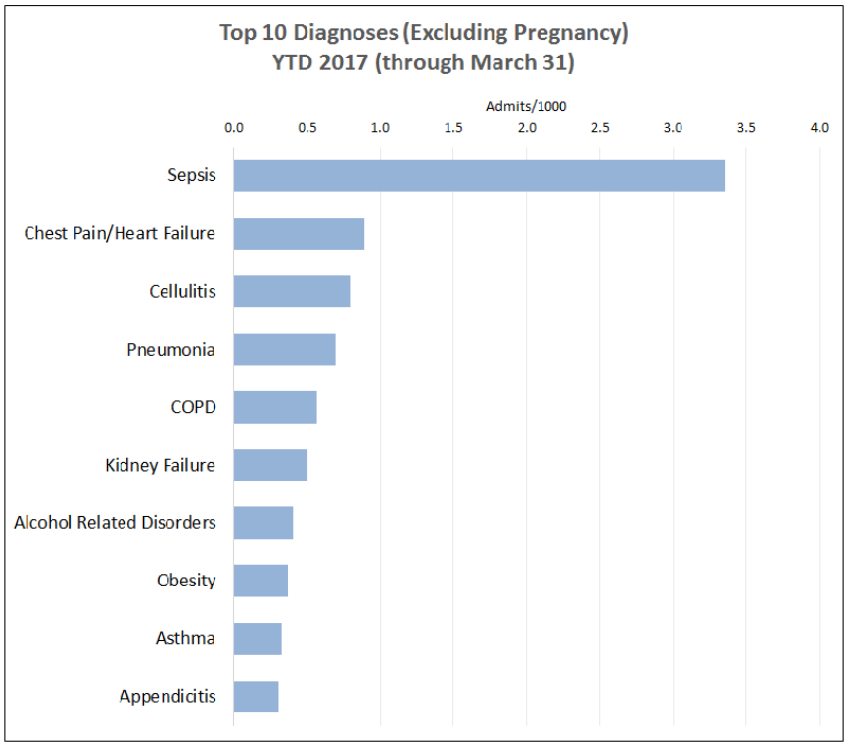
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2014-15	407	410	432	462	432	475	546	477	490	468	470	422
FY 2015-16	415	427	433	429	407	436	472	531	474	427	448	418
FY 2016-17	417	408	441	420	413	447	500	462	490	456		

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts are not included in this data.
*ER Utilization calculated on visits without an IP admit

TOP ADMITTING DIAGNOSES

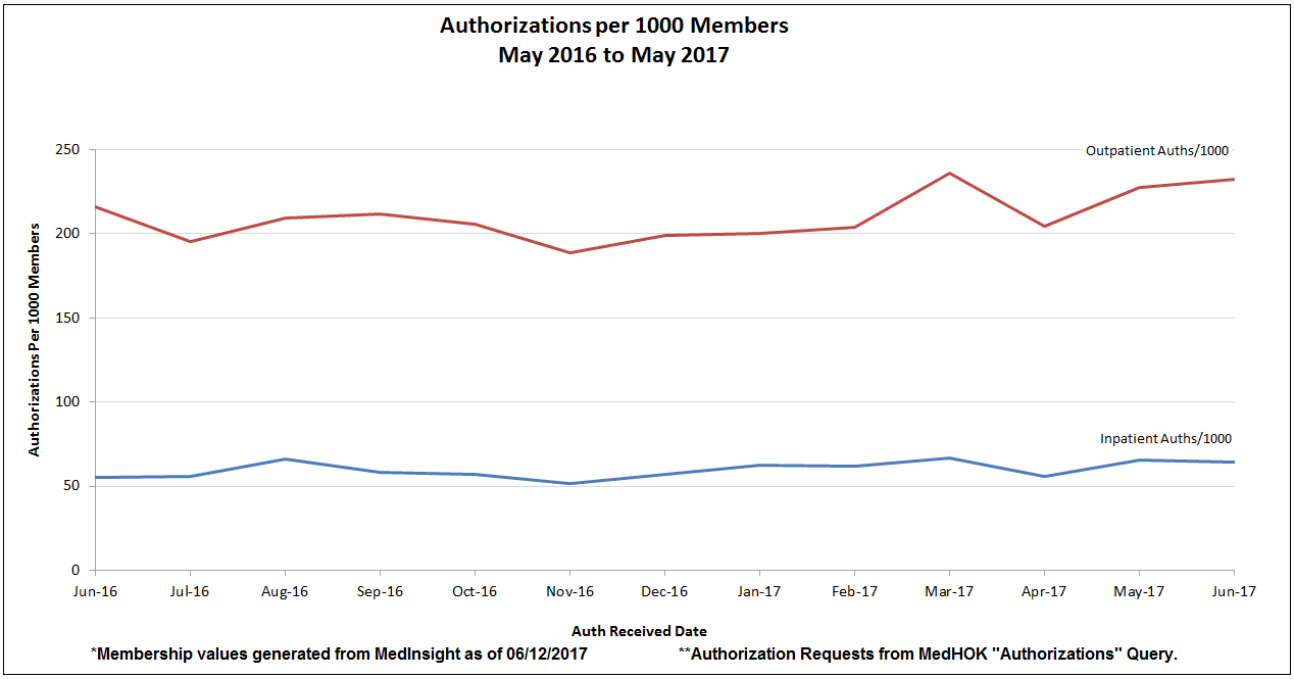
Pregnancy related diagnoses and sepsis continued to dominate top admitting diagnoses for YTD 2017. For members admitted with a primary diagnosis of sepsis, secondary diagnoses were cancer, heart disease, liver or renal transplant, and diabetes were secondary diagnoses.

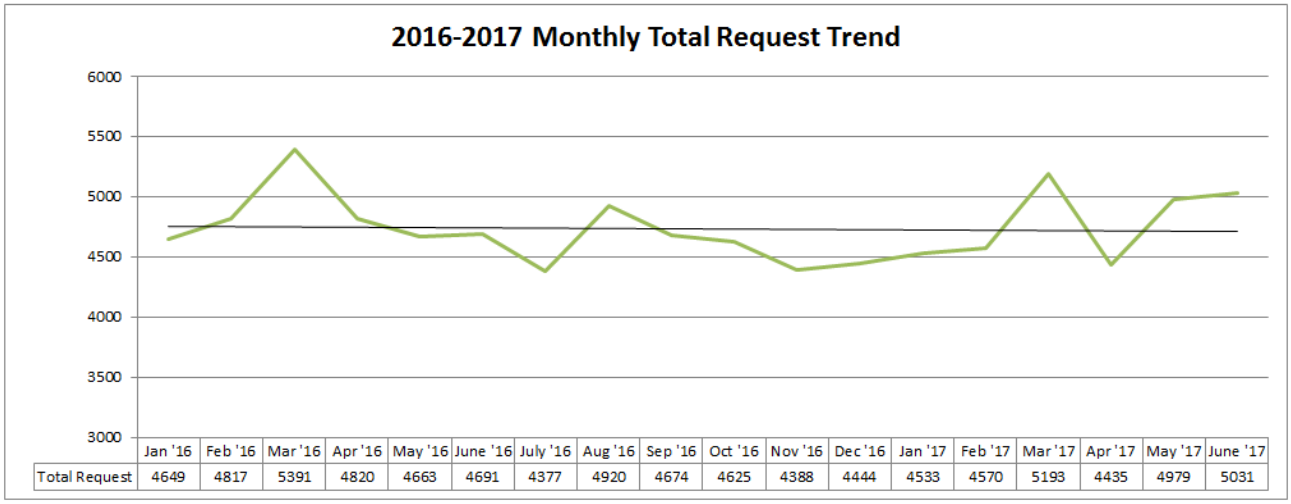




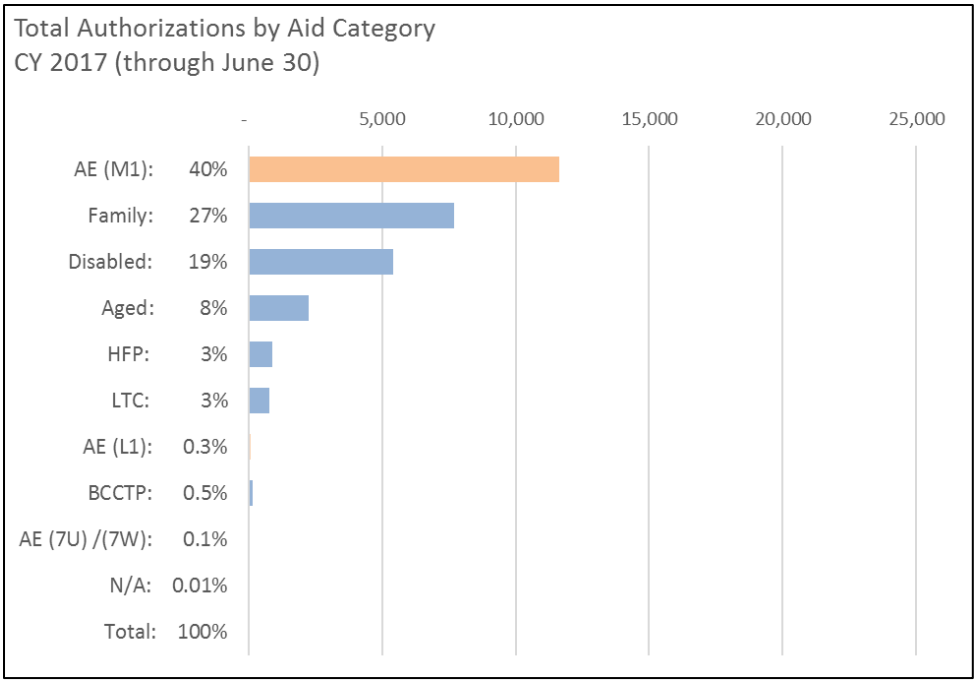
AUTHORIZATION REQUESTS

For CY2016, requests for outpatient service outnumbered requests for inpatient service by about four times. Requests for outpatient service declined to 213 requests/1000 members in CY 2016 from a peak of 255/1000 in March of 2016. For YTD 2017, inpatient request average 63/month and outpatient service requests average 217. Most authorizations are for M1 (40%), Family, and Disabled aid code groups.





	Jan '16	Feb '16	Mar '16	Apr '16	May '16	June '16	July '16	Aug '16	Sep '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr '17	May '17	June '17
Total Request	4649	4817	5391	4820	4663	4691	4377	4920	4674	4625	4388	4444	4533	4570	5193	4435	4979	5031



Clinical Grievances and Appeals

For CY2016, there were an average of 32 grievances/ quarter. There were 40 clinical grievances in Q2 2017. Most grievances (70%) were characterized as quality of care issues. Only 2% of grievances were characterized as access issues for CY 2016. Access issues comprised 1% of grievances for Q2 2017.

