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

Community Advisory Committee (CAC) Meeting

Special Meeting
Tuesday, January 28, 2025, 4:30 p.m. – 6:30 p.m.
Gold Coast Health Plan,
Community Room
711 E. Daily Drive, Suite 110, Camarillo, CA 93010
Conference Call Number:1-805-324-7279
Conference ID Number: 119 041 800 #

Para interpretación al español, por favor llame al: 1-805-322-1542 clave: 1234

1721 Saratoga St
Oxnard Ca 93035

AGENDA

INTERPRETER ANNOUNCEMENT

CALL TO ORDER

ROLL CALL

PUBLIC COMMENT

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

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

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

Welcoming Remarks

Marlen Torres, Chief of Member Experience & External Affairs
Felix L. Nunez, M.D., MPH, Acting Chief Executive Officer

CONSENT

1. Approval of Community Advisory Committee Regular Meeting Minutes of October 16, 2024

Staff: Maddie Gutierrez, MMC – Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

PRESENTATION

2. Population Needs Assessment Focus Group

Staff: Erin Slack, Sr. Manager, Population Health

RECOMMENDATION: Receive and file the presentation.

3. Model of Care Overview

Staff: Eve Gelb, Chief Innovation Officer

RECOMMENDATION: Receive and file the presentation

UPDATES

4. Governor's Budget Update

Staff: Marlen Torres, Chief of Member Experience & External Affairs
Alison Armstrong, Government Relations Manager

RECOMMENDATION: Receive and file the update.

5. Expansion Population Outreach Strategies Update

Staff: Marlen Torres, Chief of Member Experience & External Affairs

RECOMMENDATION: Receive and file the update.

6. Implementation Update: Justice Services

Staff: David Tovar, Incentive Strategy Manager

RECOMMENDATION: Receive and file the update.

7. Diversity, Equity & Inclusion (DEI) Training Update

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

RECOMMENDATION: Receive and file the update.

COMMENTS FROM COMMITTEE MEMBERS / GCHP STAFF

CAC Feedback / Roundtable Discussion

ADJOURNMENT

Unless otherwise determined by the Committee, the next regular CAC meeting will be held on April 15 2025 , from 4:30 PM – 6:30 PM in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Suite 110, Camarillo CA 93010.

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

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

AGENDA ITEM NO. 1

TO: Community Advisory Committee (CAC)

FROM: Maddie Gutierrez, MMC - Clerk to the Commission

DATE: January 28, 2025

SUBJECT: Approval of the Community Advisory Committee regular meeting minutes of October 16, 2024 .

RECOMMENDATION:

Approve the minutes as presented.

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

Community Advisory Committee (CAC) Minutes
Regular Meeting
October 16, 2024

CALL TO ORDER

Committee Chair, Ruben Juarez, called the meeting to order at 4:05 p.m. in the Community Room located at Gold Coast Health Plan, 711 East Daily Drive, Suite 110, Camarillo, California.

INTERPRETER ANNOUNCEMENT

The interpreter made her announcement.

ROLL CALL

Present: Committee members Martha Johnson, Laurie Jordan, Ruben Juarez, Victoria Jump, Ben Rhodes for Elaine Martinez, and Pablo Velez.

Absent: Committee members Rose MacKay, Juana Quintal, and Rafael Stoneman.

Attending the meeting for GCHP Executive Team were Acting CEO Felix Nunez, M.D., CPPO Erik Cho, Acting CMO James Cruz, M.D., CCO Robert Franco, CDO Ted Bagley, Marlen Torres, Exec. Director of Strategy & External Affairs, Adriana Sandoval, Luis Aguilar, Lupe Gonzalez, Veronica Estrada, Alison Armstrong, Helen Chtourou, Ifsha Buttitta, Kimberly Marquez, Johnson, Trena Tobin, Lucy Marrero, Kim Timmerman, and Lupe Harrion.

PUBLIC COMMENT

None.

Rose MacKay arrived at 4:07 p.m.

WELCOMING REMARKS

Acting CEO, Felix L. Nunez, M.D., introduced himself to the committee. He stated that the teams are constantly working to develop and enhance our programs. They are responsive to our members and providers. He advised the committee that their feedback is important to staff. He noted there is an open-door policy with the leadership team.

He stated he wanted to give an update – CEO Nunez stated that Marlen Torres has been promoted to Chief of Member Engagement & External Affairs. James Cruz, M.D., who is GCHP's Sr. Medical Director has taken on the title of Acting Chief Medical Officer while Dr. Nunez takes responsibilities as Acting Chief Executive Officer. A new Medical Director has been hired; Terri Brown, M.D., and we just recently posted a new position: Executive Director of Health Equity.

CONSENT

1. Approval of Community Advisory Committee Regular Meeting Minutes of April 17, 2024.

Staff: Maddie Gutierrez, MMC – Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

Committee member Martha Johnson motioned to approve consent item 1. Committee member Dr. Pablo Velez seconded.

Roll Call vote as follows:

AYES: Committee members Martha Johnson, Ruben Juarez, Ben Rhodes for Elaine Martinez, and Pablo Velez

ABSTAIN: Committee member Laurie Jordan

NOES: None.

ABSENT: Committee members Juana Quintal and Rafael Stoneman.

The motion carries.

PUBLIC COMMENT

None

FORMAL ACTION

2. Approval of the 2025 CAC Meeting Calendar

Staff: Maddie Gutierrez, MMC – Clerk to the Commission

RECOMMENDATION: Selection and approval of the 2025 Community Advisory Committee (CAC) calendar as presented

The committee reviewed the calendar. It was recommended to move the meeting day to Tuesdays for all committee members to be able to attend. It was also requested that the meeting time change to 4:30PM to 6:30PM to give committee members travel time so they can arrive to the meeting on time.

Committee member Laurie Jordan motioned to approve agenda item 2 with a revised meeting day and time. Committee member Dr. Pablo Velez seconded.

Roll Call vote as follows:

AYES: Committee members Martha Johnson, Ruben Juarez, Ben Rhodes for Elaine Martinez, and Pablo Velez

ABSTAIN: Committee member Laurie Jordan

NOES: None.

ABSENT: Committee members Juana Quintal and Rafael Stoneman.

The motion carries.

3. Community Advisory Committee (CAC) Charter Review and Approval

Staff: Marlen Torres, Chief of Member Experience & External Affairs

RECOMMENDATION: Approve the revised charter.

CMEEA Marlen Torres gave a brief background on the revised charter. She stated that with the implementation of our new contract with the state there are a number of additions to policies and procedures that went to the state for review and approval. These added enhancements of the materials that this committee will be reviewing. DHCS wants to ensure that this committee is actively participating and providing

feedback that will go to the Commission. We will begin regular updates to the Commission throughout the year so that feedback is provided.

CMEEA Torres stated one important topic will be quality. The committee will hear reports presented the team that will review quality initiatives and will in turn seek feedback from this committee. Provider engagement will also be presented to this committee. There is now an increased scope and review that this committee will have. There are positive changes being added to this committee.

The election process will continue as is. The AdHoc committee will review applications to fill vacant seats on the committee. DHCS wants us to make sure that we have representation of various categories of populations. The AdHoc committee will review applications, make recommendations and then at the next meeting present their recommendations to the entire committee for a vote, then present to the Commission for final approval.

Ms. Torres stated that she also meets with the Committee Chair and Vice Chair to review agenda topics. The committee is now taking charge of the meeting.

Committee Chair, Ruben Juarez asked how many seats were on the committee, Ms. Torres stated there are eleven seats for this committee.

Dr. Velez asked if there is a discrepancy on a presentation, and the rest of the committee is not comfortable with that presentation, how would that be handled. Ms. Torres stated that if further discussion is needed before a vote, the item would be tabled for another time. She noted that there are some things that cannot be changed because it is a regulatory requirement, we would clarify the requirement and then bring it up to vote later. Mr. Juarez stated that there is an opportunity for the committee to submit topics for discussion.

Committee member Martha Johnson motioned to approve agenda item 3. Committee member Laurie Jordan seconded.

Roll Call vote as follows:

AYES: Committee members Martha Johnson, Ruben Juarez, Ben Rhodes for Elaine Martinez, and Pablo Velez

ABSTAIN: Committee member Laurie Jordan

NOES: None.

