Gold Coast Health Plan℠
A Public Entity

Quality Improvement Program 2021

www.goldcoasthealthplan.org

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I. BACKGROUND

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

II. MISSION, VISION, VALUES

Mission

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

In line with that goal, GCHP's Quality Improvement Program will define the processes for continuous quality improvement of clinical care and services, patient safety, and member experience, provided by GCHP and its contracted provider network, through its commitment to improving and sustaining its performance through the prioritization, design, implementation, monitoring, and analysis of performance improvement initiatives. Core values of the program include maintaining respect and diversity for members, providers and employees.

Vision

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

Values

The QI Program supports the organization's values of:

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

III. PURPOSE AND SCOPE

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

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

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

The Quality Strategy is anchored by three linked goals:

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

The seven priorities of the Quality Strategy are to:

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

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.

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

The scope of the QI process encompasses the following:

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

2. Quality of nonclinical services including, but not limited to:
   - Accessibility.
   - Availability.
   - Member and provider satisfaction.
   - Grievance and appeal process.
   - Cultural and linguistic services.
   - Network adequacy.

3. Patient safety initiatives including, but not limited to:
   - Facility site reviews / medical record review / physical accessibility review surveys.
   - Credentialing of practitioners / organizational providers.
   - Peer review.
   - Sentinel event monitoring.
   - Potential Quality Issues (PQI) / Provider Preventable Condition (PPC) monitoring.
   - Health education.
   - Utilization and risk management.

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

IV. AUTHORITY AND RESPONSIBILITY

The Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) promotes, supports, and has ultimate accountability, authority, and responsibility for a comprehensive and integrated Quality Improvement (QI) Program. The VCMMCC is ultimately accountable for the quality of care and services provided to members, but has delegated supervision, coordination, and operation of the program to the GCHP Chief Executive Officer (CEO) and QI Department under the supervision of the Chief Medical Officer (CMO) and its Quality Improvement Committee (QIC). The Chief Medical Officer is responsible for the day-to-day oversight of the QI Program. The CMO, through the Quality Improvement Committee (QIC), guides and oversees all activities in place to continuously monitor health plan quality initiatives.

The VCMMCC's role is to approve the overall QI Program and QI Work Plan annually and receives regular updates to the QI Work Plan for review and comment. The VCMMCC receives operational information through regular reports from the CMO in conjunction with the operations of its various committees as described below.

To address the scope of the GCHP's QI Program goals and objectives, the structure consists of the QIC supported by seven subcommittees that meet at least quarterly:

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

To further support the community involvement and achieve GCHP's QI goals and objectives, the VCMMCC organized two committees reporting directly to them:

1. Provider Advisory Committee
2. Community Advisory Committee

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

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

V. QI PROGRAM GOALS AND OBJECTIVES

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

- Ongoing activities to monitor care and service delivery.
- Issues identified by tracking and trending data over time.
- Issues / outcomes identified in the previous year's QI Program evaluation.
- Accreditation standards, regulatory and contractual requirements.

The QI Program goals include:

