Gold Coast Health Plan℠
A Public Entity

Population Needs Assessment 2024

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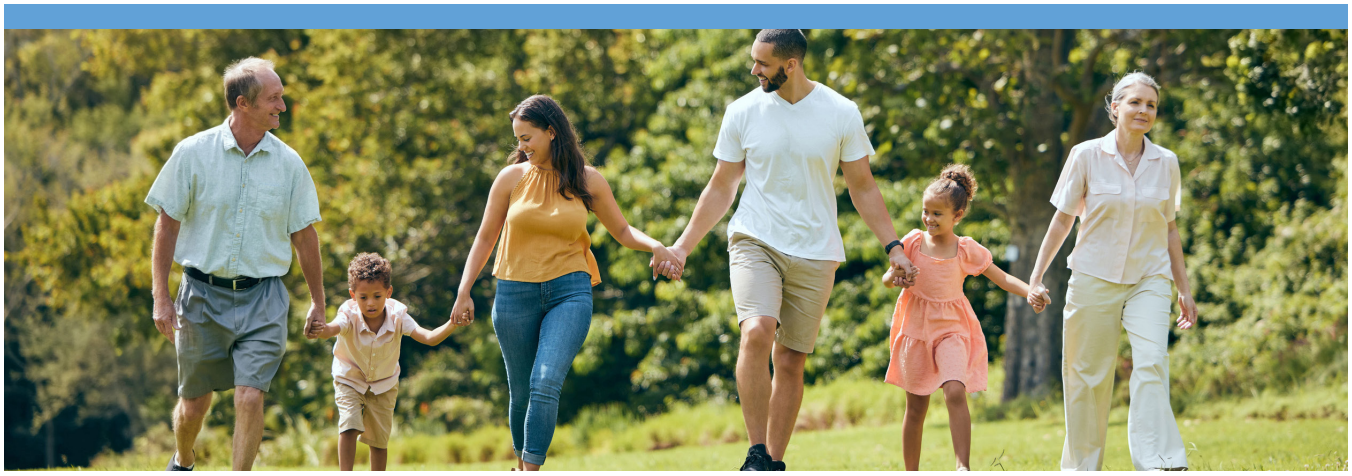

Introduction

Gold Coast Health Plan (GCHP) assesses the characteristics and needs of its member population at least annually. The needs of the following subpopulations are also assessed:

- Child and adolescent members (0-20 years of age)
- Persons with disabilities
- Members with persistent mental illness
- Members of racial and ethnic groups
- Members with limited English proficiency

This report summarizes the data analysis activities completed by GCHP, to appraise membership and membership subpopulation characteristics and needs for plan year 2024. Membership data reflects active membership as of June 2024, claims data reflects July 2023 through June 2024, and HEDIS® data reflects regulatory measurement year (MY) 2023. Data from the annual population needs assessment will be presented to the GCHP Quality Improvement Committee on an annual basis.

Objectives

The objectives of this report are to:

- Identify the methodologies for data collection of membership needs.
- Summarize the needs of GCHP's membership.
- Identify areas where population health management (PHM) strategy changes may have a positive impact on membership needs.

Characteristics and Needs of Membership

Introduction

To determine the necessary structure and resources for GCHP's PHM program, the organization assesses its population, taking into consideration the characteristics of the population, including social determinants of health (SDoH). SDoH are economic and social conditions that affect a wide range of health, functioning, and quality-of-life outcomes and risks. GCHP also identifies other membership characteristics by stratifying membership by age, race / ethnicity, language, and city of residence.

Membership Segmentation by Age, Race / Ethnicity, Language, Sex, and City

Methodology

Member reported demographic data is used to stratify by age, race / ethnicity, language, sex, and city of residence. The total membership count was 248,923 as of June 2024.

Table 1: Membership Gender Stratification

Gender	Percent of Gender	Unique Member Count
Female	53.4%	133,025
Male	46.6%	115,898
Total Membership	100%	248,923

Source: Membership based upon June 2024 active enrollment.

Key finding:

- Females make up a larger proportion of total membership by 6.8%.

Conclusion Statement:

Gender plays a crucial role in health care delivery, influencing both access to services and the effectiveness of medical interventions. Our higher female population demands that health care programs and interventions be designed with a gender-sensitive approach, addressing the unique needs and health challenges faced by women.