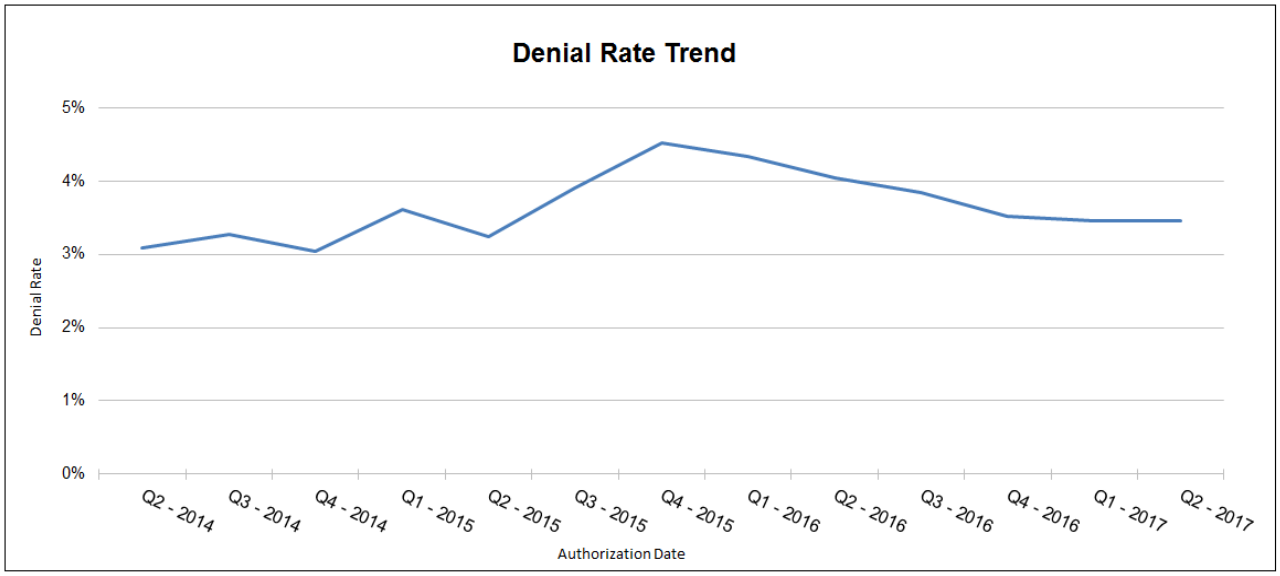
QTR	Grievance Total	Appeals Total	Upheld	Partial Overturn	Overturned	Withdrawn	Dismissed
2016							
Q1	26	9	3 (34%)	-	4 (44%)	1 (11%)	1 (11%)
Q2	32	9	7 (78%)	-	2 (22%)	-	-
Q3	33	24	7 (29%)	-	14 (58%)	1 (5%)	-
Q4	27	21*	7 (33%)	-	6 (29%)	1 (5%)	-
2017							
Q1	34	15	6 (40%)	-	8 (53%)	1 (7%)	-
Q2	40	17	9 (54%)	-	4 (23%)	4 (23%)	-

*Q4 2016 total appeals includes 7 (33%) in progress.

Denial Rate

Denial rate is calculated by dividing all not medically necessary denials by all requests for service. Denials for duplicate requests, member ineligibility, rescinded requests, other health coverage, or CCS approved case are not included in this calculation.

The denial rate has ranged between 2.7% and 4.5% since 2013. The average denial rate for CY 2016 was 3.9% and for YTD 2017 was 3.46%.



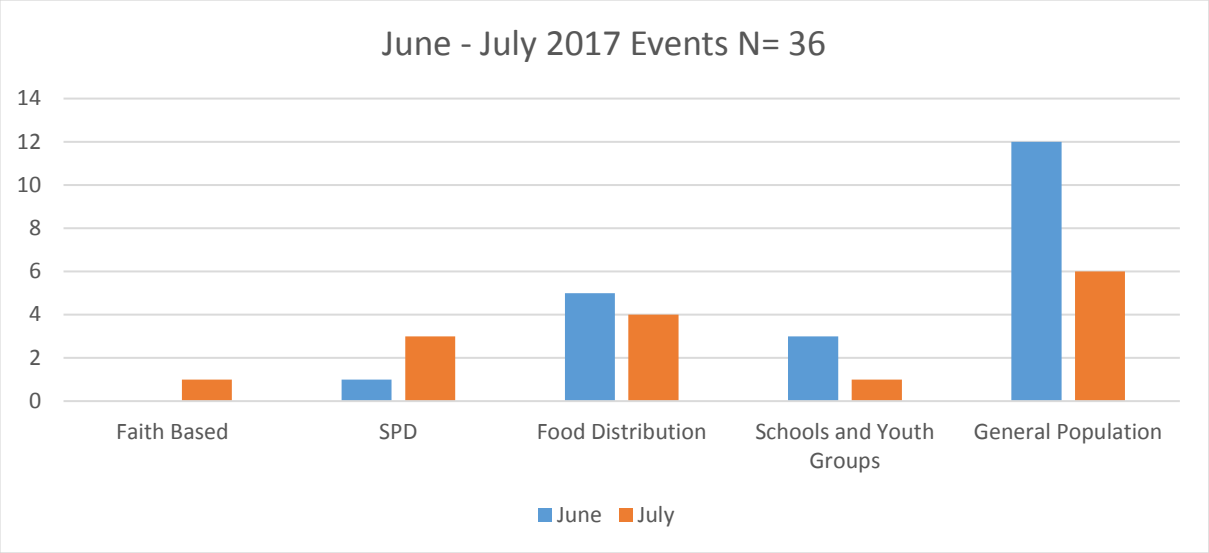
COMMUNITY OUTREACH SUMMARY REPORT

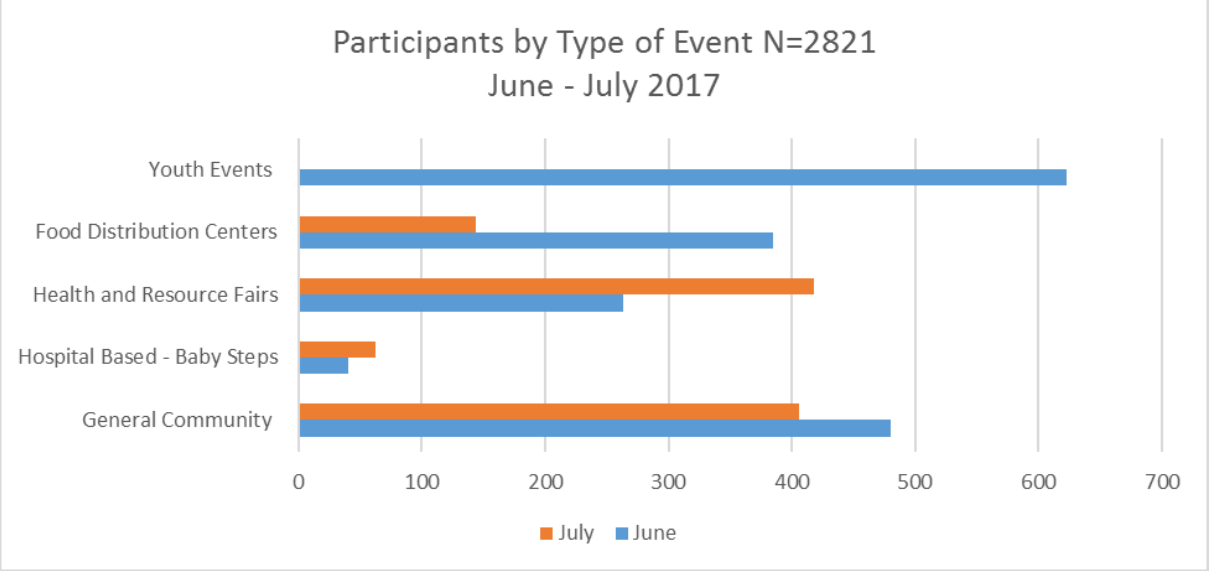
Summary

Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. The health education and outreach team maintains a positive presence in the community by working with various county public health departments, community based organizations, schools, senior centers, faith-based centers and social service agencies.

Outreach Activities

Below are combination charts that highlight the total number of events and participants for the months of June and July. On average, the health education team participated in roughly 36 different outreach events monthly and reached approximately 2821 individuals per month.





Outreach Events. Below is a list of activities during the months of June and July:

June 2017	List of Activities
6/2/2017	Sharing the Harvest hosted by Santa Clara Valley Neighborhood for Learning, Santa Paula
6/3/2017	12th Annual Summer Fest at Ventura Unified School District
6/8/2017	Dementia: Current Trends & Future Directions Conference hosted by Alzheimer's Association at Ventura Beach-Marriott
6/13/2017	Baby Steps Program hosted by Ventura County Medical Center, Ventura
6/15/2017	Child Center Inauguration of the Consulate - Inaguracion Centro Infantil del Consulado, Consulate of Mexico, Oxnard
6/17/2017	27th Annual Juneteenth Celebration at Oxnard Plaza Park
6/17/2017	Saticoy Family Fun Day at Saticoy Park, Ventura
6/20/2017	Baby Steps Program hosted by Santa Paula Hospital, Santa Paula
6/21/2017	Westpark Community Center Monthly Food Distribution Program & Health Services, Ventura
6/22/2017	Community Market Produce Giveaway hosted by Moorpark Neighborhood for Family Learning, Moorpark
6/22/2017	Community Market Produce Giveaway hosted by Simi Valley Neighborhood for Family Learning, Simi Valley
6/23/2017	Family Health and Safety Expo hosted by Moorpark/Simi Valley Neighborhood for Family in Moorpark
6/24/2017	"Be Prepared" Safety Fair at the Thousand Oaks Civic Arts Plaza Park
6/24/2017	Brain Injury Resource Fair at Ventura County Office of Education (VCOE), Camarillo
6/24/2017	MICOP Community Monthly Meeting at Haydock Intermediate School, Oxnard
6/29/2017	Ventura County CCS Pediatric Vendor & Community Resource Fair at Pleasant Valley Recreation and Park, District Community Center Auditorium, Camarillo

July 2017	List of Activities
7/7/2017	Sharing the Harvest hosted by Santa Clara Valley Neighborhood for Learning (NfL)
7/9/2017	25th Annual Rehab Point Project hosted by the City of Oxnard
7/11/2017	Baby Steps Program hosted by Ventura County Medical Center, Ventura
7/18/2017	Baby Steps Program hosted by Santa Paula Hospital, Santa Paula
7/19/2017	Westpark Community Center Monthly Food Distribution Program & Health Services, Ventura
7/22/2017	Family Day hosted by United Methodist Church, Cabrillo Development Corp (Valle Naranjal), Promotoras y Promotores Foundation, and One Step A La Vez of Fillmore
7/22/2017	Fruit and Veggie Fest Hosted by Ventura County Public Health, Oxnard
7/26/2017	Project Access Health and Resource Fair, Family Resource Center, Oxnard

7/27/2017	Community Market Produce Giveaway hosted by Simi Valley Neighborhood for Family Learning, Moorpark
7/27/2017	Community Market Produce Giveaway hosted by Simi Valley Neighborhood for Family Learning, Simi Valley
7/29/2017	Homeless Veterans hosted by Ventura County Stand Down, Ventura
7/30/2017	Jornada Dominicales hosted by the Consulate of Mexico, Oxnard

Health Education

The Health Education Department continues to educate members throughout the community on various health topics. During the months of June and July, the Health Education Department conducted workshops on nutrition and physical activity, cancer awareness, asthma for children, prediabetes and youth, skin cancer, men's health, and living with diabetes. GCHP health navigators will call members after an event if they have completed a health education referral and are active GCHP members. Below is the flyer for the cancer awareness event:

Cultural and Linguistic Services

GCHP Health Education Department, Cultural Linguistic Services coordinates interpreting and translation services for members. GCHP offers interpreting services at no cost and in over 200 languages, including sign language. GCHP monitors requests for interpreting and translation services daily. Below are the totals for the month of June:

A) Telephonic Interpreting Services
- A total of 342 requests for telephonic interpreting services for June.
- A total of 319 requests for telephonic interpreting services for July.