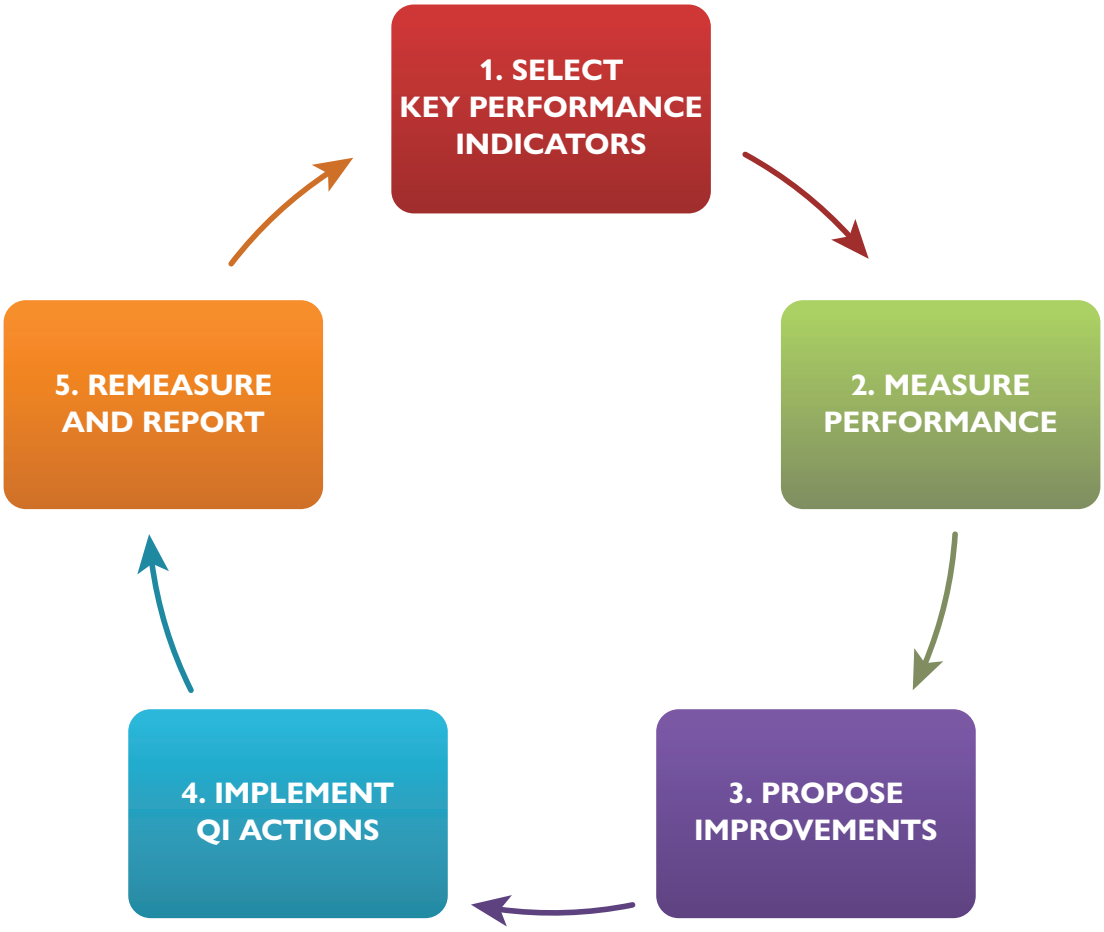
- Develop and maintain QI resources, structure, and processes that support the organization's commitment to equitable and quality health care for our members.
- Coordinate, monitor, and report QI activities.
- Develop effective methods for measuring and reporting the outcomes of care and services provided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

The Program Objectives include the following:

- To integrate the 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 utilization patterns and through information collected from quality and performance metrics including the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS), the National Committee of Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), and the Centers for Medicare and Medicaid (CMS) Core Measures for Medicaid.
- To encourage feedback from members and providers regarding delivery of care and services and to use the feedback to evaluate and improve the manner by which care and services are delivered.

VI. QI PROGRAM METHODOLOGY

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



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

The indicators may reflect the following parameters of quality:

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

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

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

VII. KEY PROGRAM INITIATIVES

Care Management

The Care Management team uses a population health framework, an interdisciplinary structure that utilizes data from across the healthcare continuum, to support and align Gold Coast Health Plan's (GCHP) efforts to achieve positive health outcomes for defined populations. Care Management accepts referrals from a variety of resources which may include population health data resources, such as:

1. Medical and/or behavioral claims / encounters
2. Pharmacy Claims
3. Utilization Management
4. HIF/MET
5. Laboratory Results
6. Health Appraisal results
7. Electronic Health Records
8. Advanced data sources may include, but are not limited to:
   - Regional immunization registries (CAIR Registries)
   - Integrated data warehouses between providers, practitioners, and the organizations

These data sources will be evaluated to develop actionable interventions to meet the care needs of targeted populations. GCHP offers Care Management services as part of Care Coordination, which also includes Basic Case Management (provided by the members' primary care physician), Utilization Management, Discharge Planning and Transitions of Care. Care Management uses person centered planning and collaboration with the member to address the member's stated health and/or psychosocial needs; this process may or may not include the development of an Individualized Plan of Care (IPC). Interventions are tailored in response to the member's assessed needs or stated goals. Throughout the care management process, the member's needs are reassessed, and adjustments are made as needed to provide the appropriate level of care.