ABSENT: Committee members Juana Quintal and Rafael Stoneman.

The motion carries.

4. Creation of an Ad Hoc Subcommittee for the review and selection of new members to Serve on the Ventura County Medi-Cal Managed Care Commission's Community Advisory Committee

Staff: Marlen Torres, Chief of Member Experience & External Affairs

RECOMMENDATION: Staff recommends the CAC establish a AdHoc subcommittee to commence the review and selection process of new members to the CAC.

Ms. Torres stated that there are open seats for the CAC. Plus, a seat that we have not been able to fill – which is a member seat. The other open seats are Ms. Paula Johnson is no longer able to continue with the committee. Ms. Victoria Jump is also not able to continue with the committee. Therefore, there are three seats currently open. There is a potential member that might not be able to continue with the committee as well, so we might have four seats open. We need to convene an AdHoc committee. We will be accepting applications and the AdHoc makes recommendations. They review the applications and determine if these individuals are to move forward for a formal vote at the January 2025 CAC meeting. We will need three to four committee members to volunteer.

Ms. Jordan asked if the committee could support Mixteco. Ms. Torres replied yes.

Martha Johnson, Laurie Jordan, Rose MacKay, and Dr. Pablo Velez volunteered to participate in the AdHoc committee. Now that we have the committee, the recruitment process will begin.

Committee member Martha Johnson motioned to approve agenda item 4. Committee member Dr. Pablo Velez seconded.

Roll Call vote as follows:

AYES: Committee members Martha Johnson, Ruben Juarez, Ben Rhodes for Elaine Martinez, and Pablo Velez

ABSTAIN: Committee member Laurie Jordan

NOES: None.

ABSENT: Committee members Juana Quintal and Rafael Stoneman.

The motion carries.

PRESENTATIONS

5. The National Committee for Quality Assurance (NCQA) Health Equity Accreditation Survey

Staff: Ted Bagley, Chief Diversity Officer.

RECOMMENDATION: Receive and file the presentation

CDO Ted Bagley reviewed the survey in the meeting packet. He stated that it is a survey which is part of a concentrated effort on the part of HCQA and HCS. We are looking closed at the make-up of committees to ensure that there is fairness across the board. He noted that CEO and the Executive Team look to the CDO to make sure that the number in the county are consistent with what we do internally. Fairness for equity, for promotions, pay. Etc. This survey is under the MCQA guidelines to look at the cultures within Ventura County and within Gold Coast Health Plan, making sure that when we assign people to the committees, we are doing it in a fair and equitable manner.

CDO Bagley noted that an electronic version of the survey will be sent out to the committees, and they are encouraged to fill it out and submit their responses. We want to make sure that the committees represent the members that we serve.

CDO Bagley noted that there has been a history at GCHP and things that have happened. He noted that things have gotten much better but and have a long way to go. We want to fill seats to address gaps. We need to have a baseline. The quality of this committee will remain the same Ms. Torres stated that we are looking at diversifying committees and we will target improvements.

CIO Gelb proposed that we will add how NCQA defines culture representation. CDO Bagley stated that we want to hear the voice of the committee members. We want to make sure that everyone is represented. Mr. Rhodes asked how the responses will be coded. CDO Bagley stated there is not a targeted percentage. We will present the information from the data gathered. CIO Gelb stated that we are required to ask certain things, but we would like to hear if you do not identify with a particular question. We want to create a survey that people feel asks good questions. This survey is for you to decide what you want to say and how you identify. It is a baseline.

Mr. Juarez asked about the deadline for submission. CDO Bagley stated that currently there is no deadline, which will be determined when the electronic version goes out.

CDO Bagley state that currently this is the final format, but you can tell us if there some changes that should be made.

6. Diversity, Equity & Inclusion (DEI) Training

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

RECOMMENDATION: Receive and file the presentation.

Dr. Lupe Gonzalez stated she is going to share some of the work being done in health, education, cultural and linguistic services. She noted that there are some changes regarding the diversity, equity, and inclusion training. DHCS has issued an All-Plan Letter to expand our current cultural linguistic training, and cultural competency training to be more inclusive and be broader, and more comprehensive to the populations that we serve. She reviewed guidelines and highlights, and the NCQA accreditation.

Dr. Gonzalez stated that there are currently seven elements within the Health Equity requirement, and some are specific to DEI training, and cultural competency training. She noted that she provided a link to review the class standards. We are evaluating our services and the quality of our translation services – we need to determine if we are really meeting the needs of our members.

Dr. Gonzalez stated that our materials will be reviewed against some of the class standards. She noted that the purpose to get feedback from the committee on two training modules – there will be changes implemented. Data collection of populations that we serve are not typically incorporated into the modules, but DHCS as well as NCQA noted that it is important and must be included. We must include the demographic membership specific to our county. We want to look at the demographics and discuss health conditions.

We need to submit our application /our curriculum to DHCS and put together a series of training modules that include key components that must be included. Dr. Gonzalez noted that we are looking at new modules that fulfill the SPD (seniors and persons with disabilities) requirements. The one we were using has changed so we will be expanding that and looking for guidance. A new area that we do not have train on is the specialty mental health services and substance abuse disorder. We are looking at our vendors and working with Lucy Marrero, Director of Behavioral Health for training

modules we can incorporate as part of our DEI training. We will be looking at enhancing what we currently have available. For our staff and providers.

DHCS through the All-Plan Letter recently released is providing us with two planning phases. Currently we are in phase one which is the development of the curriculum – testing, reviewing, and getting community input. Implementation will be by the end of December of 2025. We have created a training module and customized if for our members. We have a culture competency and patient engagement video; we also have other training videos that have been approved by the Office of Minority Health and DHCS.

We have two videos that we would like to request your feedback. The goal is to determine if this is an appropriate video that we want to incorporate in our training for staff, as well as providers. You will receive the link in an email for the two videos and we look forward to your feedback and comments. We want your perspective.

Dr. Gonzalez noted that we are in the process of revising six or seven of our policies to incorporate Health Equity and diversity. CIO Gelb stated the training is to ensure that we change culture so that it is always something we look at, that we create that environment where that is what happens all the time, at every level of the organization and the health Equity position within the organization.

Committee member Rose MacKay asked if these training are going to be implemented to guide new people coming in or to train the people now. Dr. Gonzalez stated that what we want to do when we partner with providers is to look at what is currently being provided, what type of cultural competency or DEI training is being provided. Part of the NCQA requirements is offering the training and partnering.

Committee Chair Ruben Juarez stated that in the interest of time, it might be good to add this item to the next meeting because there are lots of questions and it is also a lot of information. This committee is interested in providing feedback.

7. Non-Specific Mental Health Services (NSMHS): Member Outreach Workplan

Staff: Lucy Marrero, Director, Behavioral Health

RECOMMENDATION: Receive and file the presentation

Lucy Marrero, Director of Behavioral Health, gave a background on SB1019 which is now an All-Plan Letter (APL). There is a list of requirements, and the state is beginning to look at the process of building services and educational materials. This is an outreach and education plan which focuses non-specialty mental health services. The

intent is to assist providers to ensure they have the right information for members to have access to services and help members who will have direct information about services. We are using data to help determine the outreach and education plan.
We are looking at utilization in our county and how are we doing in terms of access.
Committee member Dr. Pablo Velez asked what is meant by non-specialty mental health services, what would be a category. Ms. Marrero stated that in our county there are people who are experiencing complex issues that could include trauma, homelessness, incarceration, child welfare, etc. which all impact on a person's ability to work, play and love. This also includes substance use services which the county has most all the substance use services, with just a few services on the Medi-Cal side.

Acting Chief Medical Officer, James Cruz, M.D. stated that theses are first level mental health services. The issues are manageable with some therapy as well as medication. If they get worse then they are elevated to specialty provider for their care. Dr. Velez stated that there was a new regulation passed by the Governor; SB-805, which is for families that are on the spectrum and the only alternative that has been prescribed to the is ABA. There has been trauma generated by ABA because they were not given a choice. These individuals are now talking about how this affected them. SB-805 is opening other alternative services that families feel are more culturally appropriate for them. He asked how this is being handled. Ms. Marrero stated that she will investigate it more and noted some of the harm that ABA can do based on people's experiences.

