Gold Coast Health Plan℠
A Public Entity

Quality Improvement and Health Equity Transformation Program 2025

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.

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II. MISSION, VISION, VALUES, AND MODEL OF CARE

Mission

The Quality Improvement and Health Equity Transformation (QIHET) Program is designed to support Gold Coast Health Plan's (GCHP) mission to improve the health of our members through the provision of high-quality care and services. Our member-first focus centers on the delivery of exceptional service to our beneficiaries by enhancing the quality of health care, providing greater access, and improving member choice. In line with that goal, GCHP's QIHET Program defines the processes for continuous quality improvement of clinical care and services, patient safety, and member experience, provided by GCHP and its contracted provider network and community partnerships, through its commitment to improving and sustaining its performance through the prioritization, design, implementation, monitoring, and analysis of performance improvement initiatives with a specific focus on health equity.

GCHP is a community-based health plan. The primary purpose of our work and the fundamental principle that guides us in how we do that work is better health for our members and community. Core values of the program include advancing the health of the community by reducing health inequity, and maintaining respect and diversity for members, providers, and employees.

Vision

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

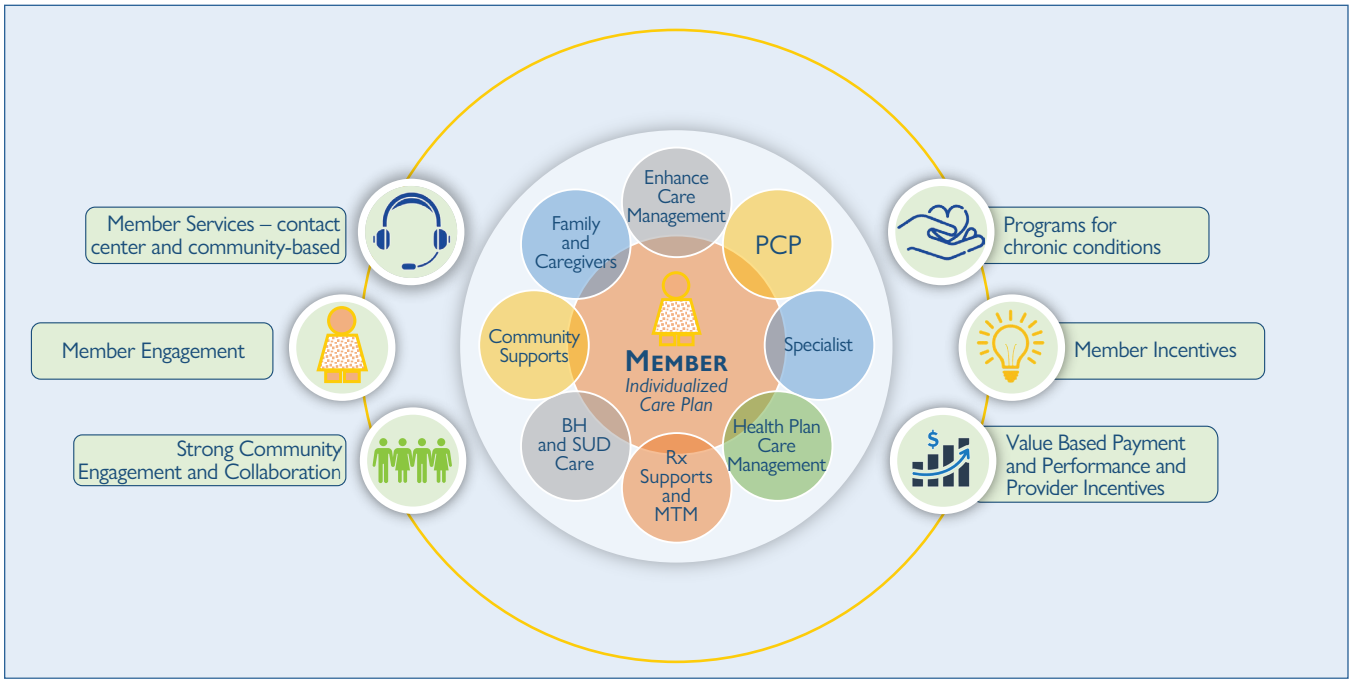
Values

The QIHET Program supports the organization's values of:

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

Model of Care

Our Model of Care is built to meet the unique needs of our members and our community through deep understanding of needs and preferences. By providing the care and services to meet those needs and preferences through internal programs and partnerships with providers and community-based service delivery organizations, we achieve high quality of care and services, as measured by the DHCS Managed Care Accountability Set (MCAS), the National Committee of Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), the Centers for Medicare and Medicaid (CMS) Core Measures for Medicaid, the Consumer Assessment of Health Plans and Systems (CAHPS®), as well as other standard quality measures.



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

III. PURPOSE AND SCOPE

The purpose of the Gold Coast Health Plan (GCHP) Quality Improvement and Health Equity Transformation (QIHET) Program is to achieve the **best health possible, best access possible to equitable, quality health care, and superior experience for the members and communities we serve** in accordance with the state's mission to preserve and improve the health of all Californians. The QIHET Program provides the framework for GCHP to:

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

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

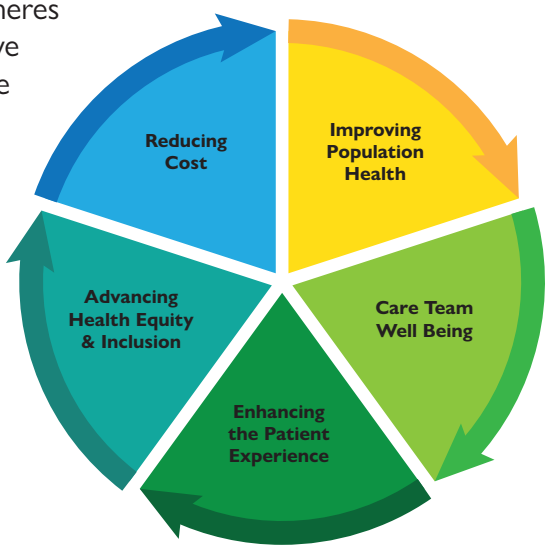
The DHCS Comprehensive Quality Strategy is anchored by three linked goals:

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.

Quintuple Aim

The Institute for Healthcare Improvement's Quintuple Aim adheres to the concept that healthcare quality improvement should have five aims with connectivity between all the points. The aims are synergistic, build upon one another, and are interdependent. In alignment with the quintuple aim, the eight priorities of the Quality Strategy are to:

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



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The QIHET Program consists of the following elements:

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

The QIHET Program will ensure that all medically necessary covered services are available in a culturally and linguistically appropriate manner and are accessible to all members regardless of race, color, national origin, ethnic group identification, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, medical condition, physical or mental disability, or identification with any other persons or groups identified in Penal Code 422.56.