B) Sign Language Interpreter Services
- A total of 32 requests for sign language interpreting services for June.
- A total of 22 requests for sign language interpreting services for July.

C) In-Person Interpreter Services
- A total of 5 requests for in-person interpreting services for June.
- A total of 7 requests for in-person interpreting services for July.

D) Translation Services

- A total of 19 requests for translation services for June.
- A total of 3 requests for translation services for July.

Sponsorship Program

A total of $6,800 was allocated to four organizations under the GCHP Sponsorship Program during the month of July (no requests for June). The fiscal year-to-date (YTD) total is $43,200. Below is a summary of the programs and funding approved.

Agency/Organization	Approved Award Amount	Event/Org Summary
Mixteco/Indigena Community Organizing Project (MICOP)	$2,500	Night in Oaxaca dinner held on August 5, 2017. MICOP supports, organizes, and empowers Ventura County's indigenous Mexican community of 20,000 people to achieve just working and living conditions, equality, and full human rights.
American Diabetes Association	$2,500	Camp PowerUp: Prevention Camp for Children - type 2 diabetes and obesity. Influencing healthy lifestyles in children and taking necessary steps in prevention and education.
Ventura County Housing Trust Fund	$1,000	Housing Our Agricultural Workforce. Supports more housing choices by generating and leveraging financial resources, working in partnership with public and private, and nonprofit sectors throughout Ventura County.
Ventura County Medical Resource Foundation	$800	24th Annual Fainer/Tauber MD Awards dinner held on August 17, 2017. To improve access to needed health care for the most vulnerable and underserved residents in Ventura County.

PHARMACY BENEFIT PERFORMANCE AND TRENDS

SUMMARY:

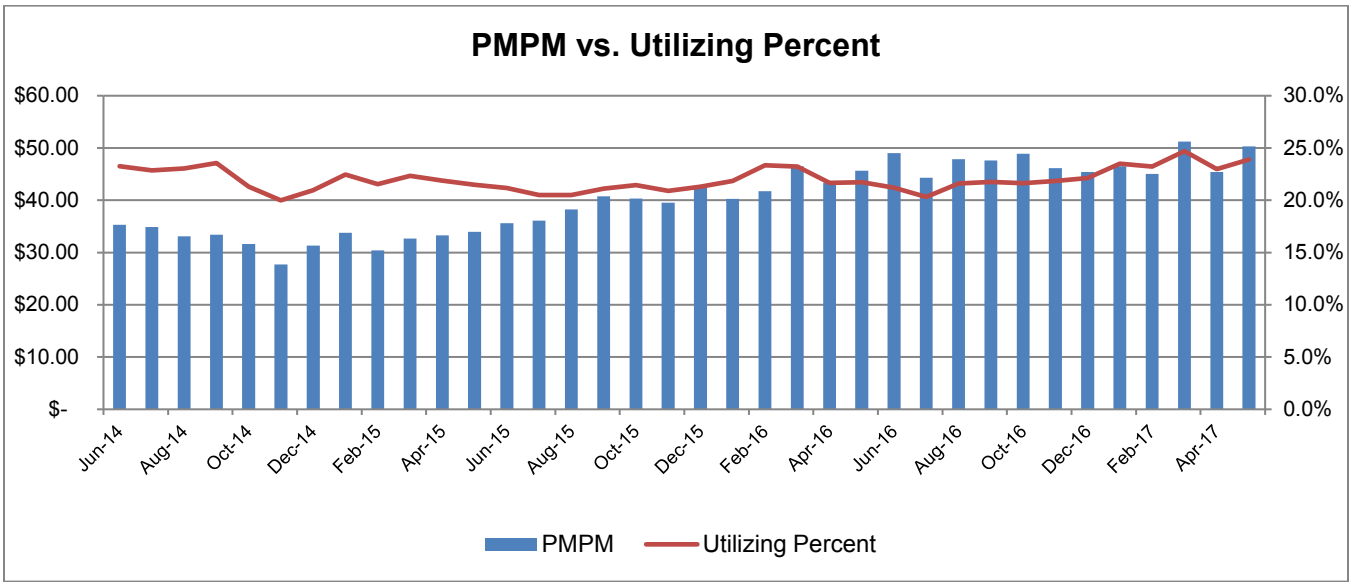
Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP's ASO's operational membership counts, and invoice data. The data shown is through the end of May 2017. Although minor changes may occur to the data going forward due to the potential of claim adjustments from audits and/or member reimbursement requests, the data is generally considered complete due to point of sale processing of pharmacy data.

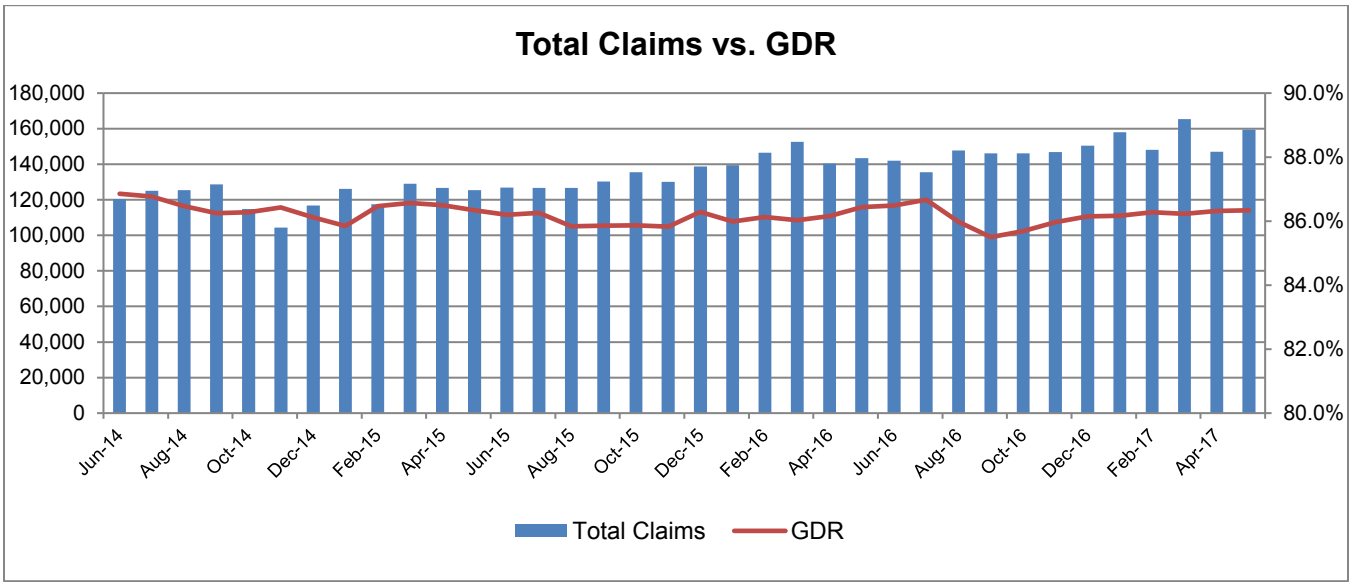
GCHP has seen a slight membership drop in 2017, while utilization has generally remained flat. Slight cost declines occurred in November and December 2016, however costs increased again in January, March, and May 2017.

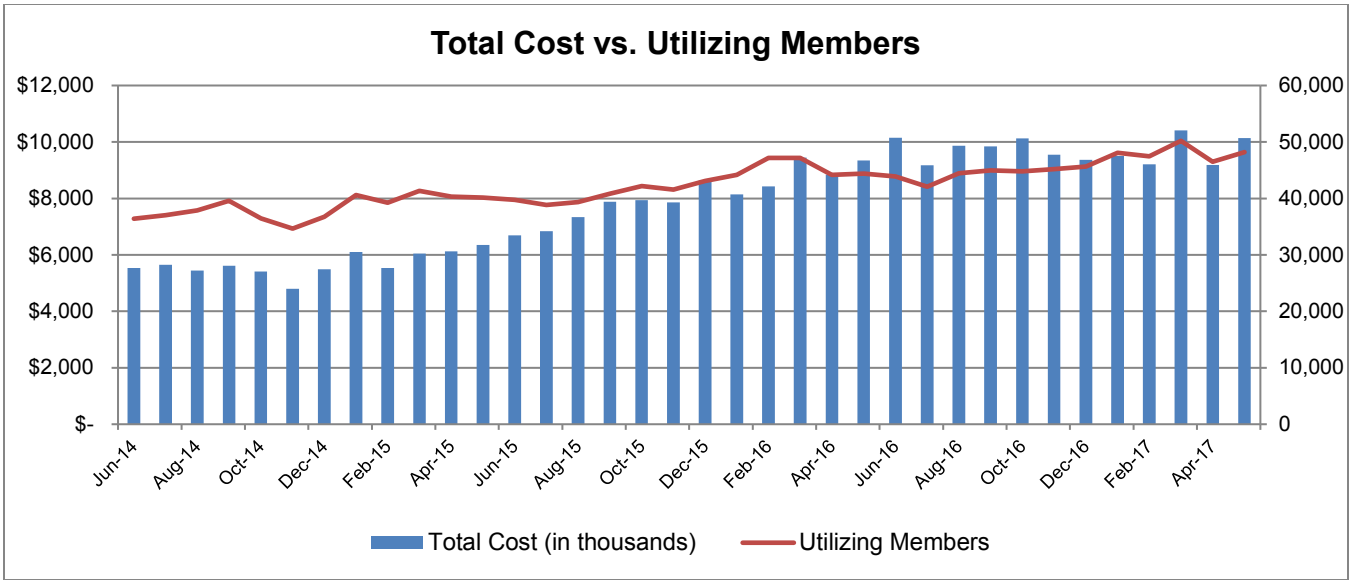
Hepatitis C continues to be a major driver of pharmacy costs though cost has decreased since the peak in May 2016. Formulary changes and the implementation of preferred products to align with DHCS kick payment utilization and cost assumptions have resulted in the Plan estimating to recoup all costs related to Hepatitis C from March 2017 through May 2017. As expected, DHCS has released the kick payment rates for FY17-18, which does include reductions in the rate.

