Gold Coast Health Plan℠
A Public Entity

2026 Population Health Management Strategy

This strategy outlines Gold Coast Health Plan's approach to ensure access to a comprehensive health and wellness program that leads to longer, healthier, and happier lives for members.

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Introduction

The **Population Health Management (PHM) Program** at Gold Coast Health Plan (GCHP) is designed to ensure that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care. The program aims to support longer, healthier lives, improve outcomes, and advance health equity. Specifically, the PHM Program intends to:

- Build trust with and meaningfully engage members.
- Gather, share, and assess timely and accurate data to identify effective opportunities for intervention through data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes. These data are provided by, or developed in collaboration, with the Quality Improvement (QI) department.
- Address upstream drivers of health by integrating public health and social services.
- Support members in staying healthy through PHM interventions guided by Quality Improvement Health Equity Transformation Program- (QIHETP) identified focus areas. This includes providing gaps reporting and identifying target populations through QI analyses and GCHP's HEDIS®-certified software platform.
- Provide care management services for members at higher risk of poor outcomes.
- Deliver transitional care services (TCS) for members moving between care settings or levels of care.
- Reduce health disparities.
- Identify and mitigate social drivers of health (SDOH).
- Complete a collaborative Population Needs Assessment (PNA) to understand member needs – particularly social drivers of health – and deepen relationships among GCHP, public health, and other local stakeholders.

GCHP's PHM Program has implemented a behavioral economics program that incentivizes members to engage in healthy behaviors to improve their health and wellness, with a focus on members with multiple chronic conditions. In 2026, the program will launch a chronic disease management program for members with diabetes.

GCHP will continue to improve the depth and breadth of services available to members as we learn more about their needs and characteristics through a data-driven quality improvement approach.

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Keeping Members Healthy

GCHP prioritizes access to, utilization of, and engagement with a primary care provider (PCP) as a key component of preventive care. Regular engagement with a PCP supports improved access to preventive health services and better health outcomes.

Goals related to primary care access are outlined below.

Goal: Increase the percentage of children who had well-child visits with a primary care provider.

- Well-child visits in the first 15 months of life: Increase the percentage of children with six or more well-care exams within the first 15 months of life to meet or exceed the 75th percentile (67.49%) as specified by the state Department of Health Care Services (DHCS) MY 2025 MCAS/HEDIS®.
- Well-child visits between 15 and 30 months of age: Increase the percentage of 30-month-old children who had two or more well-child exams between 15 and 30 months of age to meet or exceed the 90th percentile (82.12%) as specified by DHCS MY 2025 MCAS/HEDIS®.

Target Population: Children 0 to 15 months and children 15 to 30 months, enrolled for 11 of the last 12 months.

Programs or services offered by GCHP to accomplish goal:

- Provide clinics/providers with the annual MY 2025 MCAS/HEDIS® rate reports.
- Provide clinics/providers with monthly prospective MY 2025 MCAS rate and gaps in care reporting via INDICES®.
- Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g. Community Relations Department, Help Me Grow/First 5, CHDP, VCPH, VCOE) to implement interventions, promote best practices and increase awareness.
- Create and/or update provider and member education campaigns.
- Conduct text/secure digital member outreach campaign to increase well-child preventive care screenings.

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Goal: Increase the percentage of members, 3 to 21 years of age, who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year to meet or exceed the minimum performance level (55.41%) as specified by DHCS MY 2025 MCAS/HEDIS®.

Target Population: Members 3 to 21 years of age, enrolled for 11 of the last 12 months.

Programs or services offered by GCHP to accomplish goal:

- Provide clinics/providers with the annual MY 2026 MCAS/HEDIS® rate reports.
- Provide clinics/providers with monthly prospective MY 2026 MCAS rate and gaps in care reporting via INDICES®.
- Evaluate MY 2026 performance to identify barriers, disparities and opportunities for improvement and interventions.
- Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g. Community Relations Department, Help Me Grow/First 5, CHDP, VCPH, VCOE) to implement interventions, promote best practices and increase awareness.
- Create and/or update provider and member education campaigns.
- Evaluate effectiveness of the well care member incentive program and identify program changes/enhancements, as applicable.
- Implement and evaluate effectiveness of the provider member incentive award program.
- Conduct text/secure digital member outreach campaign to increase child/adolescent preventive care screenings.

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Goal: Increase the percentage of members who receive follow-up care after an emergency department visit for mental illness (FUM)/ substance use disorder (FUA) to meet or exceed the minimum performance level (45.8%, 57.13%) as specified by DHCS MY 2025 MCAS/HEDIS®.