Ms. Marrero stated that we do not have a blueprint yet, but we do have pieces. There are materials that are being assessed and staff is requesting input from the committee. Ms. Marrero reviewed questions with the group. She asked about barriers, accessing mental health services, and navigating the system. We want to establish process that is consistent, and people will respond. Ms. Marrero reviewed the rest of her questions with the committee.

UPDATES

8. Implementation Update: Justice Services

Staff: Pauline Preciado, Exec. Director of Population Health
David Tovar, Incentive Strategy Manager

RECOMMENDATION: Receive and file the update.

Agenda Item 8 was tabled.

9. Expansion Population Outreach Strategies Update

Staff: Marlen Torres, Chief of Member Experience & External Affairs

RECOMMENDATION: Receive and file the update.

Agenda 9 was tabled.

10. MCAS Measures and Interventions: Chronic Disease Management and Preventive Screenings

Staff: James Cruz M.D., Acting Chief Medical Officer
Kim Timmerman, Sr. Director of Quality Improvement
Helen Chtourou, QI Program Manager III

RECOMMENDATION: Receive and file the update

Helen Chtourou, QI Program Manager III was introduced and will be presenting on MCAS Measures and interventions related to chronic disease management and preventive screenings. She stated that at the end of the presentation she would like to request feedback and recommendations from the committee. She also asked for linguistically appropriate interventions that could be implemented to help reduce some health disparities. Ms. Chtourou stated that five measures would be reviewed today.

Ms. Chtourou shared GCHP background information. She stated that there are forty-two measures selected by DHCS and some of the measures must meet the minimum performance level benchmark. This benchmark equates to the national Medicaid 50th percentile rank. We compare the fie measures being reviewed today to their 2022 and 2023 rates. Some of the measures improved significantly. The asthma medication ratio declined and did not meet the DHCS MPL benchmark. Although there were rate improvements in four out of five measures, we still found health disparities in each measure. Some members are still not getting the care they need.

Ms. Chtourou reviewed the first measure – child and adolescent well care visits and reviewed the interventions used. She noted that Member Outreach helped schedule appointments, offering a $25 gift card to complete the well-care visit, along with a monthly letter reminding members to schedule their exam.

Interventions for the asthma medication measure included provider and member education on asthma medication management, member outreach to coordinate care, connecting members with their provider and scheduling appointments. GCHP also offers a chronic disease self-management program where members can enroll and learn skills to manage their chronic conditions.

Interventions for controlling high blood pressure include promoting the medical benefits for members to obtain free blood pressure monitoring device so that can take their blood pressure at home and then report results to their doctor.

Ms. Chtourou noted that the metrics are set by NCQA, and we follow the metric. Even though a blood pressure reading of 140/90 is still high, it calls attention to the member the raise health outcomes. Chief Innovation Officer, Eve Gelb, stated that we are focusing on the requirements from the state.

Intervention for managed blood sugar is a gift care to patients with diabetes who complete lab tests. We also have collaborated with vendors to collect lab tests at community health fairs, and considered offering test kits so members do not have to go to the clinic or lab and the chronic disease self-management can be done.

We have also done outreach for colorectal cancer screenings and help schedule screening appointments and offering home test kits.

Ms. Chtourou stated that she would like to request committee feedback or recommendations on whether these interventions are appropriate to help reduce the health disparities identified, and what barriers to care should be considered when developing new interventions. She noted that in all five measures males are not getting the screenings or managing their chronic conditions – so does this mean they delay getting care or defer care and are there suggestions on how to we need to improve this issue. She did note that the gift cards are a good incentive and no shows for appointments has gotten less. We want to know what we can do differently to engage the men. Committee member Ben Rhodes stated that often peer messaging can be helpful. Often listening to someone in a position of authority can be put off, but if a friend or someone within you age group can have influence.

Committee Chair, Ruben Juarez, stated that students in sports are sometimes embarrassed to use their medication pump. The coach can require a health exam/physical if you want to compete. He also stated that a peer approach might also work.

Committee member, Dr. Pablo Velez stated that educating parents is vital. The parents must be targeted too. Classes on-line might be helpful as well. There can also be conversations where they individual does not feel threatened and might change their lifestyle and embrace their long-term situation. You can also give the member some sense of control by documenting their medication intake and offering a reward for consistency.

Meeting parent to parent and offering suggestions such as removing carpeting because that could be effective in allergies. Committee member Rose MacKay stated that along with an asthma management specialist, include a nutritionist and explain what some foods, such as dairy can do to the lungs. Review the household and look for mold on the walls.

11. D-SNP Member Journey and Model of Care Review

Staff: Kimberly Marquez-Johnson, Director of Dual Special Needs Plan

RECOMMENDATION: Receive and file the update

Agenda 11 was tabled.

Committee member Martha Johnson motioned to approve agenda items 5, 6,7, and 10. Committee member Rose MacKay seconded.

Roll Call vote as follows:

AYES: Committee members Martha Johnson, Laurie Jordan, Ruben Juarez, Ben Rhodes for Elaine Martinez, and Pablo Velez

NOES: None.

ABSENT: Committee members Juana Quintal and Rafael Stoneman.

The motion carries.

ADJOURNMENT

With no further business to discuss the meeting was adjourned at 6:08 p.m.

Approved:

_____

Maddie Gutierrez, MMC Clerk to the Commission

AGENDA ITEM NO. 2

TO: Community Advisory Committee (CAC)

FROM: Erin Slack, MPH, Senior Manager of Population Health

DATE: January 28, 2025

SUBJECT: **Population Needs Assessment Focus Group**

PowerPoint with Verbal Presentation

ATTACHMENTS:

Name of PowerPoint

Gold Coast Health Plan℠
A Public Entity

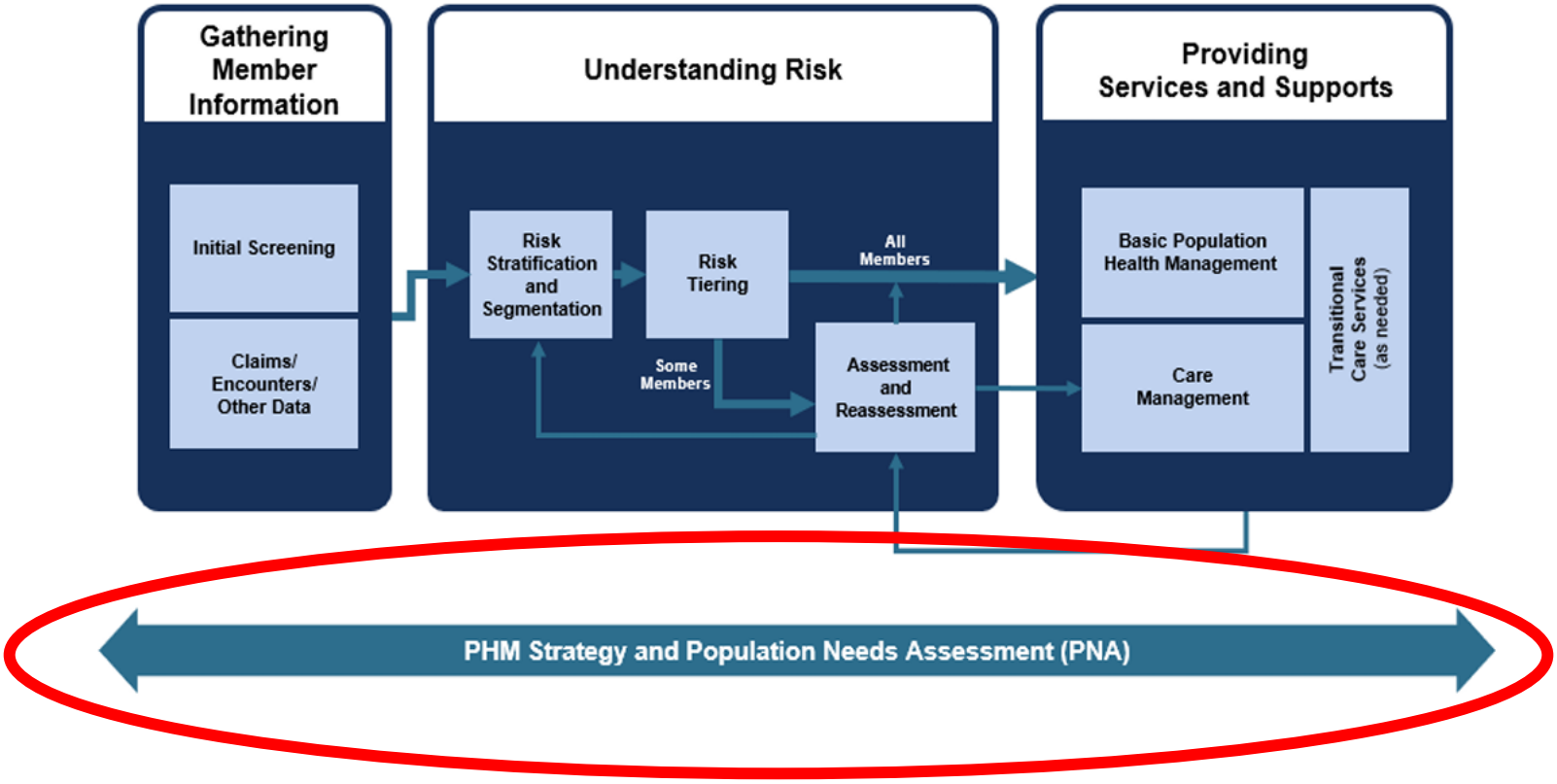
Integrity
Accountability
Collaboration
Trust
Respect