Table 2: Membership Race Stratification

Race	Percent of Race	Unique Member Count
Some Other Race	64.0%	159,937
Unknown	15.7%	39,185
White	15.4%	38,254
Asian	2.9%	7,296
Black or African American	1.3%	3,154
Native Hawaiian and Other Pacific Islander	0.5%	1,286
American Indian and Alaska Native	0.1%	351
Total Membership	100%	248,923

Source: Membership based upon June 2024 active enrollment.

Key findings:

- The most common racial category reported is "Some Other Race," accounting for 64.0% of the membership, with a total of 159,937 unique members.
- The least represented category is American Indian and Alaska Native, making up 0.1% of the membership, with a unique member count of 351 individuals.
- Members with unknown race data represent a substantial portion at 15.7%, totaling 39,185 unique members, highlighting a significant number of members whose race is unspecified.
- Standard racial categories such as White, Asian, and Black or African American represent 15.4%, 2.9%, and 1.3% of the membership, respectively, with White being the most prevalent among these and Black or African American the least.

Conclusion Statement:

The data reflects a diverse membership, with the "Some Other Race" category being the most prominent and a significant proportion classified as "Unknown," highlighting the need for greater clarity in racial data reporting.

Table 3: Membership Ethnicity Stratification

Ethnicity	Percent of Ethnicity	Unique Member Count
Hispanic / Latino	61.5%	152,968
Not Hispanic / Latino	20.2%	50,341
Unknown	18.3%	45,614
Total Membership	100%	248,923

Source: Membership based upon June 2024 active enrollment.

Key findings:

- The majority of members are of Hispanic / Latino ethnicity, making up 61.5% of the total, with 152,968 unique members.
- Members who are not Hispanic / Latino represent 20.2% of the total membership, with 50,341 unique members.
- A significant portion of the membership has an unknown ethnicity, comprising of 18.3% or 45,614 unique members, indicating that nearly one-fifth of the membership's ethnicity data is unspecified.

Conclusion Statement:

A substantial majority of the membership identifies as Hispanic / Latino (61.5%), yet a significant portion (18.3%) has an unspecified ethnicity, highlighting the need for more detailed ethnicity data collection.

Table 4: Membership Language Stratification

Language	Percent of Language	Unique Member Count
English	60.4%	150,442
Spanish	37.8%	93,976
Unknown	0.9%	2,159
Other	0.7%	1,714
Vietnamese	0.3%	632
Total Membership	100%	248,923

Source: Membership based upon June 2024 active enrollment.

Key findings:

- The most common primary language among members is English, making up 60.4% of the total population with a unique member count of 150,442.
- Spanish is the second most spoken primary language, representing 37.8% of the total population, with 93,976 unique members.
- Vietnamese is the third most common primary language spoken by members at 0.3% of the total membership, with 632 unique members.
- The “Other” Category represents 20 of the least most common languages grouped together consisting of 0.7% of the total membership, with 1,714 unique members.

Conclusion Statement:

While English and Spanish are the predominant languages spoken by members, the presence of Vietnamese and other less common languages highlights the importance of addressing the linguistic needs of all members.

Members have access to interpretation and translation services, including materials in alternative formats, auxiliary aids, and other services upon request. These services are available to members at no cost to support linguistic needs.

GCHP offers the following language assistance services:

- Oral interpreting services from a qualified interpreter. This includes in-person and virtual interpreting.
- Sign language interpreting for deaf and hearing-impaired members.
- Translation of written materials in a preferred language.
- Telephone interpreting 24/7.
- Alternative format requests for Braille, audio format, large print (20-point Arial font), and accessible electronic formats, as well as requests for other auxiliary aids and services for people with disabilities.

Table 5a: Membership Age Stratification

Age	Percent of Age	Unique Member Count
21-64 years old	51.1%	127,103
0-20 years old	38.7%	96,346
65+ years old	10.2%	25,474
Total Membership	100.0%	248,923

Source: Membership based upon June 2024 active enrollment.

Key findings:

- The age group of 21-64 is the largest among members, accounting for 51.1% of the total membership with 127,103 unique members.
- Children and young adults aged 0-20 make up 38.7% of the membership, with a unique member count of 96,346.
- Members aged 65 and older make up 10.2% of the total membership, with a unique member count of 25,474.

Conclusion Statement:

The membership is predominantly comprised of individuals aged 21-64, representing over half (51.1%) of the total population. However, a significant portion of the membership, nearly half, is made up of younger members aged 0-20 (38.7%) and seniors aged 65 and above (10.2%). This diverse age distribution indicates that while the working-age population is the largest group, there remains a substantial representation of both youth and elderly members, highlighting the need for age-specific services and programs across all demographics.