The scope of the QI process encompasses the following:

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

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

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

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

IV. AUTHORITY AND RESPONSIBILITY

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

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

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

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

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6. Pharmacy & Therapeutics (P&T) Committee
7. NCQA Key Stakeholder Forum
8. MCAS Operations Steering Committee
9. Behavioral Health Quality Subcommittee

To further support community involvement and achieve the GCHP's QI goals and objectives, the VCMMCC organized four committees in addition to the QIHEC reporting directly to them. To ensure that these community advisory bodies reflect the diversity of the Plan's community, GCHP attempts to include representation by individuals who comprise 5% of the racial, ethnic and linguistic groups within the community. GCHP makes every attempt to recruit members through mail, newsletters, and social media. GCHP assesses the composition of these community advisory committees on an annual basis in the annual evaluation and makes enhancements as needed.

1. Community Advisory Committee (CAC)
2. Provider Advisory Committee (PAC)
3. Member Advisory Committee (MAC)
4. CalAIM Advisory Committee (CalAIM)

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

GCHP is governed by the 12-member VCMMCC. Commission members are appointed for two- or four-year terms, and member terms are staggered. The VCMMCC is comprised of locally elected officials, providers, hospitals, clinics, the Ventura County Healthcare Agency, and consumer advocates.

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

V. QIHET PROGRAM GOALS AND OBJECTIVES

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

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

The QIHET Program goals include:

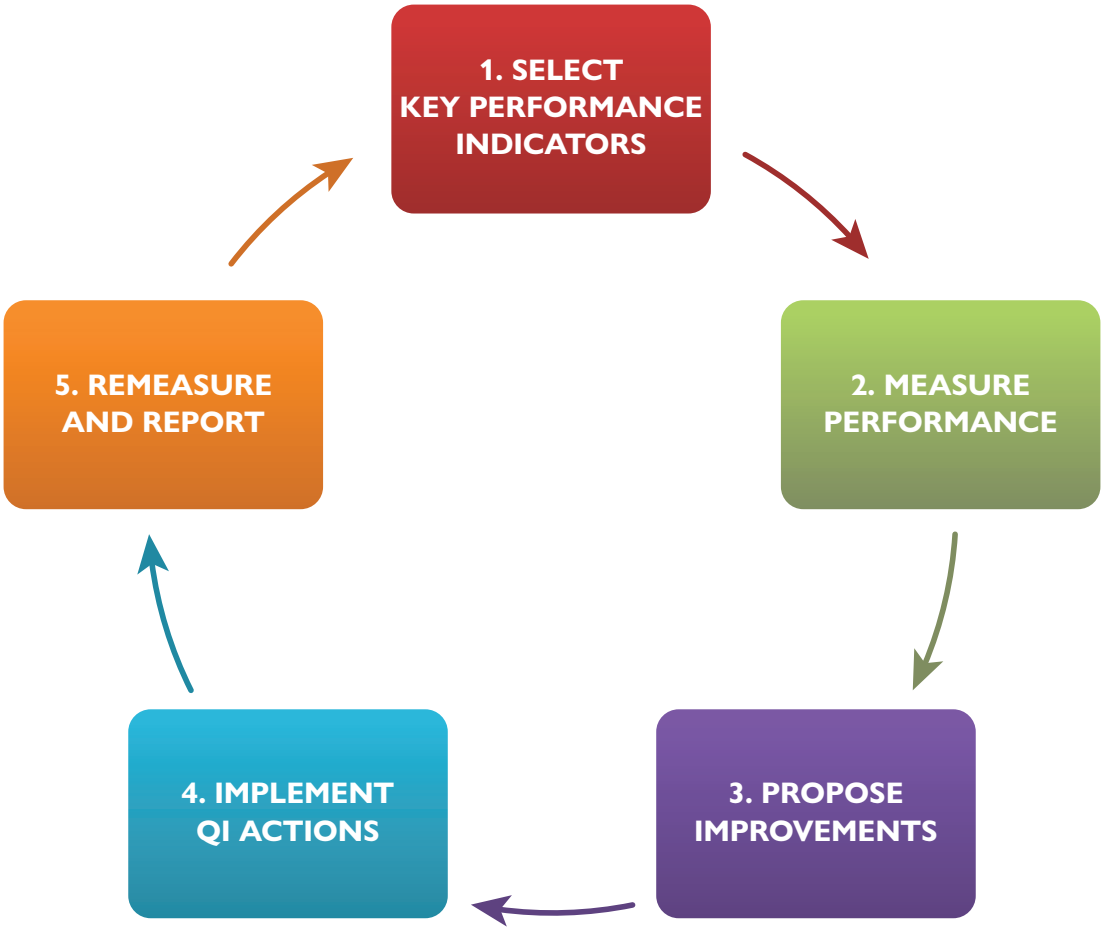
- Develop and maintain QIHET resources, structure, and processes that support the organization's commitment to equitable and quality health care for our culturally and linguistically diverse members.
- Coordinate, monitor and report QIHET activities.
- Develop effective methods for measuring and reporting the outcomes of care, including health disparities and services provided to members.
- Identify opportunities and make improvements based on measurement, validation, and interpretation of data.
- Continuously improve the quality, equity, appropriateness, availability, accessibility, coordination, and continuity of both physical and mental/behavioral healthcare 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 and ethnic and cultural concordance.
- Provide oversight of delegated entities to ensure compliance with GCHP standards as well as state and federal regulatory requirements.

The Program Objectives include the following:

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

VI. QIHET PROGRAM METHODOLOGY

GCHP utilizes industry-standard quality improvement tools such as the Plan-Do-Study-Act (PDSA) Cycle methodology, Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis, Fishbone Diagrams, etc. to test the effectiveness of interventions aimed at improving the quality of care and services. Overall, GCHP focuses 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 QIHET Program is based on the latest available research in quality improvement and health equity. At a minimum, it includes a method of monitoring, analysis, evaluation, and improvement in delivering high-quality, equitable care and service. The QIHET Program involves tracking and trending of quality indicators to ensure measures are reported, outcomes are analyzed, and goals are achieved. Contractual standards, evidence-based practice guidelines, and other nationally recognized sources (CAHPS®, HEDIS®, CMS Core Set for Medicaid) may be utilized to identify performance / metric indicators, standards, and benchmarks. Indicators are objective, measurable, and based on current knowledge and clinical experience (as applicable).

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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
  - Behavioral / mental health
  - Health disparities and inequities
  - Social drivers of health

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

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

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

Health Equity

The health of our members and our community drives our work.