Target Population: Eligible members with a recent mental health illness/SUD emergency department (ED) visit that received a follow-up appointment and/or medication treatment

Programs or services offered by GCHP to accomplish goal:

- **Data Reports:**
  - Eligble members will be identified daily from Manifest Medex, VCMC ED report, and CMH census data.
  - Consolidate daily FUA/FUM reports sent to Carelon (FUADAs) and Conejo for outreach and follow-up to members.
  - Implemented a monthly exchange of supplemental data to strengthen care coordination between County Behavioral Health, GCHP, and Carelon.
  - Weekly provider notifications for members with SUD and/or mental health illness diagnosis following an ED visit to prioritize member outreach and improve member outcome.
- **Data Exchange:** Encourage health systems to participate in Manifest HIE to streamline access to ED data into one information system.
- **Provider and Member Educational Materials:** Provide health education materials to help providers and members understand available mental health/substance use services.
- **Enhance Existing Processes:** Develop distinguished ownership to the appropriate program lane to aviod duplication outreach and clarify responsibilties (i.e., PCP, ECM, Carelon, County Behavioral Health)
- **Strengthen Care Coordination:** Leveraging Conejo Health as an onsite ECM provider to enhance care coordination and improve member support across the continuum of care.

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Patient Safety or Outcomes Across Settings

GCHP explores new and innovative ways to help members achieve better health outcomes. GCHP partners with digital healthcare company Wellth to apply behavioral economics to help people change daily behaviors, such as taking medications, eating regular meals, and checking blood pressure and blood sugar.

Goal: After identifying the target population of 1,000 members, 80% or more of those members will adhere to their individualized care plan that requires them to take their blood pressure, medication, A1c, etc.

Target Population: 1,000 members between the ages of 18 to 75 with a chronic health condition (i.e., diabetes, high blood pressure) and enrolled in the GCHP for 11 consecutive months with full-scope Medi-Cal.

Programs or services offered by GCHP to accomplish goal:

- Eligible members for the pilot project will receive a call from a Wellth representative to enroll in the program and together will customize an individualized care plan.
- The member will receive daily reminder notifications to check blood pressure, take medications and offer tips on healthy eating.
- Members who download the Wellth app will be asked to take pictures of medications taken, testing results of their glucose levels, meals or track other activities based on their individualized care plan.
- Each member will earn up to $30 per month for 12 months for a total amount of up to $500 per year or less based upon the number of activities completed that are associated with their individualized care plan.
- Members will receive a gift card in the mail and funds to be reloadable upon completion of activities identified in the care plan and will receive positive messages for completion of activities.

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Managing Members with Emerging Risk

GCHP recognizes the importance of helping members access preventive screenings and connect to other needed services and supports.

Goal: Increase the number of care gaps closed among eligible members and improve the overall colorectal cancer screening rate by using self-administered FIT-DNA (Cologuard®) tests, to meet or exceed the DHCS MY 2025 MCAS/HEDIS® minimum performance level of 42.49%.

Target Population: Members 45 to 75 years of age with an open care gap for colorectal cancer (COL-E).

Programs or services offered by GCHP to accomplish goal:

- GCHP will securely send Abbott (Cologuard manufacturer) eligibility files of members with open COL-E care gaps every three months. Abbott will use the eligibility files to conduct their auto-deploy gap closure program.
- Eligible members for the pilot program will receive an introduction letter and Cologuard colorectal screening kit at their home through the mail.
- The introductory letter will explain why the member received the kit and provide information on how to contact Abbott with questions on how to use the kit or have another kit sent if they didn't receive a kit.
- Completing the kit is voluntary.
- After the kit has been sent, Abbott will use the member's contact information from the eligibility file in their preferred language to conduct outreach throughout the year. Member outreach will be done via phone call, SMS text, and/or email to encourage the member to complete the screening and mail it back to Abbott and to answer any questions a member may have about completing the kit.
- Members will receive their screening result directly by Abbott. Abbott will also send members' results to their respective PCP for follow-up should their result be positive.

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Managing Multiple Chronic Conditions

The Complex Care Management (CCM) team uses a population health framework that incorporates an interdisciplinary structure and data from across the healthcare continuum to support members with multiple chronic conditions.

Goal: The Complex Care Management (CCM) program will complete an initial assessment on all members that meet the target population criteria who enroll in CM within 30 days of enrollment; of those who enroll in CCM, 50% will complete the goals outlined the in plan of care before disenrolling from the program.