Population Health Management
Population Needs Assessment
Focus Group

Erin Slack, MPH
Senior Manager of Population Health
January 28, 2025

711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

Population Health Management Framework



Return to Agenda

New Process for the Population Needs Assessment (PNA)

DHCS' Vision

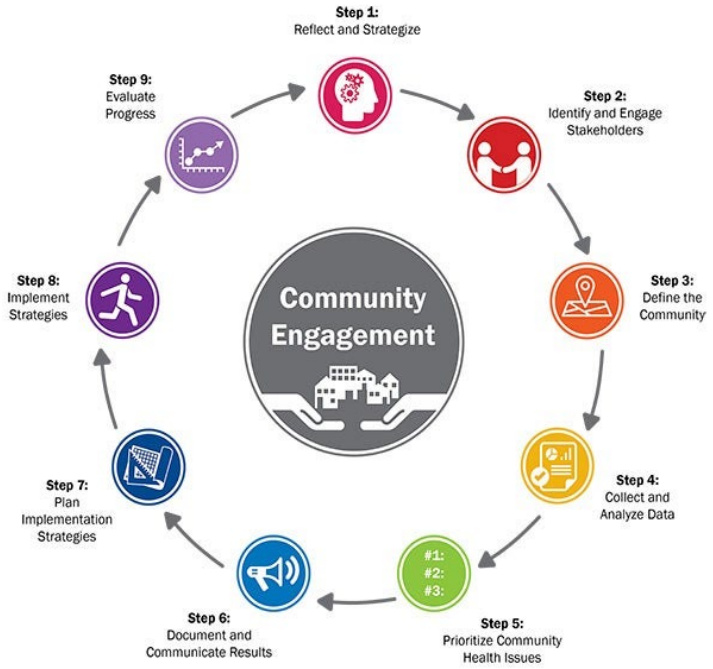
DHCS is reimagining a PNA that will:

- Promote deeper understanding of member needs, particularly social drivers of health (SDOH)
- Advance upstream interventions that look beyond the four walls of health care
- Deepen relationships between MCPs, public health and other local stakeholders
- Reduce community fatigue
- Strengthen a focus on equity by integrating more diverse sources of data
- Support public health's response to emerging trends, especially in areas where MCPs can intervene by providing coverage, education, and outreach

To achieve this vision, DHCS proposes a central requirement for MCPs to collaborate with Local Health Departments (LHDs).

Return to Agenda

Ventura County Community Health Improvement Collaborative



= **PNA**

= **PHM Strategy**

VENTURA COUNTY
COMMUNITY HEALTH
IMPROVEMENT COLLABORATIVE

Return to Agenda

Focus Group Question

1. **What resources in or aspects of your community help people become or stay healthy?**
   - Are there programs, organizations, or individuals that you look to for improving health?
   - What do you think others can learn from your community about being or staying healthy?

Return to Agenda

Focus Group Question

2. What makes it harder for people in your community to be healthy?

- What things in your community (e.g., physical environment, day-to-day experiences) harm health?
- What gets in the way of some individuals getting the care they need?

Return to Agenda

Focus Group Question

3. **Are there specific groups in your community facing unique health challenges? If so, who are they, and what challenges are they facing?**
   - How do these challenges change based on factors like age, gender, race, ethnicity, or where people live, work, or go to school?

Return to Agenda

Focus Group Question

4. What are the most important health-related challenges facing people in your community?

- Are there any specific challenges that require more urgent action?

Return to Agenda

Focus Group Question

5. What could be done to improve health in your community?

- What are new ways or approaches that can help improve health?
- How would you like to help make your community healthier?

Return to Agenda

PNA Survey Distribution

Return to Agenda

AGENDA ITEM NO. 3

TO: Community Advisory Committee (CAC)

FROM: Eve Gelb, Chief Innovation Officer
Nathan Norbryhn, Sr. Director – Model of Care

DATE: January 28, 2025

SUBJECT: Model of Care Overview

PowerPoint with Verbal Presentation

ATTACHMENTS:

QIHEC D-SNP MOC Overview

Gold Coast Health Plan℠
A Public Entity

Duals Special Needs Plan (D-SNP) Model of Care Overview

Tuesday, January 28, 2025

Eve Gelb, Chief Innovation Officer
Nathan Norbryhn, Sr. Director MOC

Integrity
Accountability
Collaboration
Trust
Respect

711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

GCHP DSNP Model of Care (MOC)

Agenda:

Review Highlights from GCHP D-SNP Model of Care

- MOC 1 – Description of SNP population
- MOC 2 – Care Coordination
- MOC 3 – Network
- MOC 4 – Quality and Performance Improvement

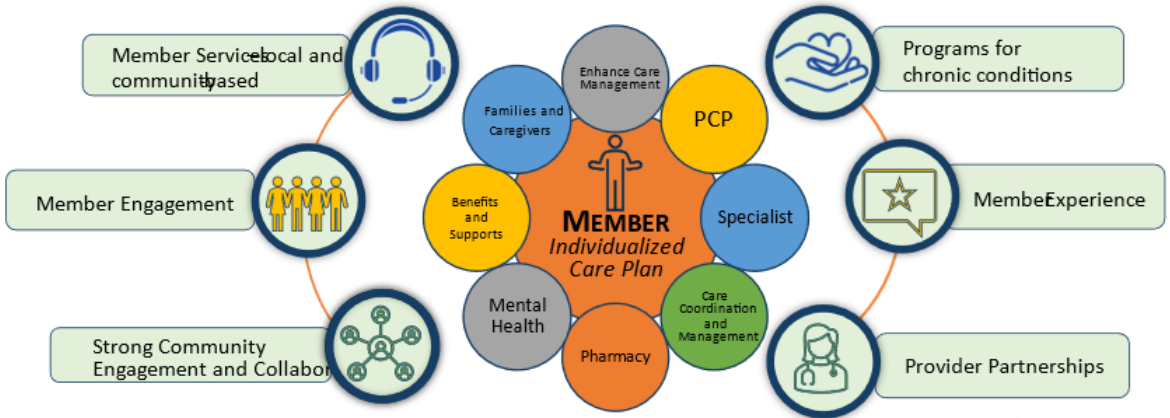
Return to Agenda

D-SNP Model of Care (MOC)

Standard—Overarching requirement based on best practice)	Element—Essential piece of the standard that must exist to meet the standard)
MOC 1: Description of the Population—Demonstrates understanding of their experience and needs	2 Elements—Ensure ability to describe the demographic, health and social characteristics of the target population and the most vulnerable members
MOC 2: Care Coordination—Ensures that needs and preferences are met	6 Elements--Ensure the right staffing, collection of health risk information, individualized care plan, interdisciplinary care team, and transition of care process
MOC 3: Network—Relevant facilities and providers to address unique and specialized needs	3 Elements—Ensures that the providers have the specialized expertise, use clinical guidelines, engage with the care team and are properly trained on the MOC
MOC 4: Quality and Performance Improvement—Continuously improve ability to deliver services and care	5 Elements—Demonstrate the process and capability to set and measure health outcomes and patient satisfaction and improve continuously

Return to Agenda

Gold Coast Health Plan D-SNP Model of Care



Understanding Our Members (Care & Services + Providers) = Quality

MOC 1—Populations Description and Eligibility

Eligibility Criteria	Method of Determining and Verifying Eligibility
Medicare	• MARx System • Viewing Federal Government Issued Medicare Card
Medi-Cal	• Viewing the individual's State Issued Medi-Cal Insurance Card • Contacting the GCHP contact center team member who can check the individual's Medi-Cal eligibility statis in the Medi-Cal Eligibility Data System (MEDS)
GCHP Enrollment	• Viewing the individual's GCHP Member Identification Card • Contacting the GCHP contact center team member who can verify individual's enrollment with GCHP for Medi-Cal
Age 21 or older	• Valid government issued identification • Individual self-declaration • Contacting the GCHP contact center team member who can check the individual's Medi-Cal eligibility statis in MEDS • MARx System

Continuity of care (COC) – Note at time of sale, GCHP enrollment resource will help identify COC needs to avoid disruption of care and services including but not limited to ECM services.