Gold Coast Health Plan (GCHP) is committed to diversity, equity, and inclusion (DEI) to maintain high-quality, equitable, and affordable healthcare for all Medi-Cal members, their families and their community. Therefore, GCHP's Quality Improvement and Health Equity Transformation (QIHET) Program will continue to focus on community health, improving health equity by work we do within the health plan and with our provider and community-based partners. Lifting the health of our community, lifts the health of our members and reduces the inequities that exist today as well as addresses the structural barriers to equity in the future. GCHP develops programs and interventions using the foundational architecture of community health, health equity, and quality improvement theory which drive system transformation and innovation. In order to do so, GCHP's 2025 QIHET Program includes a focus on whole-person care through partnerships with members, providers, community-based organizations, schools, public health agencies, outside counties, and other health care systems. Specifically, improving member SOGI and RELD data, analyzing health care utilization and performance metrics, and engaging members and the community for recommendations and input in the development of policies and interventions to address disparities. Additionally, GCHP prioritizes improving access to services and developing community support strategies for at-risk populations and those populations experiencing health disparities with an emphasis on children's preventive care, maternal health outcomes, and behavioral health.

Inclusion, Diversity, and Non-Discrimination

GCHP assigns members to Primary Care Providers (PCPs) and follows state and federal civil right laws. GCHP does not unlawfully discriminate, exclude members or treat them differently because of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. All contracted network providers, subcontractors, and downstream subcontractor 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.

Assessment of Equitable Access to Covered Services

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

- Review of member complaints and grievances including those related to culturally and linguistically appropriate level of care.
- Timely access to language assistance services for all medical and non-medical services.
- Provision of written materials in threshold language and non-threshold languages upon request, alternative formats, auxiliary aids, and services for members with visual impairments or other disabilities to ensure effective communication.

- Conducting a Population Needs Assessment as defined by DHCS.
- Provision of Cultural Competency Training for both providers and GCHP staff, and contract provider vendors. Conduct oversight of subcontract's Cultural Competency Training.
- Conducting surveys of members to determine if culture and language needs are met by providers
- Provision of diversity, equity, inclusion (DEI) training including sensitivity, communication skills, cultural competency/humility, and Seniors and Persons with Disabilities (SPD) sensitivity to network providers, subcontractors, and downstream subcontractors and GCHP staff.
- Assessment of provider and provider staff members' linguistic capabilities.
- Assessment of GCHP staff language capabilities for direct communication with members.
- Conduct readability and suitability of member informing materials set by DHCS regulations.
- Engage feedback and advice from the community advisory bodies regarding culturally and linguistically appropriate services and programs.
- Assessment of committee members to ensure that community advisory bodies reflect the diversity of the Plan's community and membership.
- Assessment of systems and activities that promote high quality and equitable services for members.
- Assessment of resources dedicated to addressing health disparities.

VIII. PROGRAM ORGANIZATION, OVERSIGHT, RESOURCES, AND EVALUATION

ORGANIZATION AND OVERSIGHT

Chief Medical Officer

The Chief Executive Officer has appointed the Chief Medical Officer (CMO) as the designated physician to support the QIHET Program by providing leadership, oversight, and management of quality improvement activities and has overall responsibility for the clinical direction of GCHP's Quality Improvement and Health Equity Transformation (QIHET) Program.

Chief Innovation Officer

The Chief Innovation Officer (CIO) is responsible for driving the execution of wide-reaching, complex, and cross-functional work plans and performance improvement initiatives in partnership with the health plan's CEO and Executive Team. The CIO reports directly to the CEO and is a member of GCHP's Executive Team. The CIO provides visioning and leadership of processes and practices for Executive / Leadership Team engagement in – and ownership of – goals / workplans / priorities, communications on goals/workplans/priorities, Operating Reviews and Status Reports, and performance reporting to innovate the company.

Executive Director of Health Equity

The Chief Executive Officer has appointed the Executive Director of Health Equity as the designated executive authority to provide health equity expertise to support the QIHET Program by providing leadership, oversight, and management of quality improvement and health equity activities. The Executive Director of Health Equity reports to the Chief Medical Officer and operates as the Health Equity Officer (HEO). The Executive Director of Health Equity partners with other leaders to guide the organization's commitment and strategy to be a diverse, equitable, and inclusive (DEI) organization with a primary emphasis on developing and implementing strategies to address health disparities and promote equity within GCHP's membership, by overseeing programs, policies, and practices that ensure equitable access to quality healthcare for all members, particularly those within underserved communities.

QIHET PROGRAM RESOURCES

Multidisciplinary Staff

Resources for the QIHET Program come from various department staff in addition to the leadership roles described above.

Support for improvement initiatives related to population health, behavioral health, care management, utilization/risk management, culturally and linguistically appropriate services, and other clinical process improvement and outcome measures are provided by Health Services, Population Health, Health Education/Cultural Linguistics, Information Technology, 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 are supported by Provider Network Operations staff.

Credentialing and peer review functions are supported by Provider Network Operations.

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

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

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

Further description of the QIHET Program's multidisciplinary resources and responsibilities are included in Attachment 1.2025 QIHETP Resources.

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

- Online Member Administration Support – provider directories, health plan benefit summaries, drug formularies and claim forms
- Online Provider Resources – providers have access to a For Providers webpage on GCHP's website with access to eligibility and benefit look-up, claims submittal, formulary information, forms and resources.
- Online Member Education and Engagement Resources – members have access to the For Members webpage on GCHP's website that includes information on health and wellness services, and comprehensive clinical information in the online Health Library.
- Online Data for performance metrics – providers have access to Inovalon's Data Insights® Quality Performance dashboards which offer visualization and customization capabilities that enable measurement of performance against benchmarks and identification of gaps in care
- Quality Performance Reports – providers receive a customized report on at least an annual basis indicating their quality performance compared to GCHP's overall quality performance as well their peer providers.

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, measurement sets, and benchmarks 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, and Quality Compass®.
- Government issued laws, regulations and guidance including those from DHCS, CMS, the U.S. Preventive Services Taskforce (USPSTF), and National Institutes of Health (NIH).
- Healthcare Quality Improvement Organizations such as the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), the National Association for Healthcare Quality (NAHQ), the Agency for Healthcare Research and Quality (AHRQ), and 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).

Data, Information, and Analytics Support

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

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

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HEDIS® Certified Software

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

- Enrollment and demographic data, including race, ethnicity, and language preference data
- Claims data
- Encounter data
- Laboratory data
- Immunization registry data
- Electronic Health Record and Health Information Exchange data
- Medical Record data
- DHCS Supplemental data
- Medi-Cal Dental Program data
- Medi-Cal Rx pharmacy data
- Provider data

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

Quality Improvement and Health Equity Transformation (QIHET) Program and Culturally and Linguistically Appropriate Services (CLAS) Program Evaluations

Written evaluations of the QIHET and CLAS Programs are completed annually. These annual reports include comprehensive assessments of the quality improvement and health equity activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the QIHET and CLAS programs, including but not limited to the results of performance measures, health equity, outcomes/findings from Performance Improvement Projects (PIPs), consumer and provider satisfaction surveys, and the quality review of services rendered. The analysis includes a review and revision of the QIHET and CLAS Program Descriptions, evaluation of the prior year's QIHET Work Plan and CLAS Work Plan, and the development of the current year's QIHET Work Plan and CLAS Work Plan to ensure ongoing performance improvement.