Table 5b: Membership Age Stratification

Age	Percent of Age	Unique Member Count
0 - 17	32.6%	81,101
18 - 34	27.2%	67,724
35 - 44	12.1%	30,190
45 - 54	9.2%	22,936
55 - 64	8.6%	21,498
65 - 74	5.9%	14,595

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Age	Percent of Age	Unique Member Count
75 - 84	2.9%	7,322
85+	1.4%	3,557
Total Membership	100.0%	248,923

Source: Membership based upon June 2024 active enrollment.

Key findings:

- Children and young adults aged 0-17 make up the largest proportion of this age grouping at 32.6% of the total membership, with a unique member count of 81,101.
- More than half of the total population (59.8%) are 34 years old or younger.
- The smallest proportion of the age grouping are members 85 years of age or older at 1.4% or 3,557 unique members.

Conclusion Statement:

A significant proportion of our members are children and young adults. Eighty percent of the total population are under the age of 55. This age distribution highlights the importance of addressing the distinct health care needs of each group, as members across all ages require tailored services to meet their evolving needs at various stages of life.

Table 6: Top Five Membership City Stratification

City	Percent of City	Unique Member Count
Oxnard	41.9%	104,272
Ventura	12.8%	31,798
Simi Valley	10.8%	26,880
Santa Paula	6.2%	15,443
Thousand Oaks	5.6%	13,846
Other	22.8%	56,684
Total Membership	100.0%	248,923

Source: Membership based upon June 2024 active enrollment.

Key findings:

- Oxnard has the largest membership population, with 41.9% of the total city membership or 104,272 unique members.
- Ventura is the second most represented city, accounting for 12.8% of the total city membership or 31,798 unique members.
- Simi Valley ranks third, with 10.8% of the members from the cities or 26,880 unique members.
- Santa Paula ranks fourth and has 6.2% of the total city membership or 15,443 unique members.
- Thousand Oaks has the smallest percentage among the top five cities at 5.6%, with a total of 13,846 unique members.
- The remaining 22.8% of membership or 56,684 unique members live in other cities.

Conclusion Statement:

Oxnard leads in membership, followed by Ventura and Simi Valley, which are also key contributors to the membership base. While Camarillo is not listed in the top five cities, it holds a substantial portion of membership similar to the membership size of Thousand Oaks, accounting for 5.4% of the total city membership, or 13,393 members.

Table 7: Top Five Chronic Conditions Segmented by Geographic Area

1. Disorders of Lipid Metabolism

Disorders of Lipid Metabolism		
Geographic Location	**Unique Member Count**	**Prevalence Percentage**
Oxnard	15,604	15.0%
Simi Valley	4,866	18.1%
Ventura	4,605	14.5%
Thousand Oaks	2,485	17.9%
Santa Paula	2,240	14.5%
Camarillo	2,213	16.5%
Port Hueneme	1,209	14.7%
Moorpark	1,139	14.9%
Newbury Park	1,081	18.1%
Fillmore	984	12.1%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- The city of Oxnard has the highest number of members with disorders of lipid metabolism, at 15,604 members, making up 15% of Oxnard's 104,272 membership count.
- Simi Valley, Newbury Park, and Thousand Oaks have a much smaller population than Oxnard but have a higher prevalence of Disorders of lipid metabolism with 18.1% and 17.9% of their population respectively.

Conclusion Statement:

While Oxnard has the largest proportion of members with disorders of lipid metabolism, there are cities with a higher prevalence percentage rate, highlighting the need for interventions across different areas of Ventura County.

2. Hypertension without Major Complications

Gold Coast Health Plan identified members with hypertension without major complications as a relevant subpopulation due to its widespread prevalence—34,301 members—and its role as a leading risk factor for stroke, heart attack, and kidney disease. Clinically, early management of hypertension is essential to prevent progression to life-threatening conditions. This group was selected based on its high representation in the membership and the potential for improved outcomes through lifestyle changes

and medication adherence. GCHP addresses these needs through its Complex Case Management (CCM) program, the Wellth incentive platform, and multilingual health education resources, all designed to promote blood pressure control and reduce emergency department utilization.