Return to Agenda

MOC 1—Unique Characteristics, Limitations and Barriers

Cohort	Characteristic	Limitation or Barrier
21 – 64 Duals	Disability/Frailty/Functional Impairment	• Coordination of Long-Term Care • Support for Caregivers
	Mental Health	• Coordination of services
	New to GCHP as Primary Insurer	• Connection to primary care • Continuity of Care
60 – 64 Non-Duals	Transition from MediCalRx	• Use of Medicare PBM
	Transition to Medicare Benefits	• Familiarity with benefits and services
	Expose to Health Issues of Agriculture	• Cancer screening and other preventive services
	Food and Income Insecurity	• Long term health impacts • Long term social impacts
65+ Duals	Disability/Frailty/Functional Impairment	• Coordination of Long-Term Care • Support for Caregivers
	Prevalence of Spanish Speakers	• Access to providers who speak their language • Use of interpreter services
	New to GCHP as Primary Insurer	• Connection to primary care • Continuity of Care
All	Education Attainment	• Health communication

Return to Agenda

MOC 1—Vulnerable Populations and Possible Supports

Criteria	Possible Support Provided
Medical Complexity including CICM populations: • Individuals At Risk for Avoidable Hospital or ED Utilization • Birth Equity	• Complex Care Management • Pharmacist engagement • Chronic Condition Management Program • Referral to palliative care • Referral to high-risk obstetrics care management
Frailty including CICM populations: • Adults Living in the Community and At Risk for LTC Institutionalization • Adult Nursing Facility Residents Transitioning to the Community	• Complex Care Management • Social worker engagement • Long Term Services and Support • Referral to palliative Care • Hospice Care
Psychiatric/Behavioral Health Complexity including CICM population: • Individuals with Serious Mental Health and/or SUD Needs	• Intensive Behavioral Health Care Management • Collaboration with County Behavioral Health Services
Access to Care including CICM populations: • Adults Living in the Community and At Risk for LTC Institutionalization • Adult Nursing Facility Residents Transitioning to the Community	• Targeted outreach to support connection to primary care and to access preventive services • Dental Care Navigation • Closed loop referral to Medi-Cal services
High Social Need including CICM populations: • Individuals Experiencing Homelessness • Individuals Transitioning from Incarceration	• D-SNP Enhance Care Management • Social worker engagement • Long Term Services and Support • Community Supports and Referrals

Return to Agenda

MOC 1 – Health Disparities

While there are some variations in the cohorts, members who identify their race/ethnicity as White and those who identify as Other or No Response as well as members whose primary language is English are generally overrepresented in the vulnerable populations markers when compared to their representation in the population. The limited data on some measures, as well as the racial and ethnicity categorization that does not align with how some people chose to identify, makes it difficult to draw conclusions from the data. Data that are specific to the individual will be vital for identifying the most vulnerable individual members and ensuring programs and services for those members.

Key Differences in Hispanic/Latino Health Status in Population with Multiple Complex Conditions

- A key focus for GCHP D-SNP should be the Hispanic/Latino cohort in PNG 10. Not only does this population represent a large portion of the target membership overall, but Hispanic/Latino members have high rates for cardiovascular and endocrine conditions, particularly hypertension and diabetes.
- Type 2 diabetes has a high prevalence in Hispanic/Latino members across all cohorts.
- While mental health challenges (e.g. anxiety, depression) are significant in the general population, they are less pronounced among Hispanic/Latino members, especially in older cohorts. This may be due to under diagnosis or underreporting.
- Renal and eye-related conditions show slightly higher prevalence in Hispanic/Latino members, particularly in the 65+ cohort.

Return to Agenda

MOC 2 – Meeting Federal and State Requirements for Care Coordination

Federal SNP Requirements for Care Coordination include conducting a Health Risk Assessment (HRA), conducting a face-to-face encounter, developing an Individualized Care Plan (ICP), Interdisciplinary Care Team (ICT), and Care Transitions.

State Requirements include meeting the requirements of Enhanced Care Management which is called California Integrated Care Management (CICM) for D-SNP. The components of CICM are outreach and engagement, comprehensive assessment and care management planning, enhanced care coordination, health promotion, and coordination and referral to community and social supports.

Model of Care Component	GHCP D-SNP MOC Approach
SNP: HRA and Face-to-Face Encounter **CICM: Outreach and engagement**	Members identified via HRA, referral, or other mechanism as meeting criteria for a CICM population of focus are assigned to social worker or nurse care manager as their lead care manager. This person is a GCHP staff person, but in the case of justice involved members or members who may have existing non GCHP staff as their lead care manager, GCHP will work to ensure the member has the appropriate lead ECM care manager and continuity of care. In addition to usual D-SNP outreach, GCHP attempts to outreach in-person meetings where the Member lives, seeks care or is accessible; community and street-level outreach; follow-up if the member presents to another partner in the network; or using claims data to contact Providers the Member is known to use. GCHP continues outreach until the member is engaged and documents outreach attempt in the care management system.

Return to Agenda

MOC 2 – Meeting Federal and State Requirements

Model of Care Component	GHCP D-SNP MOC Approach
SNP: HRA, ICP **CICM: Comprehensive assessment and care management planning**	GCHP uses the D-SNP HRA which has incorporated standardized LTSS referral questions to identify and refer Members who may have LTSS needs and questions to help identify needs of all populations of focus. The frequency of assessment is at least annually but may be more frequent based on member need. The ICP is co-developed with the member/caregiver and is based on the needs and desires of the member and is reassessed based on the member's individual progress or changes in their needs and/or as identified in the care plan. The D-SNP ICP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, social supports and SDOH. As appropriate, the ICP is to prioritize, address, and communicate strengths, risks, needs, and goals. The D-SNP care management is comprehensive and may include case conferences and additional clinical and non-clinical resources to ensure that the Member's care is continuous and integrated among all service providers. For CICM, the activities with the member are primarily through in-person contact, while for other D-SNP members activities may be primarily telephonic. When in-person communication is unavailable or does not meet the needs of the member, the D-CM team use alternative methods to provide culturally appropriate and accessible communication in accordance with member choice. Additional CICM assessments may be used to further understand needs for members in specific populations of focus.

Return to Agenda

MOC 2 – Meeting Federal and State Requirements (cont.)

Model of Care Component	GHCP D-SNP MOC Approach
SNP: ICT, ICP **CICM: Enhanced care coordination**	The D-SNP Model of Care incorporates all the elements of enhanced care coordination including listing interventions or patient care activities, sharing information with the ICT, ensuring progress on the ICP is tracked. All D-SNP members have an assigned PCP, and the care managers ensures appropriate engagement with the PCP through collaboration and case conferences as needed. The GCHP Care Coordination team ensures care is continuous and integrated among all service providers based on member needs including following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed. The GCHP Care Coordination team also ensures D-SNP members are engaged in their treatment including coordination for medication review and/or reconciliation, scheduling appointments, coordinating transportation, and identifying and helping to address other barriers to member engagement in treatment. The GCHP Care Coordination team will provide appointment reminders and accompaniment to critical appointments. This is important to ensure that member's needs are met during appointments and to support communication and understanding between members and providers.