The Evaluations are reviewed and approved by the QIHEC and VCMMCC and includes the following:

- A description of completed and ongoing activities that address quality, equity, and safety of both physical and mental / behavioral healthcare provided to GCHP members, including trended measures and an analysis of barriers to success.
- A description of completed and ongoing activities that address service quality and the experience of care for GCHP members, including trended measures and an analysis of barriers to success.

- Analysis and evaluation of the overall effectiveness of the QIHET and CLAS Programs (QIHEC committee and sub-committee structures, QI program resources, practitioner participation and leadership involvement), including progress toward influencing network-wide clinical practices, population health needs, health disparities, and addressing the cultural and linguistic needs of GCHP members.
- Recommendation for restructure or changes to the QIHET and CLAS Programs for the subsequent year to improve effectiveness as appropriate.

IX. ANNUAL QIHET WORK PLAN

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

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

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

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

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

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

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

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

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

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

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

Quality Improvement and Health Equity activities that evaluate GCHP's ability to serve a culturally and linguistically diverse membership may include, but are 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 intervention implementation and monitoring

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

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

Communication and Feedback

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

X. QUALITY COMMITTEES AND SUBCOMMITTEES

Gold Coast Health Plan's Quality Committees and Subcommittee Structure consists of nine subcommittees each reporting up to the Quality Improvement Committee. The Quality Improvement and Health Equity Committee (QIHEC) then reports directly to the Ventura County Medi-Cal Managed Care Commission (VCMCC) as the overseeing body for quality within Gold Coast Health Plan. In addition to the QIHEC, the VCMCC oversees the Provider Advisory Committee (PAC), Community Advisory Committee (CAC), Member Advisory Committee (MAC), and the CalAIM Advisory Committee. The PAC, CAC, MAC, and CalAIM Advisory Committee function to support quality improvement and health equity activities by engaging with community stakeholders regarding QI activities, however each reports directly to the VCMCC.

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

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

i. Quality Improvement and Health Equity Committee (QIHEC)

The QIHEC is the principal organizational unit that has been delegated authority to monitor, evaluate, and report to the VCMMCC by the VCMMCC on all component elements of the GCHP Quality Improvement and Health Equity Transformation Program. The QIHEC shall have a minimum of eight voting members and be chaired by the GCHP Chief Medical Officer (CMO) in collaboration with the Executive Director of Health Equity (HEO) and facilitated by the Sr. QI Director.

Membership consists of the chairs of the nine QIHEC Subcommittees, and at least one Commissioner, and at least one practicing physician in the community, and a behavioral health care practitioner.

Network Providers, delegated subcontractors, and downstream subcontractors participating in the QIHEC will represent the composition of the GCHP Provider Network and include, at a minimum, Network Providers, delegated subcontractors, and downstream subcontractors who provide health care services to:

- Members affected by Health Disparities
- Limited English Proficiency (LEP) Members
- Children with Special Health Care Needs (CSHCN)
- Seniors and Persons with Disabilities (SPDs).
- Persons with chronic conditions

The QIHEC shall meet six times per year. Ad hoc committees, however, will meet on an as needed basis. The QIHEC will critically examine and make recommendations on all quality and equity functions of GCHP described in this program and by California and Federal regulatory authorities as appropriate.

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

An annual QIHET Report is submitted to the VCMMCC addressing:

- Quality improvement and health equity activities such as:
  i. Utilization Reports
  ii. Review of the quality of services rendered
  iii. MCAS / HEDIS® / CMS Core Set for Medicaid results
  iv. Quality Improvement Projects and initiatives - status and/or results
  v. Health Equity Projects and initiatives – status and/or results
  vi. Satisfaction Survey Results
  vii. Collaborative initiatives both internally and externally – status and/or results

- Success in improving patient care and outcomes, health equity, and provider performance.
- Opportunities for improvement.
- 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 External Quality Review Organization (EQRO).
- Effectiveness in performing quality and health equity management functions.
- Reporting and achievement of goals and objectives through quality and health equity monitoring and improvement programs.
- Presentation of the QIHET Work Plan including recommendations for revision identified as a result of the review.

QIHEC Objectives:

- Ensure communication processes are in place to adequately track work plan and QIHET activities and enable system-wide communication as well as closing the loop when issues are resolved.
- Ensure QIHEC members can have a candid discussion about barriers to achieving quality goals and objectives, and to facilitate the removal of such barriers.

QIHEC Responsibilities:

- Oversees the annual review, analysis, and evaluation of goals set forth by the Quality Improvement and Health Equity Transformation Program as well as GCHP's quality improvement policies and procedures.
- Makes recommendations for implementation of interventions or corrective actions based on results of quality improvement and health equity activities including those recommended by network providers, fully delegated subcontractors, and downstream contractors.
- Facilitates data-driven indicator reviews and development for monitoring key quality management activities, including but not limited to: MCAS/HEDIS®, CAHPS®, Access/Availability, Performance Improvement Projects, Service / Clinical Quality measures, UM/CM metrics, Population Health metrics, Behavioral Health metrics, Credentialing performance, and Delegation Oversight.
- Analyzes and evaluates the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other committees such as the Member Advisory Committee and the Community Advisory Committee.
- Institutes actions to address performance deficiencies, including policy recommendations.
- Ensures appropriate follow-up of identified performance deficiencies.
- Reviews reports from GCHP committees and departments, including quarterly dashboards, key activities and action plans including subcommittee updates, and reports regarding monitoring of health plan functions and activities.

QIHEC Membership:

- Chief Medical Officer (Chair)
- Chief Innovation Officer
- Executive Director of Health Equity
- Sr. Medical Director
- Sr. Director of Quality Improvement
- Sr. Director of Health Education / Cultural Linguistics
- Chief of Member Experience and External Affairs
- Executive Director, Delivery System Operations & Strategies
- Sr. Director of Network Operations
- Director of Pharmacy Services
- Sr. Manager, Population Health
- Chief Compliance Officer
- Sr. Director of Compliance
- Sr. Director of Care Management
- Sr. Director of Utilization Management
- Director, Behavioral Health & Social Programs
- Chief Executive Officer
- Executive Director of Population Health
- Executive Director of Operations
- Director of Operations
- External Practitioner Representatives
- Commissioner
- Carelon (formerly Beacon) Regional Chief Medical Officer Behavioral Health
- Sr. Manager, Quality Improvement

QIHEC Reporting Structure:

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

Meeting Frequency:

The QIHEC meets at a minimum six times per year.

ii. Member Services Committee (MSC)

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

MSC Objectives:

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

MSC Membership:

- Manager of Operations (Chair)
- Sr. Manager of Operations
- Executive Director of Operations
- Director of Network Operations or designee
- Manager of Community Relations Strategy and External Affairs
- Director of Operations or designee
- Director, Member Contact Center or designee
- Sr. Director of Quality Improvement or designee
- Sr. Director of Care Management or designee
- Chief Medical Officer
- Sr. Director of Health Education & Cultural Linguistics or designee
- Director of Communications
- Sr. Director of Compliance or designee

Meeting Frequency:

The MSC meets quarterly at a minimum.

iii. 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 Gold Coast Health Plan 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 and/or equity of care delivered to members.
- Ensure all GCHP departments are educated on the appropriate process for communicating member and provider grievances and/or appeals to the correct area for resolution.
- Ensure that issues needing intervention are reviewed and routed to the appropriate area for discussion and intervention.