Utilization Management

GCHP's Utilization Management (UM) Program is integrated with the QI Program to ensure continuous quality improvement. The UM Program is designed to ensure that medically appropriate services are provided to all GCHP members through a comprehensive framework that assures the provision of high-quality, cost effective, medically appropriate health care services in compliance with the benefit coverage and in accordance with regulatory and accreditation requirements. The UM Program Description defines how UM decisions are made by appropriately trained individuals in a fair and consistent manner. The Utilization Management Program functions ultimately under the direction of the Medical Director / Associate Chief Medical Officer or his/her designee, who is fully involved in the UM Program implementation. The UM Program Description is approved by the UMC and the program evaluation is reported to the QIC.

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. The UM and QI committees work together to collaborate on and resolve cross-related issues.

Diversity and Inclusion

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

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

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

VIII. PROGRAM ORGANIZATION, OVERSIGHT AND EVALUATION

Chief Medical Officer

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

The CMO has the overall responsibility for the clinical direction of GCHP's QI Program. The CMO 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.

Medical Director / Associate Chief Medical Officer

The Medical Director / Associate Chief Medical Officer assists (MD/ACMO) 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 MD/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 MD/ACMO.

Director of Quality Improvement

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.

Specific roles and responsibilities of the QI Director include, but are not limited to:

- Ensuring that the annual QI description and work plan are created and reviewed by all appropriate areas.
- Working with all appropriate departments in the creation of the annual QI Evaluation and analysis of results.
- Ensuring QIC approval of all QI documents annually.
- Guiding the collection of MCAS / HEDIS® / CMS Core Set for Medicaid 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 initiatives.

QI Program Evaluation

A written evaluation of the QI Program is completed annually. This annual report includes a comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to the results of performance measures, outcomes / findings from Performance Improvement Projects (PIPs), consumer and provider satisfaction surveys, and the quality review of services rendered. The analysis includes a review and revision of the 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.

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IX. ANNUAL WORK PLAN

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

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

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

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

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

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

- MCAS / HEDIS® / CMS Core Set for Medicaid
- Coordination of Care Studies
- Facility Site Reviews
- Potential Quality Issue Investigation

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

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

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

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

Communication and Feedback

Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, mailings, website content and announcements. Providers are educated regarding quality improvement initiatives via on-site quality visits, provider update memos, the Provider Operations Bulletin, and the GCHP website. Reporting of specific MCAS / HEDIS® / CMS Core Set for Medicaid measures is communicated to providers via an annual report card and monthly progress reports of current and projected rates including care gap reports of members who need specific clinical services.

X. PROGRAM RESOURCES DEDICATED TO QUALITY IMPROVEMENT

Quality Improvement Program Resources - Multidisciplinary Staff

Resources for the Quality Improvement (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 population health / care management, utilization / risk management and other clinical process improvement and outcome measures are 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 Provider 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.

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

- Assisting in creating the annual QI Program Description.
- Assisting in coordination of MCAS / HEDIS® / CMS Core Set for Medicaid data collection, reporting and analysis of results.
- Working with other departments to gather information for the annual QI Evaluation.
- Collaborating in developing activities for the annual QI Work Plan.
- Identifying areas for improvement and assist in implementing quality improvement initiatives.
- Assisting the QI Director in achieving the goals of the QI Program.

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.
- Online Data for performance metrics – providers have access to Inovalon's INDICES® dashboards that offer visualization and customization capabilities that enable measurement of performance against benchmarks and identification of gaps in care.

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®), Centers for Medicare and Medicaid (CMS) Core Set for Medicaid, Quality Compass
- Government issued laws, regulations and guidance including those from DHCS, CMS, the U.S. Preventive Services Taskforce (USPSTF), and National Institutes of Health (NIH)
- Health care quality improvement organizations such as the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), and the Agency for Healthcare Research and Quality (AHRQ), Health Services Advisory Group (HSAG)
- The Guide to Community Preventive Services (The Community Guide); a collection of evidence-based findings of the Community Preventive Services Task Force established by the U.S. Department of Health and Human Services (DHHS)

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

XI. QUALITY COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)

The Quality Improvement Committee (QIC) is the principal organizational unit that will have delegated authority to monitor, evaluate and report to the Ventura County Medi-Cal Managed Care Commission (VCMMCC) on all component elements of the Gold Coast Health Plan (GCHP) Quality Improvement (QI) Program. The committee shall have a minimum of eight voting members and be chaired by the GCHP Chief Medical Officer (CMO) and facilitated by the Quality Improvement Director. Membership will consist of the chairs of the seven 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 program and by state 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 GCHP committees and makes recommendations on their implementation.