Hypertension without Major Complications		
Geographic Area	**Unique Member Count**	**Prevalence Percentage**
Oxnard	13,183	12.6%
Ventura	4,866	15.3%
Simi Valley	4,172	15.5%
Santa Paula	2,286	14.8%
Camarillo	2,069	15.4%
Thousand Oaks	1,946	14.1%
Port Hueneme	1,129	13.8%
Moorpark	1,073	14.0%
Fillmore	1,070	13.2%
Newbury Park	820	13.7%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- The city of Oxnard has the highest number of members with hypertension without major complications at 13,183 members, making up 12.6% of Oxnard's 104,272 membership count.
- Ventura , Simi Valley, and Camarillo have a much smaller population than Oxnard but have a higher prevalence of hypertension without major complications with 15.3%, 15.5% and 15.4% of their populations respectively.

Conclusion Statement:

There is a significant concentration of hypertension without major complications, with Oxnard having the most members, but other cities having higher prevalence within their populations. Community incidence data also shows a higher rate of age-adjusted emergency room visits due to hypertension in zip codes within Oxnard and Simi Valley. This suggests that preventive care efforts focused on control of hypertension should be focused in these geographic areas.

3. Anxiety, Neuroses

Anxiety, Neuroses		
Geographic Area	**Unique Member Count**	**Prevalence Percentage**
Oxnard	9,739	9.3%
Ventura	4,726	14.9%
Simi Valley	3,194	11.9%
Camarillo	1,904	14.2%
Santa Paula	1,859	12.0%
Thousand Oaks	1,593	11.5%

Anxiety, Neuroses		
Geographic Area	**Unique Member Count**	**Prevalence Percentage**
Fillmore	982	12.1%
Port Hueneme	894	10.9%
Moorpark	766	10.0%
Newbury Park	670	11.2%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- The city of Oxnard has the highest number of members with Anxiety, neuroses at 9,739 members, making up 9.3% of Oxnard's 104,272 membership count.
- Ventura and Camarillo have a much smaller population than Oxnard but have a higher prevalence of Anxiety, neuroses with 14.9% and 14.2% of their population respectively.

Conclusion Statement:

Oxnard has the highest number of members with anxiety / neuroses, but community incidence data also shows a higher rate of age-adjusted emergency room visits due to adult mental health in zip codes within Oxnard, Piru, Port Hueneme, and Simi Valley. Resources should be identified throughout the county to address behavioral health needs of our member population.

4. Obesity

Obesity		
Geographic Area	**Unique Member Count**	**Prevalence Percentage**
Oxnard	10,577	10.1%
Ventura	3,134	9.9%
Simi Valley	2,235	8.3%
Santa Paula	1,535	9.9%
Camarillo	1,222	9.1%
Port Hueneme	858	10.5%
Thousand Oaks	852	6.2%
Fillmore	811	10.0%
Moorpark	563	7.4%
Newbury Park	360	6.0%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- The city of Oxnard has the highest number of members with obesity at 10,577 members, making up 10.1% of Oxnard's 104,272 membership count.
- Port Hueneme and Fillmore have a much smaller population than Oxnard but have a higher prevalence of obesity with 10.5% and 10% of their population respectively.

Conclusion Statement:

The distribution of members with obesity is heavily weighted toward Oxnard, which is consistent with community prevalence data for adults with obesity but also identifies Port Hueneme and Fillmore as areas of concern.

5. Gingivitis

Gingivitis		
Geographic Area	**Unique Member Count**	**Prevalence Percentage**
Oxnard	7,951	7.6%
Simi Valley	2,169	8.1%
Ventura	1,411	4.4%
Thousand Oaks	982	7.1%
Fillmore	937	11.6%
Santa Paula	759	4.9%
Camarillo	687	5.1%
Moorpark	676	8.8%
Newbury Park	565	9.4%
Port Hueneme	438	5.3%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- The city of Oxnard has the highest number of members with gingivitis at 7,951 members, making up 7.6% of Oxnard's 104,272 membership count.
- Fillmore has a much smaller population than Oxnard but has a higher prevalence of gingivitis with 11.6% of their population.

Conclusion Statement:

Oxnard has the highest number of members with gingivitis. Fillmore, with a total population of 8,104 members, has a higher prevalence percentage of 11.6% affecting 937 unique members, highlighting the need for focused efforts in not only Oxnard, but areas with smaller populations and a higher percentage rate. Gingivitis ICD10 coding was implemented toward the end of 2023 and has quickly become one of the top chronic conditions affecting our member population.