Target Population: Members included in the 10% costliest, considered part of Johns Hopkins ACG® Resource Utilization Band 3 or 4, who have diabetes, cardiovascular disease, and/or hypertension, and have had two or more hospitalizations in the past year.

Programs or services offered by GCHP to accomplish goal:

- Eligible members will be identified each month and will receive a letter and phone call offering them CCM services.
- Members interested in participating in CCM will receive an initial assessment evaluating medical, psycho-social, emotional, and behavioral needs by their CCM case manager within 60 days of enrollment.
- The member and CCM case manager will develop an Individualized Care Plan (ICP) that addresses both medical and Social Determinants of Health (SDH) concerns. CM staff will collaborate with the member to identify prioritized goals and select interventions/behaviors intended to meet these goals.
- Together, the member and CM staff will work throughout the care management process to overcome barriers to meeting these goals and achieving the health/wellness outcome(s) identified by the member.

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Goal: The Arine pilot program will target 750 members with diabetes, aiming for 70% of participants to remain enrolled in the diabetes management program for a minimum of six months and demonstrate a decrease in A1c.

Target Population: Members ages 18+ with diabetes and enrolled in GCHP for 11 consecutive months with full-scope Medi-Cal.

Programs or services offered by GCHP to accomplish goal:

- Members who have been identified as eligible for clinical intervention will be sent a welcome letter introducing them to the program and inviting them to reach out with any questions.
- These high-risk diabetic members will then receive a phone call from a pharmacist that is culturally and linguistically similar to the member. The pharmacist will conduct a medication review and offer the member recommendations for their medication regimen and health behavior modification.
- After the call is complete, an overview of all the information that was discussed with the pharmacist will be sent to the member via mail.
- The platform will continue to monitor members for high-risk factors and follow-up interactions will occur with a pharmacist as needed.
- Arine will send an eFax to the member's provider after each clinical interaction with a member for review.
- Providers will also have access to Arine pharmacists for clinical consultation to review recommended medication regimen changes.

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Community Wellness Activities (not direct member interventions)

GCHP takes a collective approach to population health, benefiting both members and the broader communities we serve.

Ventura County Community Health Improvement Collaborative

GCHP is a founding Member of Ventura County Community Health Improvement Collaborative (VCCHIC) along with Adventist Health Simi Valley, Camarillo Health Care District, Clinics del Camino Real, Inc., Community Memorial Health System, Dignity Health, Ventura County Health Care Agency, Ventura County Behavioral Health and Ventura County Public Health.

VCCHIC builds partnerships to improve population health outcomes in Ventura County. These partnerships are necessary to accomplish the shared vision of working collaboratively to develop strategies based upon the identified health priorities from the triannual community health needs assessment (CHNA).

Key priorities include:

- Behavioral health
- Older adult health
- Women's health

The final report and implementation strategy plan are available at www.healthmattersinvc.org.

Sharing Data and Information with Providers and Community Partners

GCHP participates in the California Health and Human Services Data Exchange Framework (DxF), which facilitates health information sharing across hospitals, physician organizations and medical groups, skilled nursing facilities, healthcare service plans and disability insurers, clinical laboratories, and acute psychiatric hospitals. The DxF and the policies and procedures that are being established help to address some of those challenges in sharing data between payers, providers, hospitals, and public health systems that became readily apparent during the response to the COVID-19 pandemic.

Data-driven efforts to better coordinate human and social supports with the medical and healthcare sectors provide opportunities to deliver services that are more client-centered, efficient, effective, and tailored.

Health Information Exchanges (HIEs) and Community Information Exchanges (CIEs) provide the mechanism by which organizations can implement DxF policies and procedures and share information across partner organizations. GCHP participates in Manifest Medex (Ventura County's HIE) and serves on the Ventura County CIE Governance Board.

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DHCS is establishing its own Population Health Management Service called Medi-Cal Connect that will aggregate and correlate Medi-Cal member-level data sources to anticipate Member needs and deliver appropriate interventions. Some of this information will eventually come from the network of HIEs and CIEs throughout California.

Birth Equity Stakeholder Group

GCHP leads a Birth Equity Stakeholder Group of community partners, healthcare providers, and organizational leaders to advance fair and just outcomes for birthing people and their families. The group works collaboratively to identify gaps in care, elevate community voices, and design strategies to reduce disparities and improve perinatal health. Through shared learning, data informed decision making, and coordinated action, the group aims to ensure that every birthing person—regardless of background, identity, or circumstance—has access to respectful, high quality, and culturally responsive care throughout their pregnancy journey. The group meets quarterly to align efforts, share updates, and drive collective progress.