Return to Agenda

MOC 2 – Meeting Federal and State Requirements (cont.)

Model of Care Component	GHCP D-SNP MOC Approach
SNP: ICT, Transitions of Care **CICM: Health promotion**	All D-SNP members receive support related to health promotion and are encouraged and supported in making lifestyle choices based on healthy behavior, and appropriate self-management. The GCHP Care Coordination team, other GCHP staff and providers working with members build support networks and strengthen skills that enable assist them in managing their conditions and preventing other chronic conditions. Members are linked to health education and management resources and ICT members using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care. Health promotion may be done in person and may incorporate more social skill building supports.

Return to Agenda

MOC 2 – Meeting Federal and State Requirements (cont.)

Model of Care Component	GHCP D-SNP MOC Approach
SNP: Transitions of Care **CICM: Comprehensive transitional care**	All D-SNP members receive comprehensive transitional care services designed to supporting members as they transitions from discharge planning until they have been successfully connected to all needed services and supports. The GCHP Care Coordination team collaborates with hospital discharge planners and other discharging facility staff as well as with PCPs and other receiving providers about the member's needs and ICP. The goal is to avoid unnecessary readmissions and support the member through the transition process. D-SNP transitional care services include getting information about transitions from ADT feeds and discharge planners from ED, hospital inpatient facility, SNF, residential or treatment facilities. The process includes ensuring discharge risk assessment and sharing of discharge plan, timely follow up with providers and/or community partners, conducting medication reconciliation, closed loop referrals for community services, arranging transportation, self-management activities and medication management. The lead CICM care manager is the assign single point of contact (TCS navigator) and additional steps are taking to ensure transitional care services for members in incarceration facilities. As stated above, for justice-involved members, ECM is usually conducted by a contracted partner, not GCHP staff.

Return to Agenda

MOC 2 – Meeting Federal and State Requirements (cont.)

Model of Care Component	GHCP D-SNP MOC Approach
SNP: ICT **CICM: Member and family supports**	The usual D-SNP care coordination process ensures that members and family are supported by ensuring the authorized caregivers are documented in the care management system and engaged in the care process and are knowledgeable about the member's condition(s) so as to improving the member's health outcomes and assist the member to accessing needed support services and making informed choices. The GCHP Care Coordination team also assesses caregiver needs and support caregivers to reduce stress and burden through engaging needed respite and other services. Members may need assistance identifying family and other supports and may need additional resources and services to build positive family/caregiver relationships.
SNP: HRA, ICP, ICT **CICM: Coordination and referral to community and social supports**	Addressing social factors is part of the usual D-SNP Care Coordination activities. The HRA assesses for needs and the ICP incorporated goals and interventions related to community and social supports. Housing, food, transportation, caregiver support and other services are coordinated by the ICT based on the needs of the member. Assessment and support is more likely to be in person for members in populations of focus and sustained than for longer than it may be for a less vulnerable D-SNP member.

Return to Agenda

MOC 3 – Network Collaboration

Method of Collaboration	Information Shared/Care Need Addressed
Electronic/Paper: Letters, Faxes, Electronic Data, Request for Authorization, Referral for Care or Service, Care Management System, Electronic Health Record	• Health Risk Assessment • Individualized Care Plan • Notification of diagnoses • Notification of admission • Identification of new medical or social need • Notification of closure of gap in care • Goal completion or update
Live/Realtime: Phone Calls, Case Conference Meeting, Joint Face-to-Face Encounter, Provider to Provider Consult, Medical Director to Provider Consult	• Goal prioritization • Identification of urgent new need • Problem solving • Access to care issues • Other escalated needs

Return to Agenda

MOC 3 – Network Training

Topic Heading	Summary of Contents
Introduction	Outline of training and requirements including CMS and DHCS Regulations
Member Eligibility	Descriptions of basic DSNP eligibility
MOC 1: Understanding GCHP SNP Members	Descriptions of GCHP D-SNP membership and the most vulnerable target population
MOC 2: Understanding GCHP Care Coordination	Description of MOC 2 including HRA, ICP, Face-to-Face Encounters, and Care Transitions
MOC 3: Understanding the Provider Role	Required clinical guidelines, protocols and related reference materials Required collaborations between the member, providers and health plan. Initial screening and comprehensive assessment for dementia
MOC 4: Measuring and Improving Quality	Description of quality outcomes and measures
Conclusion	Case studies and question and answer/frequently asked questions
Attestation	Acknowledgement of training completion

Return to Agenda

MOC 3 – Barriers to Provider Training

Challenge	Description
Time Constraints	GCHP contracts with providers who primarily serve underserved populations. These organizations are often under-resourced and are protective of providers time to ensure patient treatment over administrative activities such as training.
Lack of Awareness of the Requirement	Out-of-network providers are often not aware that the patient they are treating is a member of a SNP and as such are unaware of the training requirement.
Multiple Trainings from Different Plan Partners	Providers are contracted with multiple SNP plans, each requiring its own specific training.
Provider Turnover	Provider staff turn over often. This includes office staff and clinicians who may be locum providers, interns/residents or may be reassigned to different parts of the provider system.

Return to Agenda

MOC 4 – Quality and Performance Improvement

The GCHP's three specific D-SNP goals are:

- Goal 1: Improve coordination of care and appropriate and equitable delivery of services through early identification and proactive engagement of high-risk members into care coordination.
- Goal 2: Enhance care transitions across all health care settings and providers by increasing post-hospital discharge PCP visits and ensuring timely member contact by the transitions of care team for all hospital and SNF admissions
- Goal 3: Improve access and affordability of the health care for the SNP population using preventive strategies to improve chronic disease management and member engagement with treatment plans.

Return to Agenda

MOC 4 – Quality Measures

Health or Social Need	Improved Outcome	Measures
Manage Diabetes	Improve Blood Sugar Control	• Diabetes Care—Blood Sugar Controlled (CA Required) • Medication Adherence for Diabetes Medications
Manage Hypertension	Improve Blood Pressure Control	• Controlling High Blood Pressure (CA Required)
Manage Depression	Increase screening and follow up	• Depression Screening and Follow-Up for Adolescents and Adults • Follow-Up After Emergency Department Visit for Mental Illness (CA Required) • Emergency Department Behavioral Health Services Utilization (CA Required)
Manage Multiple Chronic Conditions	Appropriate use of services	• Special Needs Plan—Care Management • Transitions of Care • HEDIS Plan All-Cause Readmissions (PCR) (CA Required) • Care Transitions Team Contact with Member within 2 days of discharge • MTM Completion Rate for Comprehensive Medication Review ICP Completion • ICT Completion • Face-To-Face Encounter Completion • Care coordinator to member ratio (CA Required) • Number of New Enrollees in Palliative Care (CA Required)

Return to Agenda

MOC 4 – Quality Measures (cont.)

Health or Social Need	Improved Outcome	Measures
Health Care System Access and Affordability	Get needed care and services	• Adults' Access to Preventive/Ambulator y Health Services (CA Required) • Breast Cancer Screening • Colorectal Cancer Screening
Cognitive Health	Improve management of Cognitive Health Needs	• Identification of Health Care Proxy • Annual Cognitive Health Assessment for Patients 65 years and older (CA Required)
Manage Pain	Improve identification of Pain	• Care for Older Adults—Pain Assessment
Housing, Safety, Food, Transportation, Long-Term Services and Social Support	Increase access to support services	• ICP Goal Attainment on Housing, Food Security and Transportation • Community-Based Adult Services Use (CBAS) (CA Required) • In-Home Supportive Services (IHSS) Use (CA Required) • Multipurpose Senior Services Program (MSSP)Use (CA Required) • Long-Term Care (LTC) Use (CA Required)
Health Communication and Experience	Improve Experience	• ICP Goal Attainment on Improved Health Communication • CAHPS Rating of Health Care Quality • Care Coordinator Training for Supporting Self-Direction (CA Required)

Return to Agenda

Questions?

Return to Agenda

AGENDA ITEM NO. 4

TO: Community Advisory Committee (CAC)

FROM: Marlen Torres, Chief of Member Experience & External Affairs
Alison Armstrong, Government Relations Manager

DATE: January 28, 2025

SUBJECT: Governor's Budget Update

SUMMARY:

The 2025-26 California State budget proposal was released by the Governor on January 10, 2025. The January budget proposes a total state budget of $322.3B total ($228.9B GF) for a balanced budget. There is approximately $17B in total remaining budget reserves including $10.9B Rainy Day Fund, $1.5B Public School Rainy Day Fund, and $4.5B Special Funds.