Table 8: Top 10 Most Prevalent Chronic Conditions

Chronic Condition	Unique Member Count	Percent of Total Population
Disorders of lipid metabolism	38,322	15.4%
Hypertension, without major complications	34,301	13.8%
Anxiety, neuroses	28,029	11.3%
Obesity	23,110	9.3%

Chronic Condition	Unique Member Count	Percent of Total Population
Gingivitis	17,340	7.0%
Major depression	14,117	5.7%
Type 2 diabetes, with complication	13,795	5.5%
Asthma, without status asthmaticus	13,663	5.5%
Depression	13,196	5.3%
Degenerative joint disease	13,032	5.2%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- Disorders of lipid metabolism is the most common chronic condition among the total member population affecting 38,322 unique members or 15.4% of the population.
- Hypertension is the second most common chronic condition affecting 34,301 unique members or 13.8% of the population.
- Three of the top 10 chronic conditions are mental health related chronic conditions, including anxiety / neuroses, major depression, and depression.
- Obesity is the fourth most common chronic condition among members, affecting 9.3% of the total member population or 23,110 unique members.

Conclusion Statement:

GCHP has several initiatives to help members navigate the complexities of the health care system while linking them to additional resources and services that can help them manage their chronic condition(s). A list of services offered by GCHP can be found on page 18.

Table 9: Top Five Most Common Primary Diagnoses by Geographic Area

1. Essential (primary) hypertension

Essential (primary) hypertension				
Geographic Area	Unique Member Count	Unique Claim Count	Average Claims per Member	Prevalence Percentage
Oxnard	3,915	10,025	2.6	3.8%
Ventura	1,551	3,435	2.2	4.9%
Simi Valley	1,137	2,564	2.3	4.2%
Camarillo	741	1,939	2.6	5.5%
Thousand Oaks	638	1,569	2.5	4.6%
Santa Paula	634	1,329	2.1	4.1%
Port Hueneme	371	945	2.5	4.5%
Moorpark	291	557	1.9	3.8%

Essential (primary) hypertension				
Geographic Area	Unique Member Count	Unique Claim Count	Average Claims per Member	Prevalence Percentage
Fillmore	260	675	2.6	3.2%
Newbury Park	236	621	2.6	3.9%

*** Analysis included only the top 10 primary diagnoses associated with all medical visits within a 12-month period.**
Source: Claims from Professional, Encounters, and All Plan Data feed from July 2023 – June 2024.

Key findings:

- Oxnard is the city with the highest number of visits related to essential (primary) hypertension, with 10,025 visits, with 3,915 unique members or 3.8% of their total member population having had a visit with this primary diagnosis.
- Camarillo is the city with the highest prevalence of visits related to this primary diagnosis with 741 unique members and 5.5% of their total population.
- Ventura and Simi Valley are next with 3,435 visits and 2,564 visits respectively.
- Of the top 10 cities, Newbury Park has the fewest visits for this primary diagnosis, with 621 visits between 236 unique members with 3.9% of their total population having had a visit for this diagnosis.

Conclusion Statement:

While Oxnard has the highest member count and claim count, there is a higher prevalence of members in Camarillo having a claim with essential (primary) hypertension as a primary diagnosis with 5.5% of their total population versus 3.8% of the total population in Oxnard.

2. Illness, Unspecified

Illness, Unspecified				
City	Unique Member Count	Unique Claim Count	Average Claims per Member	Prevalence Percentage
Oxnard	2,118	9,911	4.7	2.0%
Ventura	733	3,693	5.0	2.3%
Simi Valley	567	2,626	4.6	2.1%
Santa Paula	380	1,832	4.8	2.5%
Thousand Oaks	270	1,262	4.7	2.0%
Camarillo	257	1,222	4.8	1.9%
Port Hueneme	195	1,012	5.2	2.4%
Fillmore	160	805	5.0	2.0%
Moorpark	134	644	4.8	1.8%
Newbury Park	92	474	5.2	1.5%

*** Analysis included only the top 10 primary diagnoses associated with all medical visits within a 12-month period.**
Source: Claims from Professional, Encounters, and All Plan Data feed from July 2023 – June 2024.

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Key findings:

- Oxnard is the city with the highest number of visits related to illness, unspecified, with 9,911 visits and 2,118 unique members or 2.0% of their total member population having had a visit with this primary diagnosis.
- Ventura and Simi Valley are next with 3,693 visits and 2,262 visits respectively.
- Of the top 10 cities, Newbury Park has the fewest visits for this primary diagnosis, with 474 visits between 92 unique members or 1.5% of their total population having had a visit for this diagnosis.