G&A Committee Membership:

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

Meeting Frequency:

The committee meets quarterly.

iv. Utilization Management Committee (UMC)

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

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

UMC Responsibilities:

Responsibilities include but are not limited to the following:

- Annual review and approval of the UM and 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 (RNs and MDs) and take appropriate actions for staff that fall below acceptable performance.
- Interface with other GCHP committees for trends, patterns, corrective actions, and outcomes of reviews.

Membership:

- Chief Medical Officer
- Chief Innovation Officer
- Sr. Medical Director
- Sr. Director of Care Management
- Sr. Director of Utilization Management
- Managers of Care Management
- Managers of Utilization Management
- Director of Pharmacy Services
- Physician Reviewers
- Compliance Designee
- Sr. Director of Quality Improvement
- Carelon Regional Chief Medical Officer Behavioral Health

Meeting Frequency:

The UMC meets quarterly at a minimum.

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

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

HE/CL Committee Responsibilities:

- Ensure members have access to appropriate health education materials.
- Ensure Providers have access to health education services and materials, including alternative formats.
- Ensure Providers and GCHP staff deliver culturally and linguistically (C&L) appropriate healthcare services to GCHP's diverse membership.
- Ensure Providers and staff receive training on cultural competency, language assistance, equity, inclusion and/or diversity training.
- Ensure that all members – regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, or language capabilities have equitable access to quality healthcare.
- Ensure that GCHP implements cultural and linguistic requirements set forth by the state Department of Health Care Services (DHCS).
- Advises QIHET's programs and initiatives to include but not limited to RELD and SOGI data collection and usage, provider, members, and community intervention development that addresses disparities, and cultural and linguistic services compliant and grievances analysis and resolution reports.
- Collaborate and work with GCHP's Population Health, Health Services, Quality Improvement, Provider Network Operations, and other departments to ensure health education and cultural and linguistic services needs are addressed.
- Ensure opportunities are available to educate members on the disease process, preventive care, behavioral health, 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 forth by the Department of Health Care Services. The member informing materials shall be at a sixth grade or lower reading level and be consistent with the GCHP's membership needs.
- Educate GCHP staff on specific cultural barriers that might hinder the delivery of optimal health care.

Membership:

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

Meeting and/or Reporting Frequency:

The committee may meet at a minimum quarterly. The quarterly report will be provided via email to committee members if the committee does not meet.

vi. Credentials/Peer Review Committee (C/PRC)

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

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

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 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 informational purposes.
- 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 regarding 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.

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- Establish, implement, and make recommendations regarding policies and procedures.
- The C/PRC provides feedback and advice to the health plan on any aspect of health plan policy or operations affecting network providers or members including the adoption and approval of the following:
  - » Clinical practice and preventive health care guidelines (CPGs/PHGs)
  - » Utilization Management Criteria

Membership:

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

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

Meeting Frequency:

The committee meets quarterly.

vii. Pharmacy & Therapeutics (P&T) Committee

To provide a forum for community and practicing pharmacists, physicians, and Gold Coast Health Plan's (GCHP) Health Services team members to collaborate in the management of the Physician Administered Drugs (PAD) List for GCHP's Medical Drug Benefit for Medi-Cal members and establish evidence-based pharmaceutical management policies and procedures. The P&T Committee is responsible for ensuring GCHP's Members receive high quality, cost-effective, safe, and efficacious medical therapy.

Committee Responsibilities:

- Review PAD List inclusions and exclusions, pharmacy policies and procedures, evaluation of pharmacy benefit quality and utilization data.
- Review and approve all matters pertaining to the use of medication, including development of prescribing guidelines and protocols and procedures, to promote high quality and cost-effective drug therapy.
- Review any other issues related to pharmacy quality and utilization.

Membership:

- Director of Pharmacy Services (Chair) or designee
- Clinical Programs Pharmacist
- Chief Medical Officer

- Sr. Medical Director or Medical Director
- Physicians and pharmacists representing a variety of clinical specialties.

Meeting Frequency:

The P&T Committee will meet quarterly with ad hoc meetings called by the P&T Committee Chair as needed.

viii. NCQA Key Stakeholder Forum

The purpose of the NCQA Key Stakeholder Forum is to bring key stakeholders together to review NCQA project status, risks, progress with remediation, and next steps. The goal is to support open communication and partnership between Operational Business Teams and the Enterprise Project Management Office (EPMO) in support of achieving NCQA Accreditation.

NCQA Key Stakeholder Forum Scope:

- NCQA Health Plan Accreditation
- NCQA Health Equity Accreditation

NCQA Key Stakeholder Forum Objectives:

- Review NCQA remediation progress status and dashboard
- Discuss risks, issues, and key dependencies
- Review timelines and upcoming milestones
- Share communications and project updates from The Mihalik Group (TMG)
- Provide an open forum for discussion of project feedback, constraints, and ideas sharing

NCQA Key Stakeholder Forum Membership:

- Senior Project Manager (Chair)
- Chief Innovation Officer
- Chief Medical Officer
- Executive Director of Health Equity
- Chief Policy and Program Officer
- Chief Diversity Officer
- Executive Director, Operations
- Executive Director, Population Health
- Sr. Medical Director
- Sr. Director, Quality Improvement
- Sr. Director, Care Management
- Sr. Director, Utilization Management
- Sr. Director, Health Education & Cultural Linguistics
- Sr. Director, Compliance

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- Sr. Director, Network Operations
- Director, Operations
- Director, Communications
- Director, Pharmacy
- Director, Behavioral Health & Social Programs
- Director, IT Infrastructure and Security Operations
- Sr. Manager, CM & Special Programs
- Sr. Manager, Population Health
- Sr. Manager, Quality Improvement
- QI Program Manager II
- Key business owners and/or departmental representatives from:
  - Human Resources
  - Pharmacy
  - Credentialing
  - Information Technology
  - Communications
  - Health Education and Cultural Linguistic Services
  - Population Health
  - Provider Network Operations
  - Quality Improvement
  - Behavioral Health
  - Utilization Management
  - Case Management
  - Compliance
  - Operations
  - Member Services

Meeting Frequency:

The committee meets monthly (with ad hoc meetings added per business needs).

ix. MCAS Operations Steering Committee

The Managed Care Accountability Set (MCAS) Operations Steering Committee functions as a subcommittee of and reports directly to the Quality Improvement and Health Equity Committee (QIHEC). The QIHEC reports directly to the Ventura County Medi-Cal Managed Care Commission (VCMCC), which is responsible for the implementation and maintenance of the QIHEC as the overseeing body for quality within Gold Coast Health Plan.