How Member Programs Are Coordinated

GCHP's PHM programs are guided by collaboration, advocacy, self-care management, empowerment in decision-making, education, informed choice, anticipation of needs, linkage with community resources, and assisting the member to navigate the healthcare system. Key program functions include:

- Assess for and address members' needs across the continuum of care, including eligibility for other care management programs such as Enhanced Care Management and assess for duplication of services.
- Facilitate improvement in the health status and quality of life of members with complex and non-complex medical needs.
- Help members understand their health condition and support them to become self-advocates.
- Help members in navigating the healthcare system to minimize gaps in care, facilitate optimization of available benefits, and obtain timely access to care and services.
- Collaborate with external stakeholders, such as multidisciplinary health agencies and non-profit partners, to link members to community resources where accessible.
- Work collaboratively with the member, physician, and care team to develop and implement a care plan that meets the member's needs and addresses gaps in care.
- Improve member and provider satisfaction.

PHM program referrals originate from a variety of internal and external sources. Members may self-refer or may be referred by another member of their care team including caregivers, primary care providers, specialists, hospital case managers, or other community partners. Each eligible member who wants to participate in PHM services may be assigned to a CCM case manager that will help to coordinate member needs, including transitions in care.

Members may qualify for one or more programs. Case managers will have access to information on enrollment in various programs through GCHP's medical management system to coordinate care across different programs. This allows for a reduction in redundant calls to members and allows for case managers to leverage information collected on a member during other program enrollments.

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Informing Members About Available Programs and Services

GCHP informs members about programs through:

- **Member Handbook:** Updated annually by DHCS and Communications.
- **GCHP Website** (https://www.goldcoasthealthplan.org/for-Members/welcome-Members/): Updated as needed by Communications with two weeks' notice.
- **Community Advisory Committee (CAC):** This committee includes members and meets quarterly. Information to be shared at the CAC must be provided to Communications six weeks prior to the meeting.
- ***Your Health* Newsletter:** This newsletter is distributed four times per year to members. Content must be provided four months in advance of distribution to Communications.
- **Community Events and Town Halls:** These may be scheduled as needed by working with Strategy and External Affairs.
- **Direct Mailings:** Direct member mailings can be developed with Health Education/Cultural and Linguistics and sent on an as-needed basis.

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Informing Providers About Available Programs and Services

GCHP informs providers about programs through:

- **Provider Operations Bulletin:** This provider focused newsletter is emailed and posted on GCHP's website. It features organizational updates, including new MOUs, new programs, and information about existing programs and services.
- **GCHP Website** (https://www.goldcoasthealthplan.org/for-providers/welcome-providers/): Updated as needed by Communications with two weeks' notice.
- **Community Advisory Committee (CAC):** Providers may attend these meetings to receive updates. Information to be shared at the CAC must be provided to Communications six weeks prior to the meeting.
- **Provider Advisory Committee (PAC):** Providers may attend these meetings to receive updates. This meeting occurs quarterly.

How GCHP Promotes Health Equity

GCHP is committed to equity, inclusion, and diversity to maintain high-quality and affordable healthcare. The Quality Improvement Health Equity Transformation (QIHET) Program focuses on improving health equity through programs and interventions and whole-person care through partnerships with members, providers, community-based organizations, schools, public health agencies, outside counties, and other healthcare systems. The QIHET Program seeks to improve access to services for at-risk populations, with an emphasis on children's preventive care, maternal health outcomes, and behavioral health.

At least annually, GCHP identifies health disparities through race/ethnicity stratification of identified MCAS measures (e.g., controlling high blood pressure, timely prenatal and postpartum care, pediatric well-care including immunizations, etc.). Other disparities within reported quality measures are identified through analyses based on gender, age, and language.

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Updates	Author(s)	Title(s)
December 2022	Erin Slack	Senior Manager of Population Health
December 2023	Erin Slack	Senior Manager of Population Health
March 2023	Erin Slack Valerie Paz	Senior Manager of Population Health Population Health Program Analyst
October 2024	Erin Slack Valerie Paz	Senior Manager of Population Health Population Health Program Analyst
February 2025	Erin Slack Valerie Paz	Senior Manager of Population Health Population Health Program Analyst
April 2026	Erin Slack Valerie Paz	Senior Manager of Population Health Population Health Program Analyst

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