In 2024-25, there was a $46B budget shortfall. The budget deficit is the difference between projected state revenue and the estimated current baseline of spending on services. To mitigate the shortfall, the 2024-25 budget plan proposed a two-year spending plan and posited a variety of budget solutions including program reductions, reserve withdrawals, revenue and internal borrowing, fund shifts, programmatic delays and/or pauses, and deferrals.

Despite lower consumer spending and job market stagnation, there has been a trend of upward income growth for high-earning Californians as well as bettering stock market outcomes as 2025 begins. These current economic tendencies as well as the budget solutions enacted by the state last year were sufficient to prevent an ongoing state budget crisis. In 2025-26, California is expected to have a modest surplus of approximately $16.5B in additional revenue above the 2024 Budget Act.

In regard to healthcare, $296.1B ($83.7B GF) is allocated for California Health and Human Services and $188.1B ($42.1B GF) is allotted for the Medi-Cal delivery system in 2025-26. The Administration has opted to increase Medi-Cal GF spending by $6.2B in 2025-26 compared to the 2024-25 GF budget allocations ($35.9B). The increase in GF expenditures illustrates how the Medi-Cal delivery system remains a priority for the Administration.

The January proposal anticipates that Medi-Cal will cover around 14.5M Californians in 2025-26. The year over year change is a 0.5B reduction compared to the 2024-25 Medi-Cal caseload of approximately 15M enrollees. According to the California Department of Health Care Services

(DHCS), the likely caseload decline is attributed to the end of the discretionary unwinding flexibilities which will sunset in June 2025.

Although the Medi-Cal caseload is experiencing a decline, the Administration does anticipate an increase in Medi-Cal beneficiaries with higher needs and associated costs. Caseload projections are uncertain and there is immense volatility; these numbers may shift significantly based on impending federal guidance. In Ventura County, Medi-Cal continues to cover approximately 30 percent of all residents with one in three residents, one in two children, and one in six seniors enrolled in Medi-Cal.

Despite California's improving economic circumstances, the state is still uninterested in pursuing new programs, services, or initiatives especially those with multi-year fiscal commitments. The Administration is opting for a more conservative budget to bolster reserves and protect against future shortfalls in the years ahead.

This budget should be considered more a placeholder as budgetary updates will be made in May that better reflect federal policy changes and finalized state tax revenue numbers. The Legislature must pass the budget by June 15. GCHP's Government Relations team will attend Senate Budget and Fiscal Review Committee and the Assembly Budget Committee hearings and provide updates on key budgetary and legislative changes.

RECOMMENDATION: Receive and file the update**.**

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Gold Coast Health Plan

January 28, 2025

Alison Armstrong
Government Relations Manager

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Budget Overview

The January budget proposes a total state budget of $322.3B total ($228.9B GF)

There is approximately $17B in remaining budget reserves as follows: $10.9B Rainy Day Fund, $1.5B Public-School Rainy-Day Fund, and $4.5B Special Funds

Most of the total state expenditures will be allocated to health and human services ($127.1B), K-12 education ($84.7B), and higher education ($23.9B)

Return to Agenda

Budget Deficit

In 2024-25, there was a $46B budget shortfall

California's improving economic circumstances and 2024-25 budget solutions (ex. program reductions, reserve withdrawals, internal borrowing, fund shifts, programmatic delays, and deferrals) were sufficient to fully eliminate the shortfall

In 2025-26, California is expected to have a modest surplus of approximately $16.5B in additional revenue above the 2024 Budget Act

Return to Agenda

Healthcare

$296.1B ($83.7B GF) is allocated for CalHHS

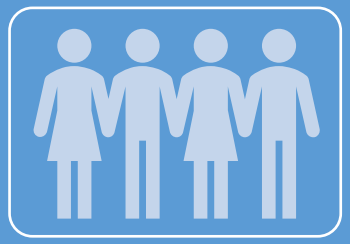
$188.1B ($42.1B GF) is allotted for the Medi-Cal delivery system in 2025- 26

The Administration has opted to increase Medi-Cal GF spending by $7.1B in 2025-26 compared to the 2024-25 GF enacted budget allocations ($35B).

The increase in GF expenditures illustrate how Medi-Cal remains a priority for the Administration

Return to Agenda

Medi-Cal



The January proposal anticipates that Medi-Cal will cover around 14.5M Californians in 2025-26 which is a 0.5B reduction compared to the 2024-25 Medi-Cal caseload (~15M enrollees)

The Administration does predict an increase in Medi-Cal beneficiaries with higher needs and associated costs

In Ventura County, Medi-Cal continues to cover approximately 30 percent of all residents

Return to Agenda

Medi-Cal Key Initiatives

Some initiatives that the Administration seek to implement and/or expand in the 2025-26 budget include:

- Behavioral health transformation;
- Managed care organization (MCO) tax and Prop 35 changes;
- Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)

Return to Agenda

Takeaways and Next Steps

Despite California's improving economic circumstances, the state remains uninterested in pursuing new programs, services, or initiatives in order to protect against future budget shortfalls

The state continues to invest in the Medi-Cal delivery system and maintaining core services

The Administration will release their updated budget in May (termed the "May Revise"). The Legislature has until June 15 to approve the budget

Return to Agenda

AGENDA ITEM NO. 5

TO: Community Advisory Committee (CAC)

FROM: Marlen Torres, Chief Member Experience & External Affairs Officer

DATE: January 28, 2025

SUBJECT: Expansion Population Outreach Strategies Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

Adult Expansion: Health Risk Assessments

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Adult Expansion: Health Risk Assessments

January 28, 2025

Marlen Torres
Chief Member Experience & External Affairs Officer

Adult Expansion – HRAs

Completed 4,555 HRAs for 26-49 Yrs

Completed 958 for 50+ Years

Referrals made to Care Management, Enhanced Care Management, and Health Education

Total Active Members 26-49 Expansion Population – 19,886

HRA Summary Statistics

22.3% OF MEMBERS IN **FAIR OR POOR HEALTH**

ONLY 43.6% OF MEMBERS **ALWAYS** GET THE CARE THEY NEED

7.7% OF MEMBERS HAD BEEN TO THE **ER OR HOSPITAL** IN THE PAST 30 DAYS

12.2% OF MEMBERS COULD USE **A LITTLE OR A LOT MORE** HELP WITH ACTIVITIES OF DAILY LIVING (ADLS)

13.5% OF MEMBERS HAVE **DIFFICULTY CONCENTRATING, REMEMBERING OR MAKING DECISIONS** BECAUSE OF A PHYSICAL MENTAL OR EMOTIONAL CONDITION