MCAS Operations Steering Committee Objectives:

The role of the MCAS Operations Steering Committee is to align and drive the organization's strategy and initiatives around MCAS, including but not limited to, prioritization, goals, work plans, and performance tracking. The MCAS Operations Steering Committee serves to ensure effective communication processes are in place to adequately track progress toward work plan activities, provide a platform for candid

discussions around barriers to achieving MCAS goals, and create pathways for escalation of performance issues, operational / financial / regulatory risks, and fleeting opportunities.

MCAS Operations Steering Committee Responsibilities:

- Holds overall oversight of the MCAS project.
- Facilitates efforts to align, integrate and focus the organization on MCAS goals, workplans, and priorities.
- Reviews measure performance, plan-level comparisons, and future projections in order to develop MCAS performance targets (e.g., MPL, 75th percentile, HPL,).
- Identifies and prioritizes disparities goals to uplift health outcomes.
- Raises and expands awareness, understanding, and application of the use of metrics to drive performance measures and key results.
- Establishes consensus around budgetary priorities to drive MCAS improvement.
- Removes barriers, advances decision-making, and resolves conflicts.
- Celebrates small wins early and often and ensures continuous improvement by acknowledging and incorporating lessons learned from intervention success or those that achieved limited impact.

MCAS Operations Steering Committee Membership:

- Chief Innovation Officer
- Chief Medical Officer
- Chief Policy and Program Officer
- Chief Executive Officer, Ex Officio
- Sr. Director, Quality Improvement
- Executive Director of Health Equity
- Executive Director, Population Health
- Executive Director, Operations
- Sr. Director, Care Management
- Sr. Director, Health Education/Cultural Linguistics
- Director, Behavioral Health & Social Programs
- Sr. Director, Network Operations
- Director, Pharmacy
- Clinical Programs Pharmacist
- Director, Medical Informatics
- Sr. Manager, Population Health
- Sr. Manager, Quality Improvement

Meeting Frequency:

The MCAS Operations Steering Committee meets at least monthly.

x. Behavioral Health Quality Committee

The Behavioral Health Quality Subcommittee is attended by both Gold Coast Health Plan (GCHP) and Carelon Behavioral Health Medical and Clinical Leadership and Practitioners to discuss Behavioral Health Network Practitioner Involvement, Medical Practitioner Involvement within the behavioral health scope, review behavioral health measure performance, and elicit provider feedback.

Behavioral Health Quality Subcommittee Objectives:

These meetings are utilized to ensure care coordination and continuity between medical and behavioral health care, to review quality reporting, develop and discuss quality improvement initiatives, and monitor progress towards addressing member care needs.

Behavioral Health Quality Subcommittee Responsibilities:

- Discussion of the data collection process (e.g., MCAS / HEDIS® data).
- Discussion of any potential issues with the data collection process (e.g., data completeness, gaps in encounter data).
- Discussion around identification of potential reasons for low preliminary rates for selected Behavioral Health Continuity and Coordination measures and/or sub measures.
- Collaboration and development of opportunities for improvement.
- Analyze the interventions developed and outcomes.

Behavioral Health Quality Subcommittee Membership:

- GCHP Chief Medical Officer
- GCHP Senior Medical Director
- GCHP Director of Behavioral Health and Social Programs
- GCHP Behavioral Health Manager
- GCHP Behavioral Health Clinician
- GCHP Behavioral Health Program Specialist
- Carelon West Region Medical Officer
- Carelon Behavioral Health Market Director
- Carelon Director of Behavioral Health Services
- Carelon Manager II, Behavioral Health Services
- Carelon Clinical Quality Program Manager

Meeting Frequency:

The Behavioral Health Quality subcommittee meets at least monthly.

XI. QIHET PROGRAM KEY FUNCTIONAL AREAS

Population Health Management

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

- Builds trust with and meaningfully engages members.
- Gathers, shares, and assesses timely and accurate data to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes. This data is provided by or through collaboration with the QI Department.
- Addresses upstream drivers of health through integration with public health and social services.
- Supports all members in staying healthy through development of PHM interventions guided by QIHETP identified focus areas. This is accomplished through the provision of gaps reporting and identification of target populations by QI. Gaps reporting and identification of target populations is completed utilizing GCHP's HEDIS® certified software engine as well as through QI analyses.
- Provides care management services for members at higher risk of poor outcomes.
- Provides transitional care services (TCS) for members transferring from one setting or level of care to another.
- Reduces health disparities.
- Identifies and mitigates Social Drivers of Health (SDOH).
- Ensures the collaborative Population Needs Assessment (PNA), which serves to identify health disparities and implement targeted interventions, is completed to promote a deeper understanding of member needs, particularly social drivers of health, and to deepen relationships between GCHP, public health, and other local stakeholders.

The PHM program instituted use of a Health Risk Assessment (HRA) to better understand the needs of our members. The PHM program includes two behavioral economics programs to incentivize members to engage in healthy behaviors to improve their health and wellness; one focusing on members with multiple chronic conditions and another focusing on members with two or more gaps in care.

The PHM program also works closely with our Community Relations and Care Management (CM) Departments to coordinate and provide self-administered test kit screenings for two MCAS measures (GSD & CHL) at GCHP produced community health fairs. The PHM program is also launching a chronic disease management program targeting diabetic members. GCHP will continue to improve the depth and breadth of services available to our members as we learn more about their needs and characteristics through a data-driven, quality improvement approach.

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

For additional information regarding the PHM Program and Strategy, see Attachment 2. GCHP PHM Strategy 2025.

Care Management

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

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

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

These data sources will be evaluated to develop actionable interventions to meet the care needs of targeted populations including addressing care gaps. GCHP offers Care Management services which includes Non-Clinical Care Coordination, Clinical Care Coordination/Non-complex Case Management and Complex Case Management. Care Management utilizes person centered planning and collaboration with the member and or the member's representative to address the member's stated health and/or psychosocial needs; this process may include the development of an Individualized Plan of Care (IPC). Interventions are tailored in response to the member's assessed needs, preferences, and stated goals. Throughout the care management process, the member's needs based on the member's preference are reassessed, and adjustments are made as needed to provide the appropriate level of care. Care Management team documents care management activities in the Medical Management System.

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

For additional information regarding the Care Management Program, refer to Attachment 3. 2025 Care Management Program Description.

Utilization Management

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

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

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

For additional information regarding the UM Program, refer to the Attachment 4. 2025 Utilization Management Program Description.