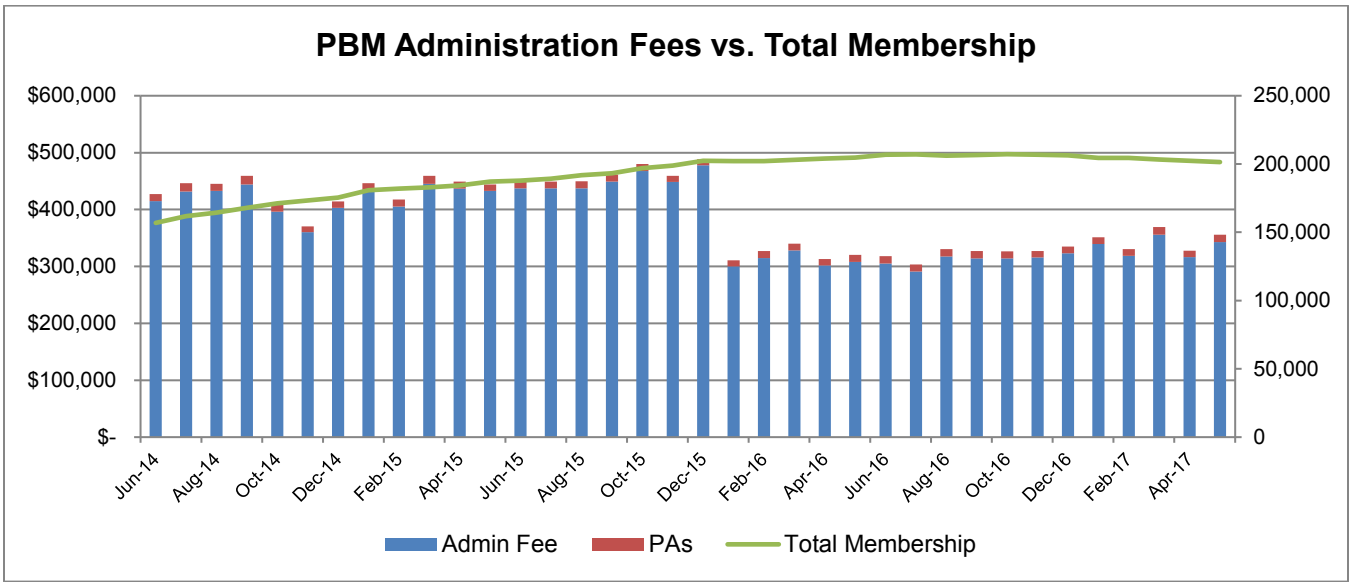
Abbreviation Key:
PMPM: Per member per month
PUPM: Per utilizer per month
GDR: Generic dispensing rate
PA: Prior authorization

PHARMACY COST TRENDS:

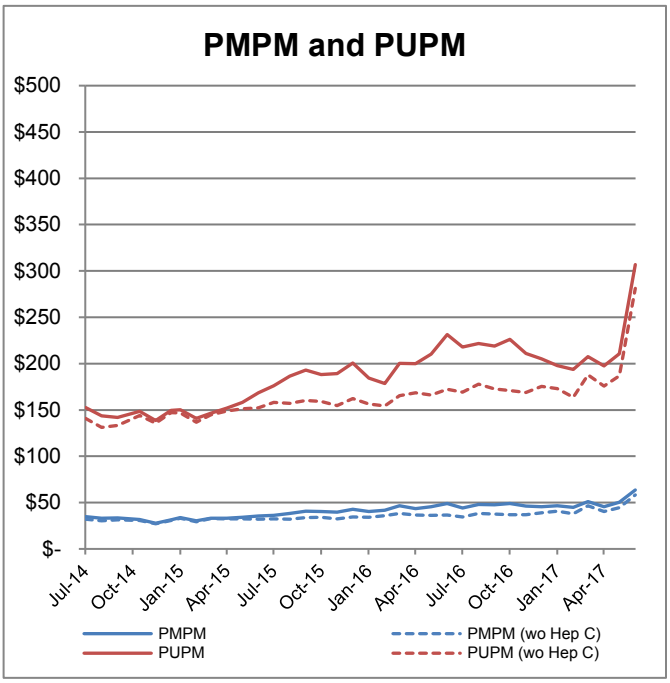


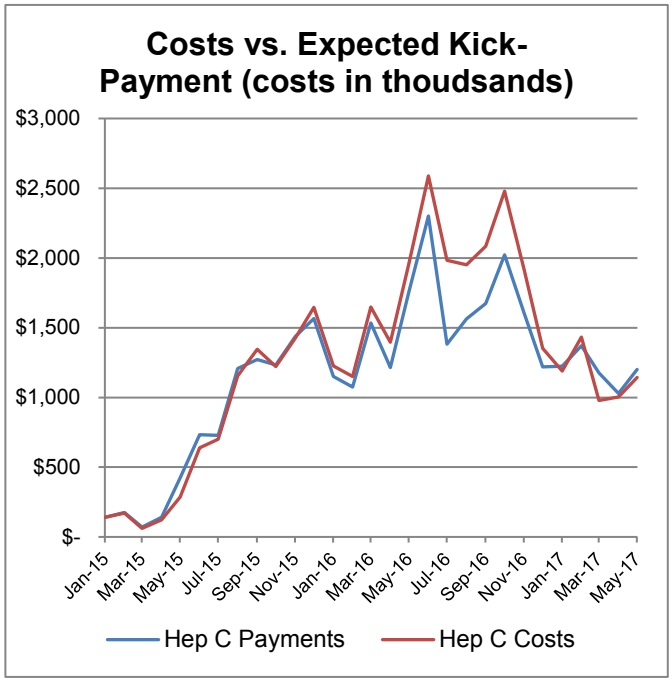



Total Cost vs. Utilizing Members
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$-
60,000
50,000
40,000
30,000
20,000
10,000
0
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Apr-17
Total Cost (in thousands)
Utilizing Members


PBM Administration Fees vs. Total Membership
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$-
250,000
200,000
150,000
100,000
50,000
0
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Apr-17
Admin Fee
PAs
Total Membership

HEPATITIS C FOCUS:





AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Melissa Scrymgeour, Chief Administrative Officer

DATE: August 21, 2017

SUBJECT: Chief Administrative Officer Update

GCHP STRATEGIC PLANNING

GCHP has updated its strategic plan to reflect Commission direction and feedback from the March 17, 2017 strategic planning session (Attachment A).

The 2017–2020 GCHP Strategic Plan is an expanded 3-year view that builds upon the Plan's core objectives:

- Collaborative community partner
- Health care leader committed to access and quality
- Strategic business partner
- Responsible fiscal steward of public funds
- Employer of choice
- Positioning for the future

Over the next three years, GCHP will identify and execute strategies to improve health and wellness, member access and quality, and financial stability through:

- Rollout of value based payment and grants programs via ARCH
- Expansion of strategic community collaborations focused on community health and wellness
- Investments in analytics infrastructure to improve population health and Plan quality and financial performance
- Continuing to drive to operational excellence
- Portfolio diversification and product development considerations

GCHP FY 16/17 PORTFOLIO UPDATE

Q2 2017 Activities:

Regulatory Initiatives:

- DHCS 274 Provider File Submission – Received DHCS final approval and moved into production.
-

Strategic Initiatives:

- OptumRX PBM implemented 6/1/2017.

Business Process Improvements (BPI)/Technology Investments

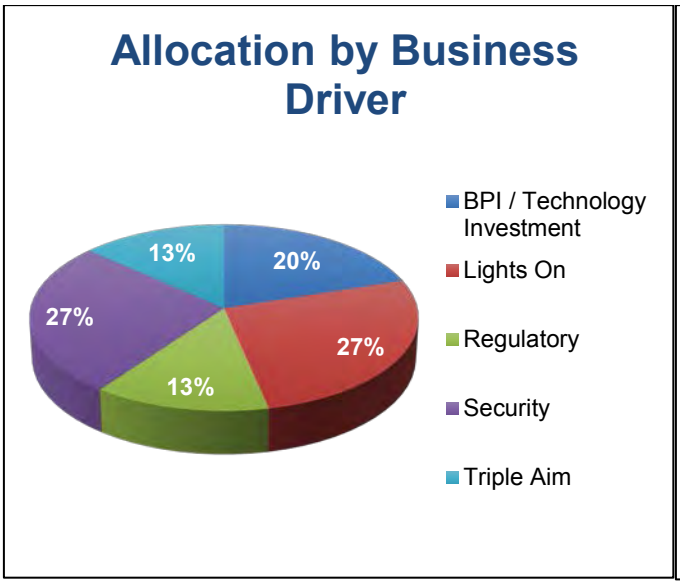
- Completed implementation of new budgeting and forecasting software.
- Published RFP for Provider Credentialing, Contracting and Data Management technology solution.
- Completed initial phase of IKA data feed optimization for reporting and analytics.

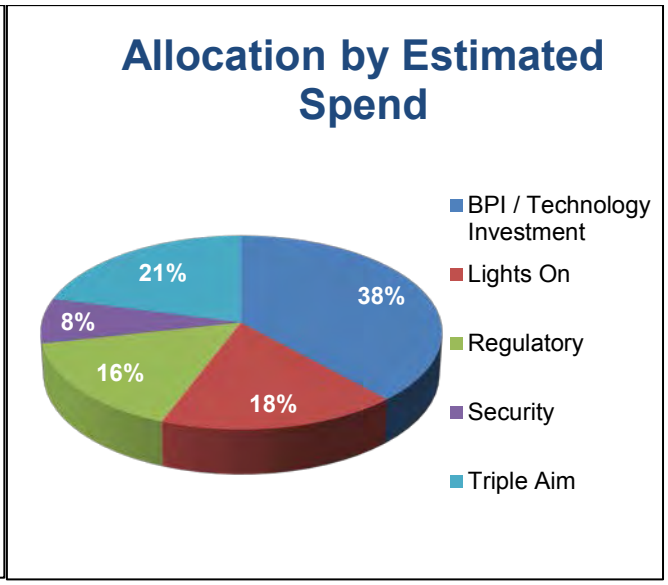
GCHP FY 17/18 PORTFOLIO

The FY 17/18 portfolio includes initiatives the Plan identified and budgeted to support key objectives of the GCHP Strategic Plan. GCHP prioritized 15 projects based on five primary business drivers: Regulatory, Security (physical and information), Lights On (run the business), Business Process Improvements (BPI)/Technology Investments, and Triple Aim (Better Health, Better Care, Lower Costs). The FY 17/18 approved budget includes $2.4MM for these initiatives.