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. MCAS / HEDIS® / CMS Core Set for Medicaid results
   iv. Quality Improvement Projects and initiatives - 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 Responsibilities:

- Oversees the annual review, analysis and evaluation for achievement of goals and effectiveness of the Quality Improvement Program, Quality Improvement Work Plan, and quality improvement policies and procedures.
- Makes recommendations for implementation of interventions or corrective actions based on results of quality improvement activities.
- Facilitates data-driven indicator reviews and development for monitoring key quality management activities, including but not limited to: MCAS / HEDIS®, Access / Availability, Performance Improvement Projects, Service / Clinical Quality measures, Health Service metrics, credentialing performance, and delegation oversight.
- Reviews recommendations from GCHP committees, which may include quarterly committee meeting minutes, action item logs and reports regarding monitoring of health plan functions and activities and makes recommendations on their implementation.

Medical Advisory Committee (MAC)

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

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

Scope:

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

Member Services Committee (MSC)

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

MSC Objectives:

- Ensure GCHP members have an understanding of their health care system and know how to obtain care and services when they need them.

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

Grievance and Appeals Committee (G&A)

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

G&A Committee Objectives:

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

Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) oversees the implementation of the UM Program and promotes the optimal utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Committee is multi-disciplinary and monitors continuity and coordination of care as well as under- and over-utilization. The committee is charged with reviewing and approving clinical policies, clinical initiatives and programs before implementation. It is responsible for annually providing input on GCHP's clinical strategies, such as clinical guidelines, utilization management criteria, population health / care management protocols, and the implementation of new medical technologies. The UMC is established as a standing sub-committee of the QI Committee, and reports to the QIC quarterly.

UMC Responsibilities:

- Annual review and approval of the UM and Population Health / Care Management Program documents.

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

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

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

HE/CL Committee Responsibilities:

- Ensure that members have access to appropriate health education materials.
- Ensure that providers have access to health education services and materials, including alternative formats.
- Ensure that providers and GCHP staff deliver culturally and linguistically (C&L) appropriate health care services to GCHP's diverse membership.
- Ensure that providers and staff receive trainings on cultural competency, language assistance, Seniors and Persons with Disabilities (SPD) and/or diversity trainings.
- Ensure that all members – regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identify or sexual orientation, or language capabilities have equal access to quality health care.
- Ensure that GCHP implements C&L requirements set by the state Department of Health Care Services (DHCS).

- Ensure the Population Needs Assessment (PNA) is completed to determine a baseline for serving education and cultural / language needs.
- Collaborate and work with GCHP's Health Services, Quality Improvement, Provider Network Operations and other departments to ensure health education, cultural and linguistic services needs are addressed.
- Ensure opportunities are available to educate members on the disease process, preventive care, plan processes and all other areas essential to good member health.
- Assist providers in educating GCHP members and promote positive health outcomes.
- Ensure that all written information materials comply with the readability and suitability requirements set by the state Department of Health Care Services (DHCS). The member informing materials shall be at a sixth grade or lower and be consistent with GCHP's membership needs.
- Educate GCHP staff on specific cultural barriers that might hinder the delivery of optimal health care.

Credentials / Peer Review Committee (C/PRC)

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

C/PRC Committee Responsibilities:

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

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

Pharmacy & Therapeutics (P&T) Committee

The Pharmacy & Therapeutics (P&T) Committee serves as the medication management program oversight committee to GCHP. The P&T Committee provides guidance to ensure optimal efficacy, safety, and cost-effectiveness of drug therapy.

XII. DELEGATION OF QUALITY IMPROVEMENT

Delegation is the formal process by which Gold Coast Health Plan (GCHP) 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 expectations and standards set forth by the state Department of Health Care Services (DHCS) and GCHP.