11.6% OF MEMBERS SCREENED AT RISK FOR MAJOR DEPRESSIVE DISORDER ON THE **PHQ-2**

Return to Agenda

HRA Summary Statistics

18.3% of Members have an unstable living situation

53.5% of Members were sometimes or often worried they would run out of food

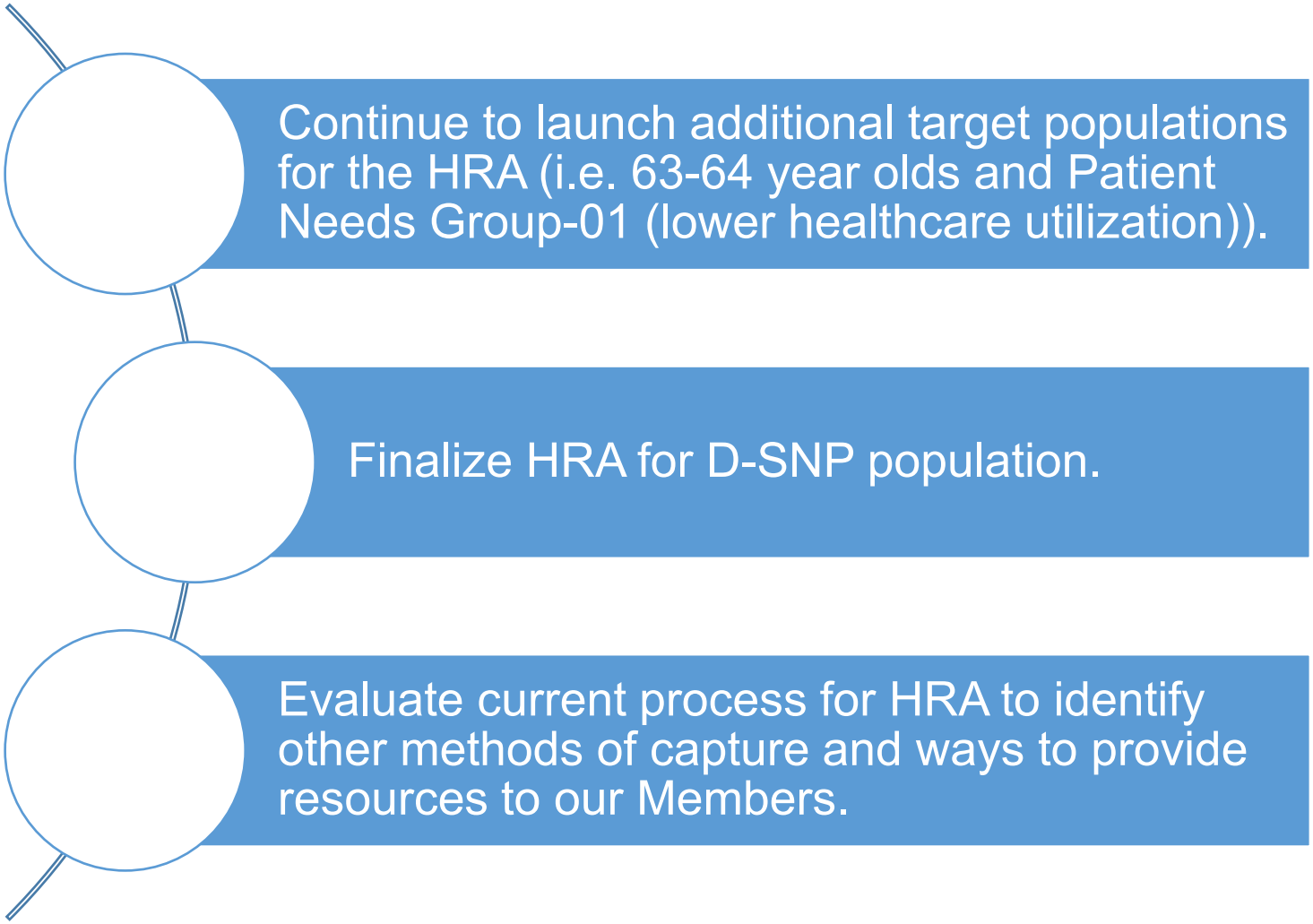
16.4% of Members had a transportation barrier

4.5% of Members were rarely, sometimes, fairly often, or frequently physically hurt by a family member or friend

47.3% of Members have seasonal or migrant farm work as their main source of income

Return to Agenda

HRA Plan for 2025



Return to Agenda

AGENDA ITEM NO. 6

TO: Community Advisory Committee (CAC)

FROM: David Tovar, Incentive Strategy Manager

DATE: January 28, 2025

SUBJECT: Implementation Update: Justice Services

PowerPoint with Verbal Presentation

ATTACHMENTS:

Justice Services Update

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Justice Services Update

David Tovar
Incentive Strategy Manager

Return to Agenda

711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

Justice Services

- GCHP continues to meet with our correctional facility partners the Ventura County Sheriff's Office and the Ventura County Probation Agency.
  - GCHP will work closely with partner to assist in the development of their readiness plans which are due to DHCS 180 days before their go live date.
    - Ventura County Sheriff's Office's intendeds launch on 10/1/2026
    - Ventura County Probation Agency intends to launch on 4/1/2026
- GCHP has onboarded its new Justice Involved ECM Provider, Interface Children and Family Services.

Return to Agenda

Questions?

Return to Agenda

AGENDA ITEM NO. 7

TO: Community Advisory Committee (CAC)

FROM: Guadalupe González, PhD, MPH, Sr. Director, Health Education, Cultural and Linguistic Services

DATE: January 28, 2025

SUBJECT: Diversity, Equity, and Inclusion (DEI) Curriculum Training Program Update

PowerPoint with Verbal Presentation

ATTACHMENT:

HECL_DEI Training Program Update_CAC_02282025

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Community Advisory Committee (CAC) Diversity, Equity, and Inclusion (DEI) Curriculum Training Program Update

January 28, 2025

Guadalupe González, PhD., MPH
Sr. Director of Health Education,
Cultural and Linguistic Services

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Agenda

- ❑ Diversity, Equity, and Inclusion (DEI) Curriculum Training Program Update
- ❑ DEI Training Videos Feedback and Recommendation:
  - Video #1: Discrimination Prevention
  - Video #2: Understanding Diversity, Equity and Inclusion
- ❑ DHCS DEI Program Curriculum Development and Training Program 2025:
  - Training Timeline
  - Training Modules
- ❑ Questions

Return to Agenda

DEI Curriculum Training Program Update

- DEI Training Videos Feedback:
  - Community Advisory Committee
  - CalAIM Advisory Committee
  - GCHP Internal Staff

    ✓ A total of 31 members were surveyed.

    ✓ Fourteen (14) responses received.

- Overall, the respondents indicated that the videos were helpful in designing and building the GCHP DEI training program.

- One respondent indicated that the videos did not cover structural racism. GCHP will supplement the training videos with a slide presentation on structural racism.

Return to Agenda

DEI Training Video #1: Feedback – Additional Comments or Suggestions

Video #1: Culture Series – Discrimination Prevention

- "Society has come a long way with growing Generations in our community. It's nice to keep up with cultures and race in this world we live in."
- "The video is a source of information for the training program, the video describes and explains in simple easy terms to understand how to better the work environment. I was able to understand and comprehend what was being discussed in the context of the video."
- "The conceptual framework of Diversity, equity, and inclusion (DEI) has been presented well in this training presentation. Understanding DEI doesn't have to be difficulty. The presentation was well thought out and the visuals help me to understand this framework with clarity."
- "Overall it was very informative."
- "I found the scenarios videos useful and easy to understand the message."
- "It does a good job at identifying discrimination. It provides real-life scenarios to apply the concepts of discrimination. Very easy to follow but still insightful."
- "The videos refer the viewer to check "discriminatory laws in your country". It should provide them or at least a reference link where they can be accessed."
- "The videos were helpful in building the DEI training curriculum for onboarding and one response indicated that "I don't recall hearing about structural racism."

Return to Agenda

DEI Training Video #2: Feedback – Additional Comments or Suggestions

Video #2: Understanding Diversity, Equity and Inclusion

- "It's too bad I wasn't given these videos when I started with the County of Ventura, things would have been much better."
- "The layout of this presentation was friendly to the eye and visuals help to understand what was being presented. I request we have more training visuals just like this one."
- "It was very informative."
- "I really enjoyed the video clips."
- "The training does a great job at breaking down each component of DEI. It provides an explanation as to what each is and how it applies to everyone. It shows the difference between equity and equality. It also explains how all three components affect one another and are needed for an inclusive environment.t"
- "More useful scenarios."
- "Good videos."
- "All good."

Return to Agenda

2025-26 DEI Training Implementation Timeline

Phase 1: January 1, 2025 – Training Development

January 1, 2024 – July 1, 2024: **Completed**

Assess specific needs for the servicing regions, biases, and member experiences.

July 1, 2024 – December 31, 2024: **Completed**

Begin to develop DEI training program.

DEI Training Curriculum Program submission to DHCS for review and approval.

Phase 2: By January 1, 2026 – Training Completion

January 1, 2025 – July 1, 2025:

GCHP to begin to pilot the DEI Training Program.

Assess and address issues/concerns learned from the pilot.

July 1, 2025 – December 31, 2025:

Training completion for all GCHP staff, contractors, subcontractors, downstream subcontractors, and Network Providers

Return to Agenda

DEI Curriculum Development and Training Plan

- **Module 1:** Language Assistance Services and Workforce Diversity
- **Module 2:** Overview of GCHP Membership
- **Module 3:** Addressing Special Populations and Health Care Needs
- **Module 4:** Health Related and Social Needs – Resources

Return to Agenda

Questions or Comments?

Return to Agenda