The Plan evaluates and prioritizes new project requests throughout the year based on business need. Since the initial FY 17/18 portfolio planning process, GCHP has added a new initiative for a pilot with America's Health Plan (AHP). The Plan held a project kickoff meeting with AHP representatives on August 10, 2017, and project planning is currently in progress. GCHP will utilize the services of Health Management Associates (HMA) to assist in pilot implementation.

Table 1: Portfolio Allocation





FY 17/18 PORTFOLIO PROJECT DESCRIPTIONS AND PROPOSED SCHEDULE

Regulatory Mandates

- Managed Care Provider Data Improvement Project (MCPDIP): Transition to reporting Provider data in a 274-mandated formatted. Implement a standardized Provider Directory reporting process as mandated by DHCS (SB 137). Provider data clean up and process improvements.
- Fraud, Waste and Abuse Cost Containment: Contract with vendor with the expertise to help GCHP cost-avoid expenses on a pre-payment basis and/or identify overpayment recovery opportunities.

Run the Business (Lights On)

- ShoreTel End of Life Upgrade: Upgrade of GCHP telecommunications ShoreTel platform. Includes implementation of new hardware and phones for remote staff.
- Administrative Services Organization (ASO) RFP(s): Issue proposal for potential insourcing and/or continuation of outsourced administrative services components.
- SharePoint Department Site Migrations: Migration of the remaining business departments onto the new SharePoint platform.
- Office 365 Upgrade: Upgrade Office 365 productivity suite. Includes improved security plus analytics and reporting tools.

Security/Information Security:

- Internet Access Security Enhancements: New technology to enhance GCHP's internet security and performance.
- Office 365 Assessment: External assessment of Office 365 security controls.
- Security Penetration Test: External test of GCHP environment security controls.
- iReceptionist: Implement a system adding an additional layer of physical security. Allows GCHP to issue time specific badges with access audit tracking.

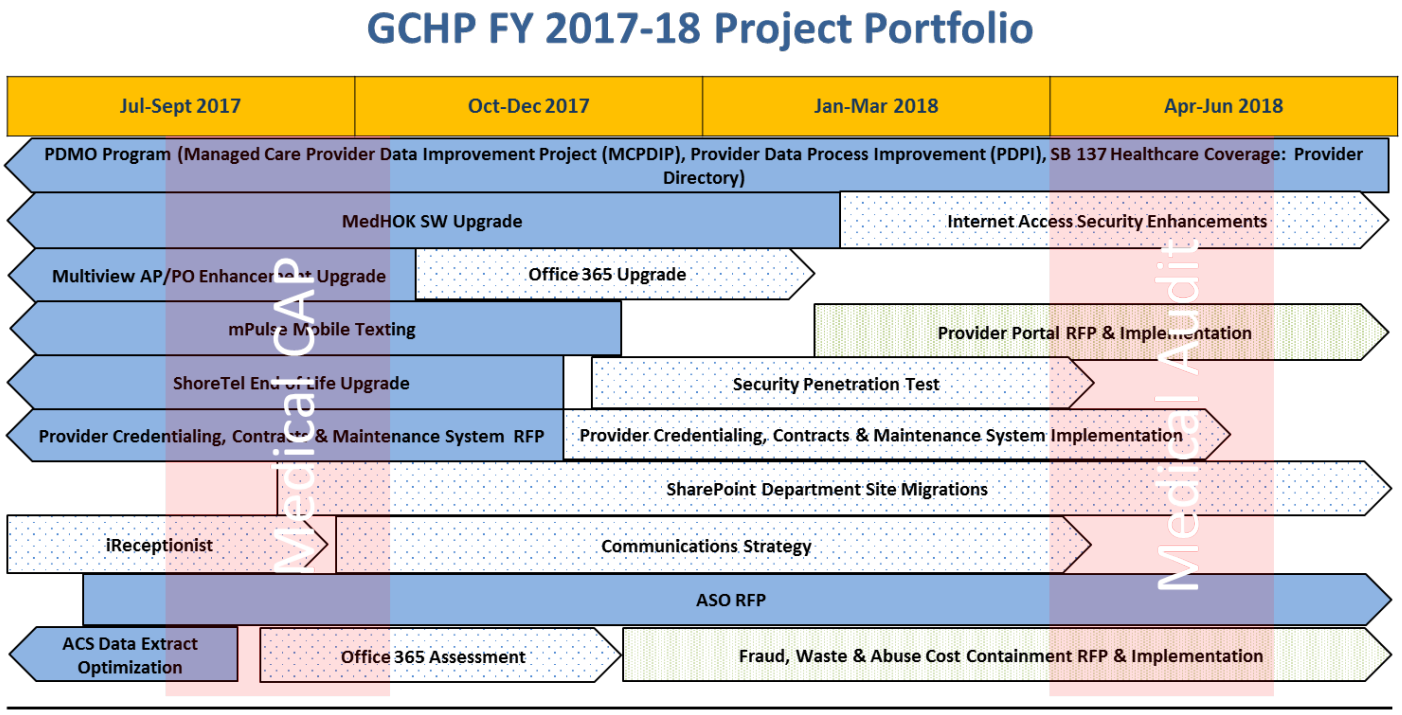
Business Process Improvement (BPI)/Technology Investments:

- Provider Credentialing, Contracting, Maintenance Tools: RFP and implementation of a suite of products to improve management of provider data, contracting, and credentialing functions. Supports state and federal regulatory requirements, organic provider network growth and replacement of limited scalability of in-house solution.
- Provider Portal: RFP and Implementation of improved provider portal to enhance provider collaboration and information sharing; supports "easy to do business" strategy.
- Communication Strategy: Investment in services and/or tools for improved internal and external communications.

Triple Aim

- ADT Real-Time Emergency Department (ED) Utilization: Provides real-time ED data for member for care coordination and interventions as appropriate. Supports Population Health Outcomes, Whole Person Care and other State mandated initiatives.
- Disease Management (DM) Registry: Implement a member registry to support GCHP DM programs.

Table 2: FY 17/18 Proposed Portfolio Schedule



Unplanned/New Initiatives

- **AHP Pilot** – Project kickoff held on 8/10/2017. Project planning in progress

Legend:
Active Project
Planned- Proposed start date and timelines based on high level resource estimates
Deferred-post ASO RFP

ATTACHMENTS:

Attachment A - GCHP 2017-2020 Strategic Plan

Gold Coast Health Plan℠
A Public Entity

GCHP Strategic Plan 2017-2020

March 2017

Dale Villani, Chief Executive Officer

Integrity
Accountability
Collaboration
Trust
Respect

GCHP Mission, Vision, Values

Mission

To improve the health of our Members through the provision of high quality care

Vision

Compassionate care, accessible to all, for a healthy community

Values

Integrity, Accountability, Collaboration, Trust, Respect

Objective: Collaborative Community Partner

Strategies	Tactics
1. Tell the "GCHP Story" more effectively	a. Enhance Commission-Management communications b. Create a Library of Communications Tool c. Develop and deploy strategies for sharing member success stories – incorporate/illustrate through multiple communications channels/tools: • Consumer Advisory Committee (CAC) • All Staff Meetings • Commission meetings • Annual Community Report
2. Refine and enhance key engagement strategies with stakeholders	a. Develop and deploy enhanced communications strategies for members, providers, and community b. Increased community events participation and sponsorship c. Develop and execute plan for Speakers' Bureau d. Effective deployment of community relations

Objective: Strategic Business Partner

Strategies	Tactics
1. “Easy to do business”	a. Implement flexible, easy to use provider tools b. Maintain provider engagement strategies c. Collaborative redesign of provider management and provider relations d. Promote specific steps to effectuate administrative simplification
2. Promote responsive delivery system to meet needs of community	a. Review full capitation for primary care providers (PCP) b. Build and deploy sustainable programs around alternative provider compensation models: • Pay for performance • Value based contracts c. Redesign Division of Financial Responsibility (DOFR) d. Incentivize ongoing submission of high quality encounter data e. Undertake deliberate planning approach with Ventura County and area agencies in connection with SMI, SUDS, homeless and transitioning populations f. Promote provider engagement and participation through PAC

Objective: Responsible Fiscal Steward of Public Funds

Strategies	Tactics
1. Ensure long-term financial solvency	a. Drive to targeted TNE with short and long-term strategic view; while maintaining appropriate TNE to fund Plan future b. Build sustainable ARCH program; focused on Triple Aim c. Maintain and enhance a robust oversight, risk management and financial control model
2. Maximize revenue to support Plan Mission	a. Attract revenue to Ventura County by identifying and leveraging means to acquire largest Federal and State shares b. Work with County and community partners to ensure maximum revenue c. Drive provider quality encounter data submission (CART) d. Ensure that aid codes are updated accurately and timely
3. Develop financial management processes that tie to the GCHP Strategic Plan	a. Establish data-driven approach to financial decision-making b. Enhance financial forecasting and modeling capacities, particularly in light of new policy direction under CA 2020 Waiver and CMS Medicaid MegaReg
4. Drive to operational excellence	a. Maximize organizational skillsets and capacity b. Focus on continuous business process improvement c. Establish process and decision support tools for 'build/buy' decision-making d. Drive a culture of best practices and operational efficiencies

Objective: Employer of Choice Committed to Diversity

Strategies	Tactics
1. Optimize workplace culture	a. Enhance internal employee communications and external communications to promote GCHP as best place to work b. Restructure HR functional responsibilities to meet Plan needs, specifically: • Robust Recruitment and Onboarding Program • Training and Development Programs • Career Paths and Salary Ranges • Employee Policies and Procedures c. Enhance HR staff skills to meet Plan needs d. Establish employee satisfaction and retention tools and metrics
2. Ensure diversity in all levels of the organization	a. Partner and collaborate with CDO to enhance and expand cultural diversity program b. Expand recruitment resources
3. Assess opportunities to enhance work environment	Establish ongoing process for employee satisfaction survey; incorporate into balanced Plan scorecard