Behavioral Health

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

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

For additional information regarding the BH Program, refer to Attachment 5. 2025 Behavioral Health Program Description.

For additional information regarding behavioral health quality, refer to Carelon's 2025 Quality Improvement Program Description.

Culturally and Linguistically Appropriate Services (CLAS) Program

Gold Coast Health Plan is committed to providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This commitment includes advancing and sustaining organizational governance and leadership that promotes Culturally and Linguistically Appropriate Services (CLAS) and health equity. GCHP recruits, promotes, and supports a culturally and linguistically diverse governance, leadership, and workforce that are responsive to members in GCHP's service area. GCHP partners with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Culturally and linguistically appropriate services include:

- Provision of education and training to GCHP leadership and staff in culturally and linguistically appropriate policies and practices on an ongoing basis.
- Ensuring the competence of individuals providing language assistance, specifically recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and non-clinical services.
- Informing all members of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Providing easy-to-understand print and multimedia materials and signage in the GHCP's threshold languages.
- Collection and maintenance of accurate and reliable demographic data to inform service delivery.
- Assessment of community health resources to implement services responsive to identified CLAS needs.
- Engagement of Community Advisory Committee feedback and advice regarding services and program including for cultural and linguistic appropriateness.

Culturally and linguistically appropriate services are monitored through established goals, and ongoing assessment of CLAS-related goals and activities. GCHP's progress in implementing and sustaining CLAS is regularly communicated to all stakeholders, constituents, and the general public via public-facing committees and stakeholder collaborations.

For additional information regarding the CLAS Program, see Attachment 6. 2025 Culturally and Linguistically Appropriate Services Program.

Pharmacy Services

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

Scope:

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

- Utilization Management
- Quality Improvement
- Grievance and Appeals
- Provider Materials / Communications
- Clinical Programs and Services
- Member Services

Pharmacy Services Objectives:

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

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

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XII. DELEGATION OF QUALITY IMPROVEMENT

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

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

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

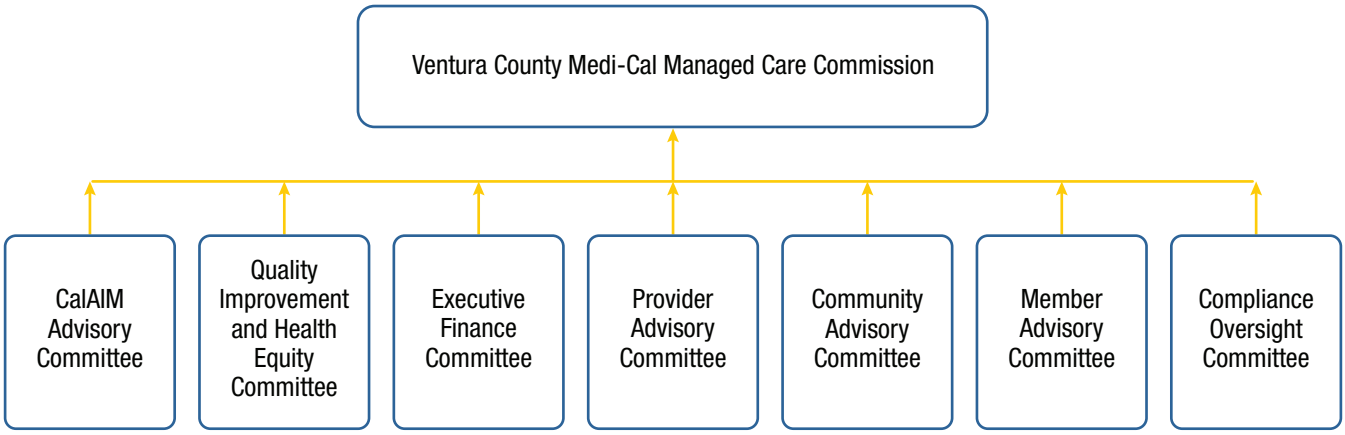
GCHP conducts ongoing oversight, evaluation, and monitoring of the delegate. At a minimum, an annual audit is conducted using an audit tool that is based upon current NCQA, DHCS, and GCHP standards and modified on an as-needed basis. In the event any deficiencies are identified through the oversight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