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

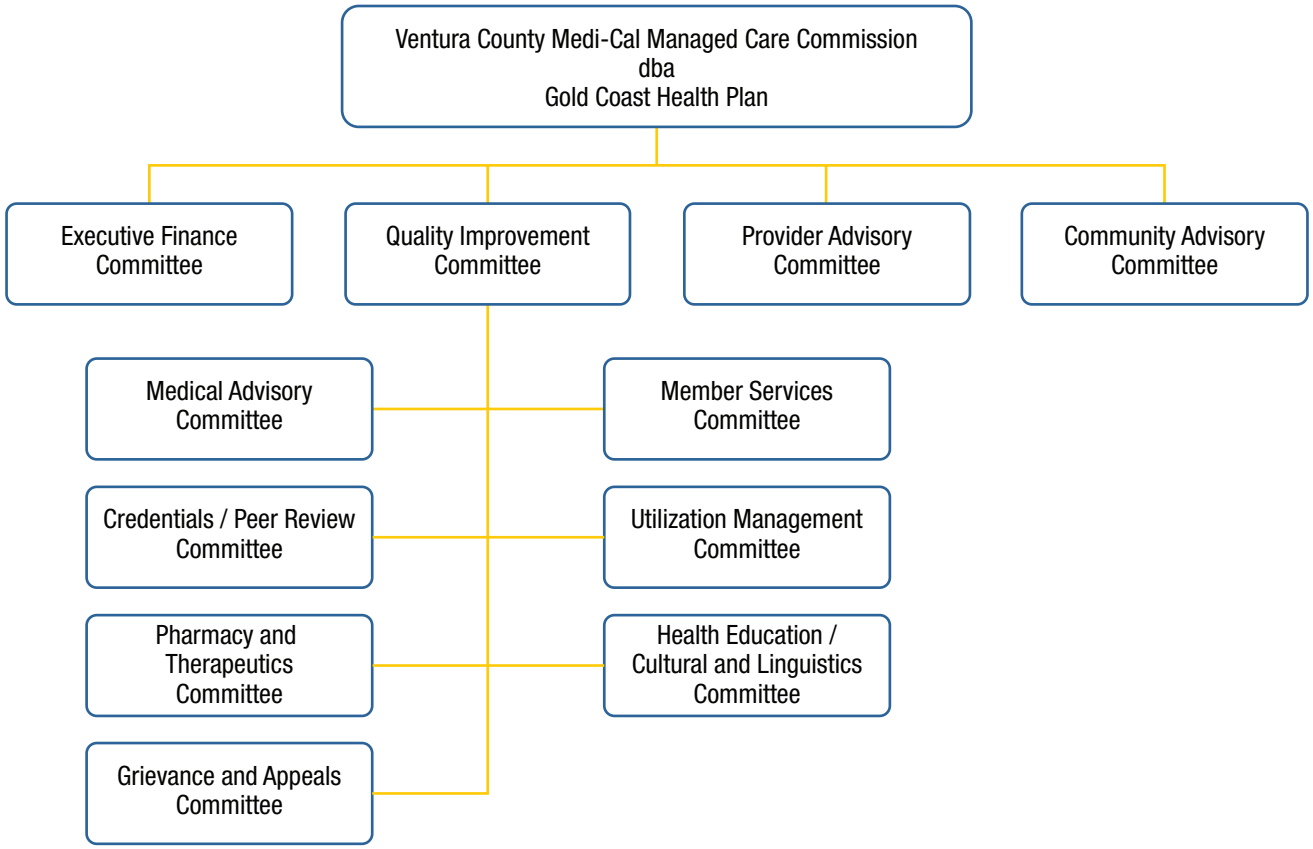
Any delegated functions are fully described in a mutually agreed upon signed and written formal delegation agreement between GCHP and each delegated entity and includes an effective date. All agreements clearly define GCHP's and the delegate's specific duties, responsibilities, activities, reporting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

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

Delegated entities are required to submit at least semi-annual reports to GCHP according to the reporting schedule specified in the delegation agreement.

XIII. 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:



Gold Coast Health Plan℠
A Public Entity

Quality Improvement Program 2021

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

Rev. 10/2021