Objective: Health Care Leader Committed to Access & Quality

Strategies	Tactics
1. Promote access to care for Plan members	a. Oversee and monitor access continuously • Partner with providers to enhance data collection • Identify care gaps and develop programs to affect triple aim b. Work collaboratively with the County, providers, and DHCS to explore ways to extend and expand access c. Develop and deploy programs to increase access to care
2. Promote a culture of quality for GCHP	a. Establish and meet goals to improve HEDIS and CAHPS b. Evaluate options for alternative reimbursement models based on quality outcomes
3. Promote community health and positive health outcomes	a. Affect positive outcomes in community health issues b. Support and collaborate with County to rollout Whole Person Care pilot c. Develop and deploy population health programs with measurable goals utilizing tools across organization
4. Promote integrated care across the continuum	a. Enhance integration of care amongst entities that support our members b. Drive effort to promote delivery system reform and optimal coordination with Plan partners

Objective: Positioning for the Future

Strategies	Tactics
1. Establish a deliberate strategic planning process	a. Contiguously align strategic planning throughout the organization. b. Launch a 3-year Strategic Plan for CY 2017-2020; evaluate and adjust as necessary c. Develop key Plan metrics (dashboard)
2. Explore opportunities for future growth	Evaluate portfolio diversification and product development considerations in light of legislative and regulatory environment, community and member needs to affect Triple Aim (care, outcomes, cost): • Full evaluation of CMS Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) • Knox Keene License
3. Enhance and expand analytics infrastructure to improve population health and Plan quality and financial performance	a. Enhance utilization of risk stratification tools for population health and financial decision making b. Stand up data governance and master data management c. Invest in data architecture, integration and presentation tools

AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Douglas Freeman, Chief Diversity Officer

DATE: August 21, 2017

SUBJECT: Chief Diversity Officer Update

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

Gold Coast Health Plan: D&I Code of Conduct Policy, Budget and Inclusive Leadership Series Pilot

Presented to VCMMCC
August 21, 2017

Compliance Strategy Pillar Deliverable: Code of Conduct Policy

Compliance (Mandatory Activities)

- Code of Conduct Policy
- Diversity and Inclusion Mission Statement
- Diversity Hotline Employee Rollout
- Completion of 2017 Investigations
- Lawsuit/Grievances Support
- Diversity Councils
- Diversity Metrics as Major Component of All Employee Evaluations
- Diversity Dashboard: Compliance/ Workforce & Workplace/ Members & Community

Gold Coast Prohibition against Discrimination, Harassment, Retaliation and Bullying (Page 1 of 7)

Gold Coast Health Plan Code of Conduct:
Policy Prohibiting Discrimination and Harassment

1. Gold Coast Health Plan's Commitment

The Gold Coast Health Plan ("GCHP") is committed to providing a workplace free of discrimination and harassment for all employees and employment applicants. GCHP has a zero tolerance policy for discrimination and harassment, which means that we will not tolerate workplace discrimination or harassment of our employees by any coworker, company officer, manager, supervisor, contractor, vendor, customer, client, or any other person.

2. What Constitutes Discrimination or Harassment

Discrimination means treating someone differently, in a way that negatively affects the terms or conditions of employment, based on gender, race, color, national origin, religion, age, disability, genetic information, or any other category protected by federal, state, or local law.

Harassment is workplace conduct that creates an intimidating, offensive, or hostile working environment and is based on someone's gender, race, color, national origin, religion, age, disability, genetic information, or any other category protected by federal, state, or local law. Sexual harassment includes all of these prohibited acts, as well as the conditioning of work benefits upon an employee's consent or submission to sexual conduct.

3. Prohibited Conduct

All discriminatory or harassing acts, behavior, and conduct are prohibited, including, but not limited to, comments, jokes, gestures, unwelcome physical contact, drawings, cartoons, videos, emails, name-calling, slurs, or use of derogatory terms. Prohibited sexual harassment includes all of these actions as well as other unwelcome sex-based conduct, such as unwanted sexual advances, requests for sexual favors, or sexually suggestive gestures, jokes, and propositions. Such conduct is prohibited whether it occurs in person; via email, text or instant messaging; or on social networking sites. These lists are intended as illustrations only. Conduct not listed may be considered discriminatory or harassing if it otherwise meets the definition above.

Gold Coast Health Plan — Policy Prohibiting Discrimination and Harassment — Page 1 of 3

Gold Coast Health Plan
A Public Entity

Gold Coast D&I Budget: Supporting 3C's Strategy

INCLUSIVE LEADERSHIP

Build and sustain an environment where our employees are embraced and can celebrate diversity, so that they can reach their full potential, enabling Gold Coast to provide cost-effective, best-in-class Plan Services, to continuously improve Members' Quality of Care

COMPLIANCE

Establish foundational diversity policies, practices and procedures, that reduce workplace conflict

CULTURE

Recruit, Retain and Develop Talent by Building a Culture of Inclusion, Engagement and High Performance

COMMUNITY

Identify and Ameliorate Disparities in Care that adversely impact members, while developing new models of community investment

Budget Estimate: 75% Salaries/Comp; 15% Travel and Conferences
3. 10% Other (TBD)

Gold Coast Health Plan℠
A Public Entity

Gold Coast Health Plan
Inclusive Leadership Series:
Foundations of Inclusion and Diversity

Presented to Pilot Group #1 (Face-to-Face Session)

Gold Coast Health Plan, Camarillo CA
August 15, 2017

Gold Coast CEO Introduction

Welcome to Gold Coast Health Plan Inclusive Leadership Series

Gold Coast Commissioner Introduction

Welcome to Gold Coast Health Plan Inclusive Leadership Series- Commissioner Alatorre

Sample Ground Rules

Listen with respect

Respect confidentiality

Speak to the group rather than in side conversations

Speak from your own experience

Respect for each individual's experiences

Learning Objectives: Your 6 Take-Aways

Standard Definition of diversity and inclusion	6 Pillars of the business case for diversity plus Diversity Return on Investment (d-ROI)	Empirical proof for Building Cultures of Inclusion, Engagement High Performance (PIE)
Diversity 5.0	The Gold Coast 3C's Strategy and D&I Code of Conduct	7 core competencies of Inclusive Leadership

Kickoff Questions

Q

Why Diversity and Inclusion in 2017?

A

Let's Hear from Deutsche Bank

https://www.youtube.com/watch?v=s6xEd2dYhOo

Definitions: Diversity and Inclusion

What is diversity and inclusion?

Diversity is the “mix” that you have inside the organization.

Inclusion is leveraging similarities and differences (i.e. the “mix”) to improve the success of the organization as a whole.

Inclusion is what you do with that mix*.

*Concept from Andres Tapia, Korn Ferry/Novations-The Inclusion Paradox

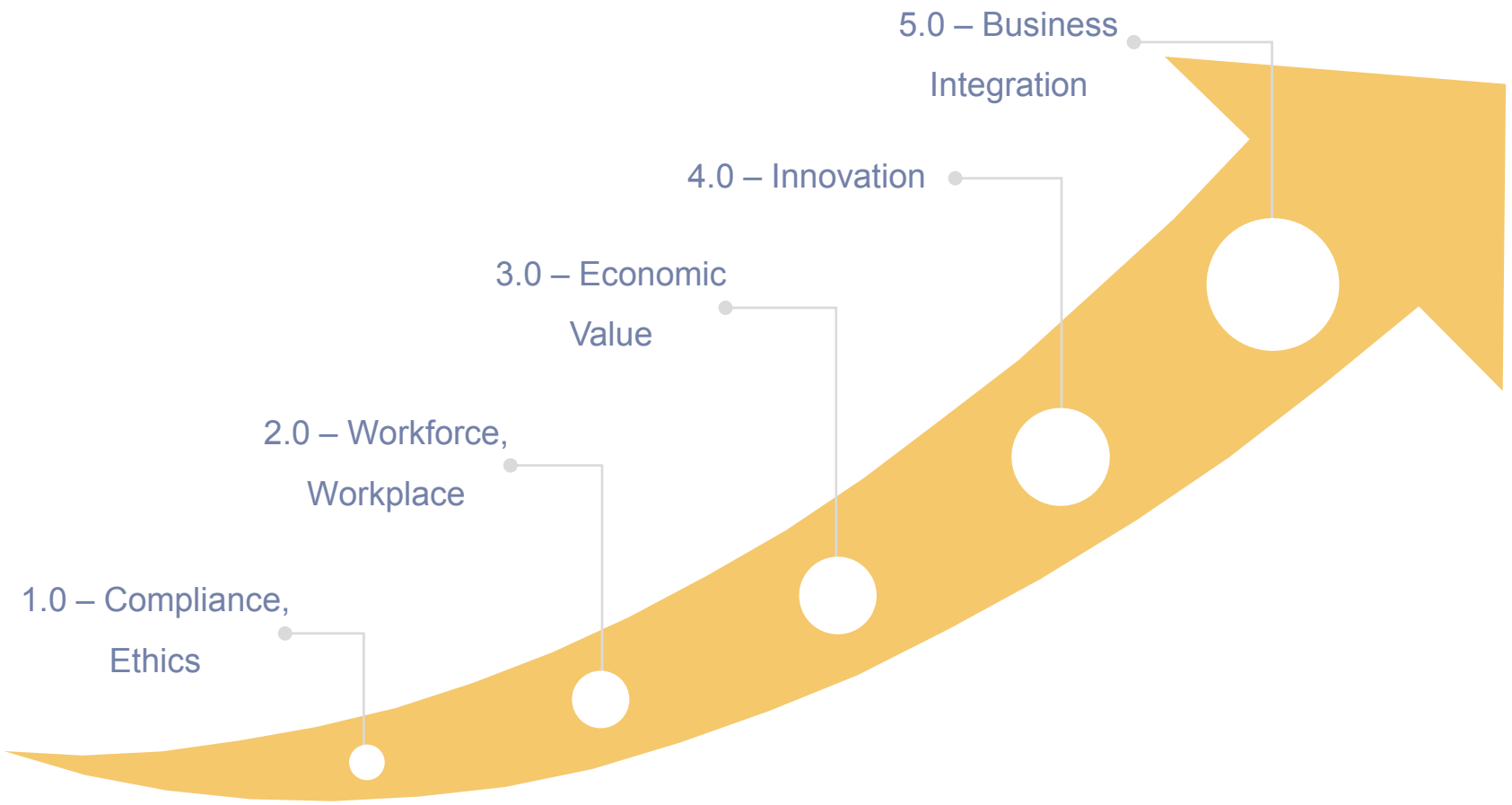
Diversity Beyond Race and Gender

Race	Gender	Ethnicity	Age	Nationality
Religion	Sexual orientation	Values	Personality	Disability
Language	Physical appearance	Marital status	Lifestyles	Beliefs
Geographic origin	Economic status	Education	Organizational tenure, level and/ or function	Thought

What Dimension or Dimensions of Diversity Matter at Gold Coast? Why?