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

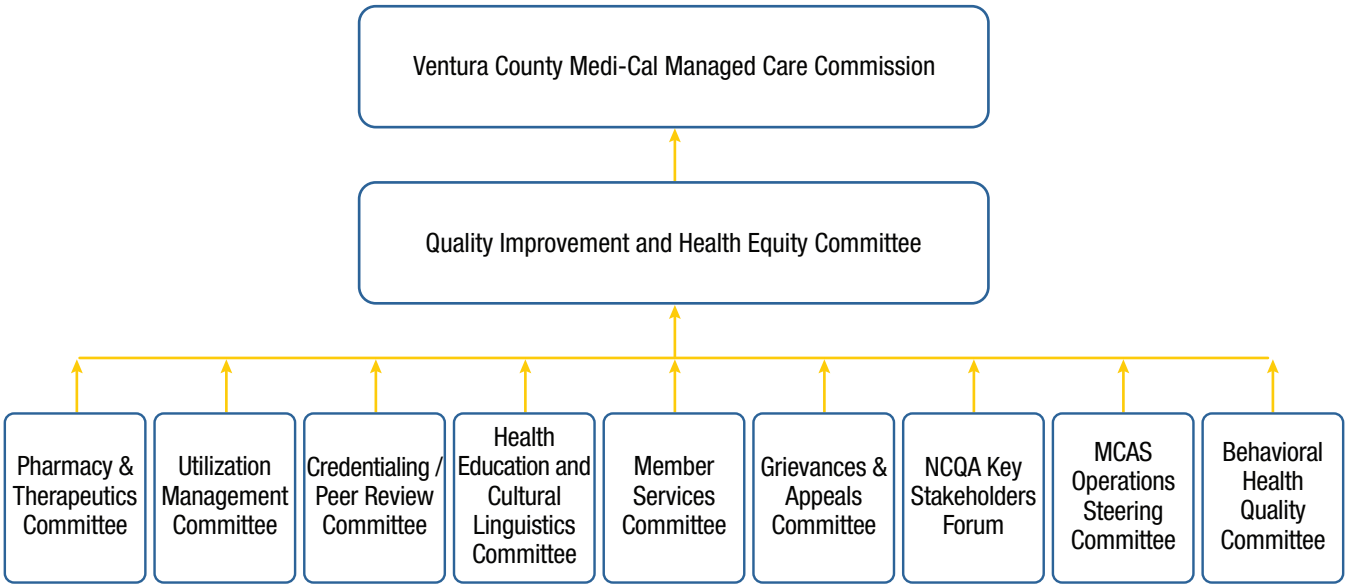
XIII. GOLD COAST HEALTH PLAN QUALITY COMMITTEE ORGANIZATIONAL CHART

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

Ventura County Medi-Cal Managed Care Commission Committee Reporting Structure



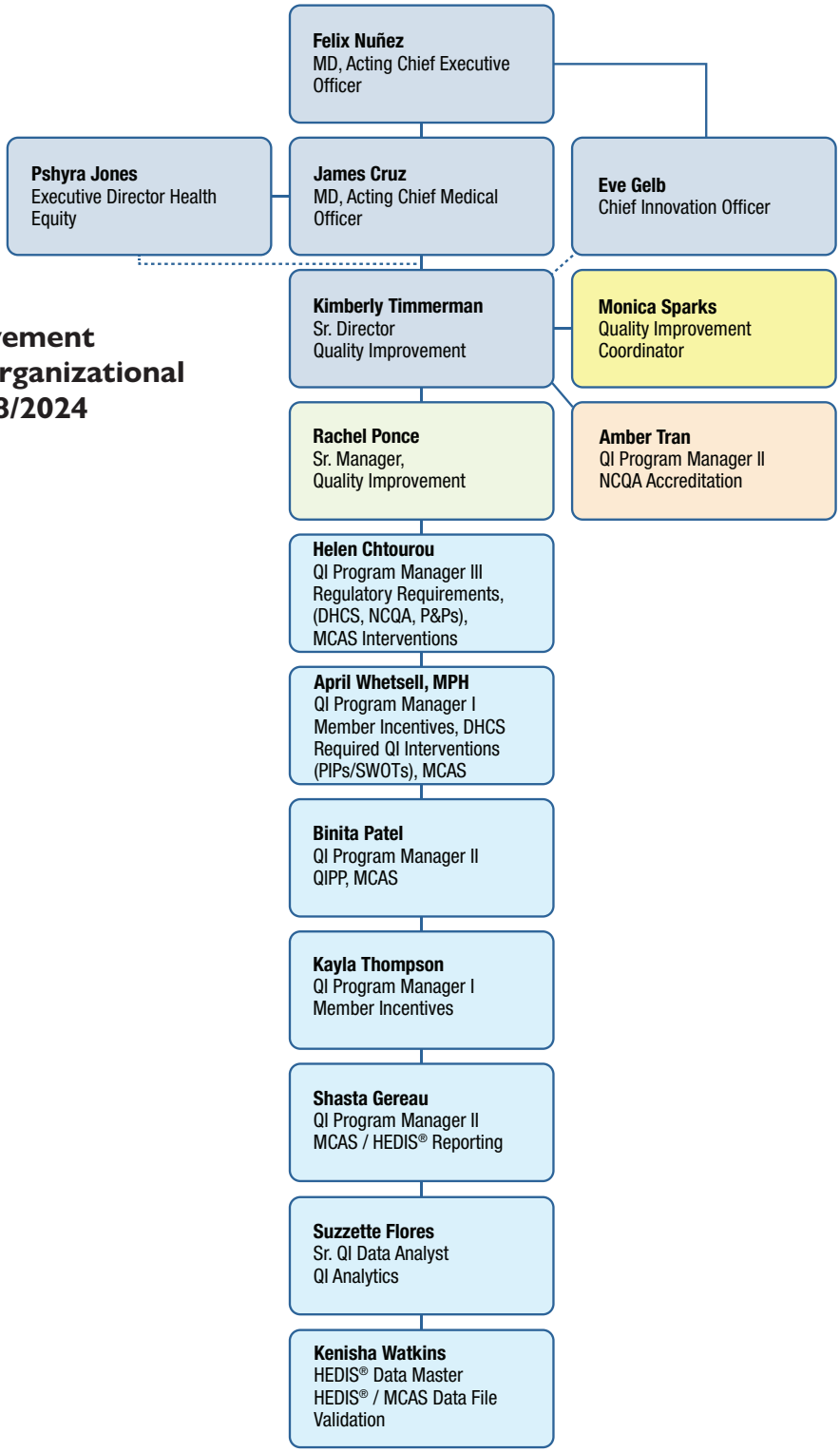
2025 Quality Improvement and Health Equity Committee Reporting Structure



XIV. QUALITY IMPROVEMENT DEPARTMENT ORGANIZATIONAL CHART

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

Quality Improvement Department Organizational Structure 12/18/2024



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XV. QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE MEETINGS FOR CALENDAR YEAR 2025

Dates	
Tuesday	Jan. 21, 2025
Tuesday	March 18, 2025
Tuesday	May 13, 2025
Tuesday	July 15, 2025
Tuesday	Sept. 16, 2025
Tuesday	Nov. 18, 2025
Location: GCHP Community Room 711 E. Daily Drive, Suite 110, Camarillo CA 93010 and via teleconference or web conference (with audio)	

XVI. RESOURCES

Availability of QIHET Program to practitioners and members
The QIHET Program Description is available to practitioners and members on GCHP's website at www.goldcoasthealthplan.org. Printed copies are available upon request.

- The 2025 Quality Improvement and Health Equity Transformation Program Description and Work Plan was approved by the Quality Improvement and Health Equity Committee on Jan. 21, 2025.
- The 2025 Quality Improvement and Health Equity Transformation Program Description and Work Plan were approved by Ventura County Medi-Cal Managed Care Commission (VCMMCC) on Jan. 27, 2025.

References

- Gold Coast Health Plan Quality Improvement and Health Equity Committee Charter
- Gold Coast Health Plan Policy QI-002: Quality and Health Equity Performance Improvement Requirements
- Carelon's 2025 Quality Improvement Program Description
- Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 19-017: Quality and Performance Improvement Requirements
- GCHP DHCS Managed Care Contract 2024, Exhibit A, Attachment III
- HEDIS® - Healthcare Effectiveness Data and Information Set - a registered trademark of the National Committee for Quality Assurance (NCQA)
- CAHPS® - Consumer Assessment of Healthcare Providers and Systems - a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for Health Equity Accreditation
- DHCS Comprehensive Quality Strategy, February 2022
- DCHS California Advancing and Innovating Medi-Cal (CalAIM)
- National Quality Strategy, Agency for Healthcare Research and Quality (AHRQ)
- The Institute for Healthcare Improvement (IHI)
- Patient Protection and Affordable Care Act, Public Law No. 111-148, enacted March 23, 2010
- Title 42, Code of Federal Regulations, Section 438.240 Quality Assessment and Performance Improvement Program

Attachments

- Attachment 1. 2025 QIHETP Resources
- Attachment 2. 2025 GCHP PHM Strategy
- Attachment 3. 2025 Care Management Program Description
- Attachment 4. 2025 Utilization Management Program Description
- Attachment 5. 2025 Behavioral Health Program Description
- Attachment 6. 2025 Cultural and Linguistically Appropriate Services Program Description

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Gold Coast Health Plan℠
A Public Entity

Quality Improvement and Health Equity Transformation Program 2025

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

Rev. 3/2025