Where are we Going?: Diversity 5.0

A Systems-Based Vision of Diversity and Inclusion



Where do you think Your Organization Is?

2nd Questions

Q

Why D&I at Gold Coast Health Plan?

A

To Build a Culture of Inclusion, Engagement and High Performance

Gallup Employee Engagement: 5 Business Outcomes- Statistically Proven

The Gallup Organization, which created the Q12 Index, has found through its research that the data from these questions are strongly linked to five business outcomes:

1. Employee Retention
2. Employee Productivity
3. Company Profitability
4. Customer Loyalty
5. Workplace Safety

	Retention	Customer	Safety	Productivity	Profitability
Opportunities to learn and grow Progress in last six months	X	X x	X X	X x	X
Best friend Coworkers committed to quality Mission Purpose of company My opinions count	X x x	X x x X	x x x X	x X X X	X X X X
Encourages development Supervisor/Someone at work cares Recognition last seven days Do what I do best every day	x X x X	X X x X	X X x X	x X x X	X x X X
Materials and equipment Know what is expected of me at work	X X	X X	X X	X	

X – strongest generalizable relationships across companies
x – strongest generalizable relationships across companies

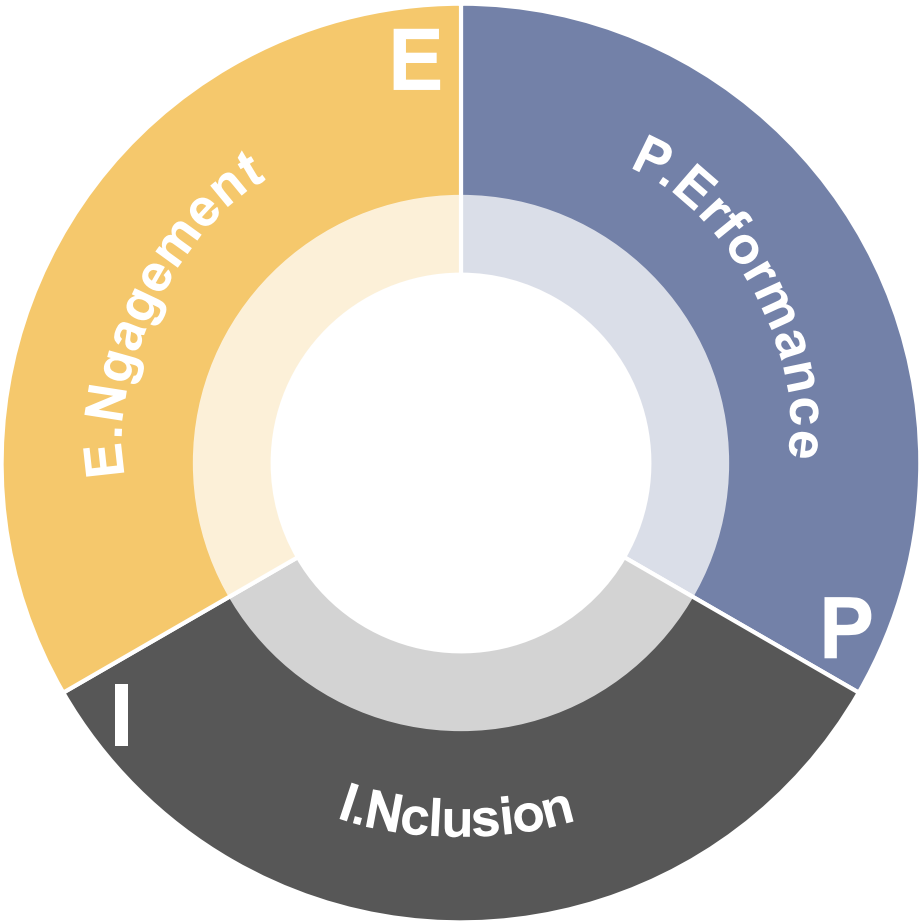
Gallup Employee Engagement: Inclusion Drives Employee Engagement

The Gallup Organization's breakthrough work at Fifth 3rd Bank shows that

An Increase in levels of Inclusion leads to an increase in Employee Engagement

By Unlocking Inclusion, your organization can drive empirically proven business impact!!

P.I.E. (Performance, Inclusion, Engagement)



How to Build A Culture of Inclusion, Engagement and High Performance (P.I.E.)

Build Foundations

Mission Statement

Strategy

Diversity Code of Conduct

Business Case for Diversity

Inclusive Leadership Skills

Diversity and Inclusion Mission Statement at Gold Coast (Draft)

A. Gold Coast D&I Mission Statement

We aspire to build a culture of inclusion, engagement and high performance, enabling all employees to support the highest quality of care and services to our members.

Our mission, values and culture embody a smart, responsive organization that is constantly improving and challenging itself. Diversity and Inclusion serves to enhance our core values of Integrity, Accountability, Collaboration, Trust and Respect.

To succeed, each employee must focus on delivering operational efficiencies by participating with full engagement. Gold Coast is building a diverse and inclusive culture that reflects that community we serve, and continues to position the organization as an employer of choice.

Gold Coast D&I Blueprint Framework: 3C's

INCLUSIVE LEADERSHIP

Build and sustain an environment where our employees are embraced and can celebrate diversity, so that they can reach their full potential, enabling Gold Coast to provide cost-effective, best-in-class Plan Services, to continuously improve Members' Quality of Care

COMPLIANCE

Establish foundational diversity policies, practices and procedures, that reduce workplace conflict

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Recruit, Retain and Develop Talent by Building a Culture of Inclusion, Engagement and High Performance

COMMUNITY

Identify and Ameliorate Disparities in Care that adversely impact members, while developing new models of community investment

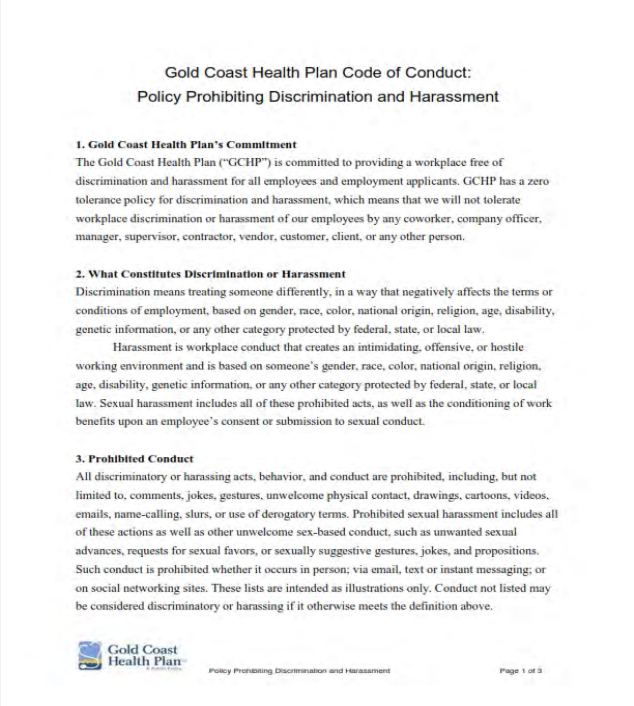
DIVERSITY RETURN ON INVESTMENT (d-ROI)

Compliance Strategy Pillar Deliverable: Code of Conduct Development

Compliance (Mandatory Activities)

- Code of Conduct Policy
- Diversity and Inclusion Mission Statement
- Diversity Hotline Employee Rollout
- Completion of 2017 Investigations
- Lawsuit/Grievances Support
- Diversity Councils
- Diversity Metrics as Major Component of All Employee Evaluations
- Diversity Dashboard:
- Compliance/
- Workforce & Workplace/
- Members & Community

Figure 1: Gold Coast Code of Conduct Policy (Page 1 of 7)



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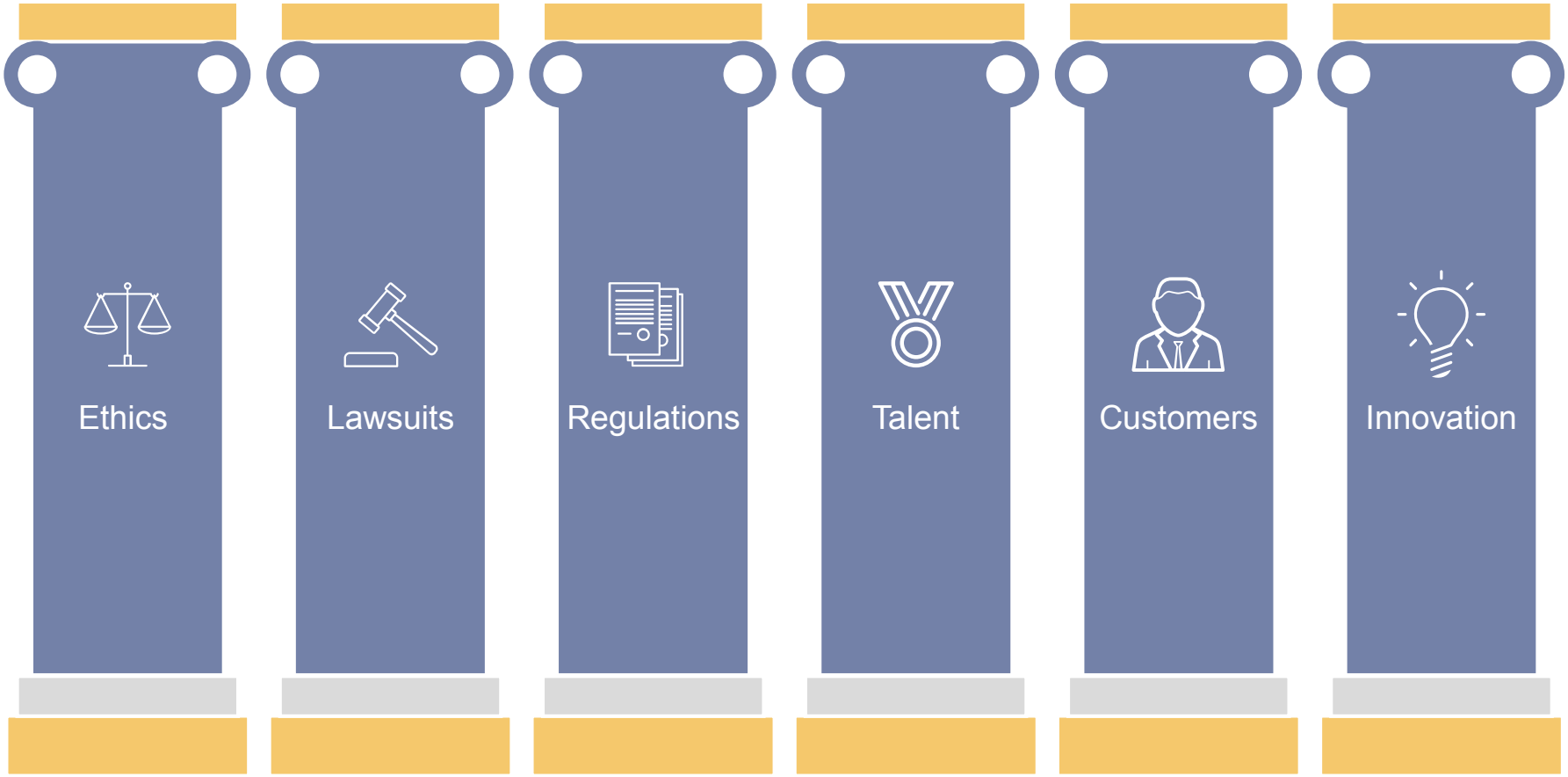
Gold Coast Health Plan

Policy Prohibiting Discrimination and Harassment Page 1 of 3

The Biz Case*: 6 Pillars**



*Urban League Corporate Inclusion Best Practices Report
** 2 Problems: 1. Can't Prove BC and 2. Can't Measure

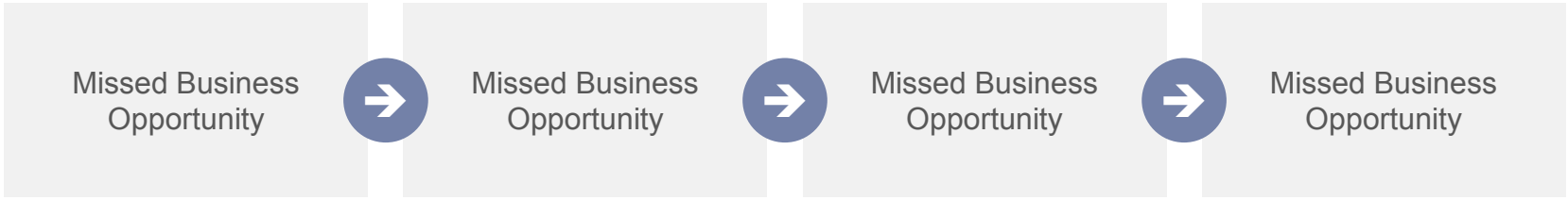
d-ROI™ in Action: d-ROI™

There are 2 Glaring Deficiencies of the Biz Case

- Can't **Prove** the Biz Case
- Can't **Measure** the Value of Diversity

What is d-ROI™ (Definition in 3 parts)

1. **Methodology Based on Missed Business Opportunities (Proof and Measurement)**



2. **We focus on a subset of Missed Business Opportunities- Missed Diversity Business Opportunities (Blindspots)**

3. **Methodology does 3 things- Identifies, Quantifies and Monetizes Missed Diversity Business Opportunities (Blindspots)!**

Does Diversity & Inclusion Have Bottom Line Impact?

Blind spots Case Study-2012 Olympics

http://www.youtube.com/watch?v=OJbcJVmgvz4

- London 2012 Wanted to be the Inclusive and Greenest Olympics in History
- How? Leverage the Talent and Innovation impacts of Diversity

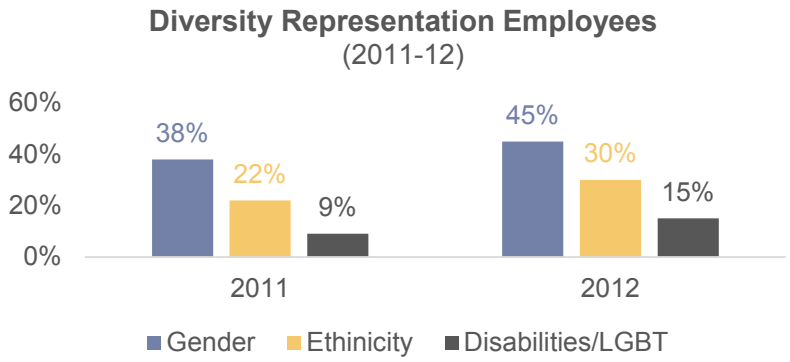
http://www.youtube.com/watch?v=OJbcJVmgvz4

D&I Led To A Better Outcome

Diversity and Inclusion at 2012 Olympics

London 2012 Olympics

The Impact of a Diverse Workforce
ON Productivity



"When you can move people to contribute to their fullest, it has tremendous impact"

Director of Diversity-Intel

Most Diverse and Inclusive Olympics workforce in history of the Games

Acted On Blind spots

Result: Increased Diversity of Thought

Result: Increased Innovative Ideas & Contributions

1.Source:Adecco, staffing provider for London Olympics 2012

Can You Think of Other Major Events Impacted by d-ROI?

The Increasingly Diverse Workforce

Women and men in the workplace

	Women	Men
1950	29.6%	70.4%
2012	47%	53%
2020	53.2%	46.8%

Five generations in the workplace

- Traditionalists/Silent Generation
- Baby Boomers
- Generation Xers
- Generation Yers
- Millennials/Linksters/Generation Zers

Source: Bureau of Labor Statistics

10% of the workforce is LGBT

Gay, Lesbian, Bisexual, Transgender

Why Inclusive Leadership Skills

To Build a Culture of Inclusion, Engagement and High Performance, for an Increasingly Diverse Workforce

7 Core Competencies of Inclusive Leadership

Based on Research, 7 core competencies:

1	dROI Blindspots
2	Micro-Inequities and Affirmations
3	Inclusive Engagement and Communications
4	Emotional Intelligence
5	Global and Local Cultural Competency
6	Inclusive Work Networks
7	Unconscious Bias and the Three Moments of Truth*

Understanding Unconscious Bias

Unconscious Bias-- It's Human Nature!

In Implicit Social Cognition: Attitudes, Self-Esteem and Stereotypes, Greenwald and Banaji argued that much of our social behaviour is driven by **learned stereotypes** that operate automatically –and therefore unconsciously — when we interact with other people.

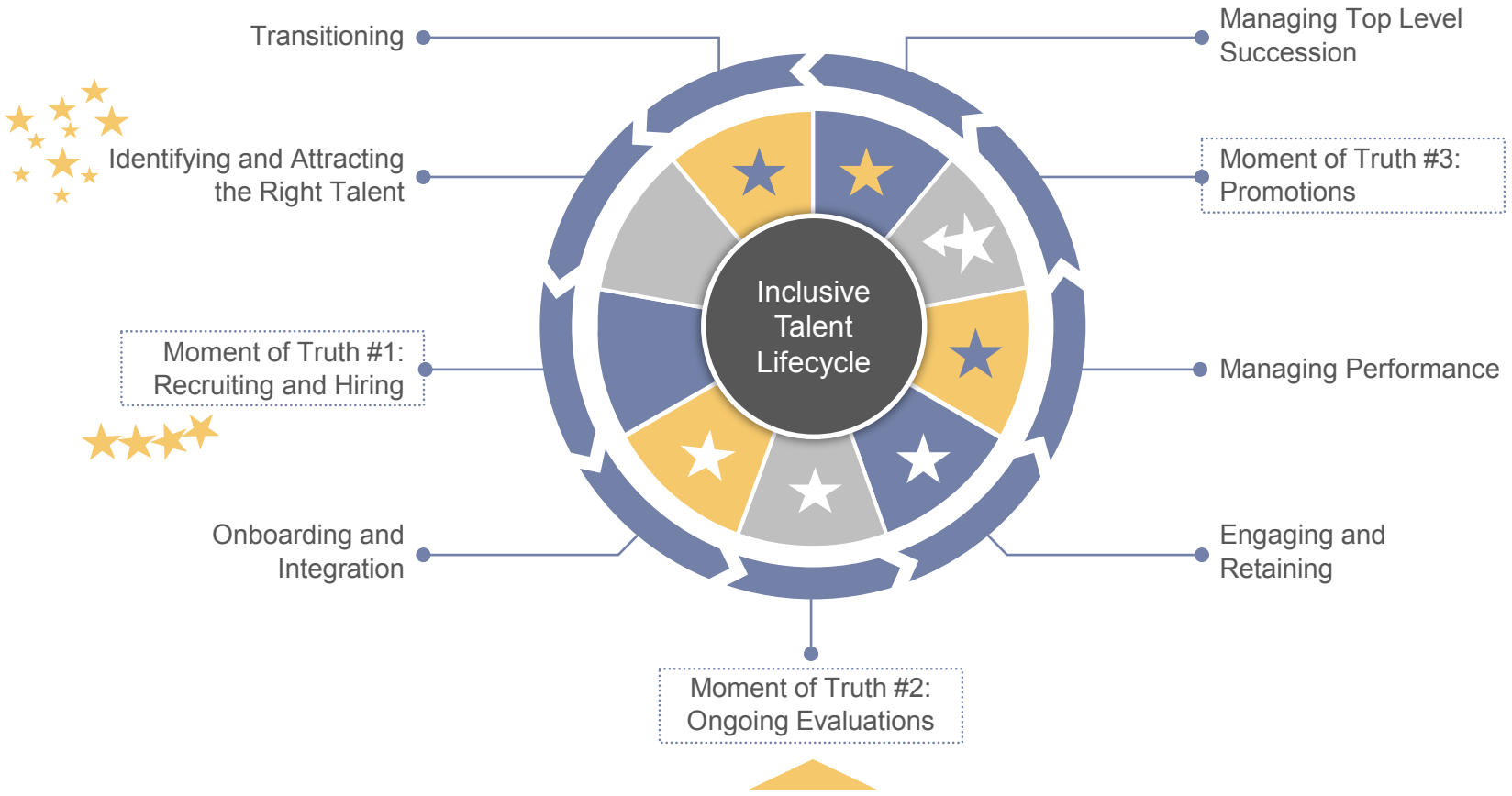
In 1995, Doctors Anthony Greenwald and Mahzarin R. Banaji theorized that it was possible that our social behaviour was not completely under our conscious control.

Unconscious Bias In Action

Let's watch this video to see Unconscious Bias come to life
https://www.youtube.com/watch?v=NW5s_-NI3JE

Holistic Inclusion Model

Inclusive Talent Lifecycle* and 3 Moments of Truth



Cultural Foundations

Inclusion	Trust	Engagement

* Joe Baliey Sr., Former CEO of Miami Dolphins; Head of Global Sports Leadership Practice - RSR Partners/Douglas Freeman - Virtcom Consulting

Questions or Feedback

Gold Coast Health Plan
A Public Entity

THANK YOU

Douglas Freeman