Conclusion Statement:

While Oxnard has the highest member count and claim count, there is a higher prevalence of members in Camarillo having a claim with essential (primary) hypertension as a primary diagnosis with 5.5% of their total population versus 3.8% of the total population in Oxnard.

3. Routine child health examination without abnormal findings

Routine child health examination without abnormal findings				
City	Unique Member Count	Unique Claim Count	Average Claims per Member	Prevalence Percentage
Oxnard	8,978	12,500	1.4	8.6%
Ventura	2,346	3,204	1.4	7.4%
Santa Paula	1,226	1,757	1.4	7.9%
Camarillo	1,091	1,696	1.6	8.1%
Simi Valley	764	859	1.1	2.8%
Port Hueneme	759	1,105	1.5	9.2%
Fillmore	677	951	1.4	8.4%
Thousand Oaks	371	449	1.2	2.7%
Ojai	331	471	1.4	7.3%
Moorpark	230	273	1.2	3.0%

*** Analysis included only the top 10 primary diagnoses associated with all medical visits within a 12-month period.**

Source: Claims from Professional, Encounters, and All Plan Data feed from July 2023 – June 2024.

Key findings:

- Oxnard has the highest number of visits related to routine child health examination without abnormal findings, with 12,500 visits and 8,978 unique members or 8.6% of their total member population having had a visit with this primary diagnosis.
- Ventura and Santa Paula are next with 3,204 visits and 1,757 visits respectively.
- Of the top 10 cities, Moorpark has the fewest visits for this primary diagnosis, with 273 visits between 230 unique members or 3.0% of their total population having had a visit for this diagnosis.

Conclusion Statement:

Oxnard has the highest visit count and unique member count. However, Port Hueneme has a higher prevalence of visits with 9.2% of their membership or 759 unique members having this as a primary diagnosis.

4. Type 2 diabetes mellitus without complications

Gold Coast Health Plan identified members with Type 2 diabetes mellitus without complications as a relevant subpopulation due to its high prevalence—7,946 members—and the clinical importance of early intervention to prevent progression to serious complications such as kidney failure, cardiovascular disease, and neuropathy. Although these members currently lack complications, unmanaged diabetes poses significant long-term risks. This group was selected based on its representation across the membership and the opportunity to improve outcomes through preventive care. GCHP supports these members through partnerships with Solera for diabetes prevention, Wellth for incentivizing healthy behaviors, and Chronic Disease Self-Management Programs (CDSMP) offered in English and Spanish, aiming to reduce disease burden and improve quality of life.

Type 2 diabetes mellitus without complications				
City	Unique Member Count	Unique Claim Count	Average Claims per Member	Prevalence Percentage
Oxnard	3,239	10,309	3.2	3.1%
Ventura	1,058	3,069	2.9	3.3%
Simi Valley	926	2,622	2.8	3.4%
Santa Paula	556	1,502	2.7	3.6%
Camarillo	438	1,358	3.1	3.3%
Thousand Oaks	425	1,279	3.0	3.1%
Port Hueneme	300	900	3.0	3.7%
Fillmore	246	659	2.7	3.0%
Moorpark	244	715	2.9	3.2%
Newbury Park	152	443	2.9	2.5%

*** Analysis included only the top 10 primary diagnoses associated with all medical visits within a 12-month period.**
Source: Claims from Professional, Encounters, and All Plan Data feed from July 2023 – June 2024.

Key findings:

- Oxnard is the city with the highest number of visits related to Type 2 diabetes mellitus without complications, with 10,309 visits and 3,239 unique members or 3.1% of their total member population having had a visit with this primary diagnosis.
- Ventura and Simi Valley are next with 3,069 visits and 2,622 visits respectively.
- Of the top 10 cities, Newbury Park has the fewest visits for this primary diagnosis, with 443 visits between 152 unique members or 2.5% of their total population having had a visit for this diagnosis.

Conclusion Statement:

Oxnard has the highest visit count and unique member count. However, Port Hueneme has a higher prevalence of visits with 3.7% of their membership or 300 unique members having this as a primary diagnosis.

5. Low back pain, unspecified

Low back pain, unspecified				
City	Unique Member Count	Unique Claim Count	Average Claims per Member	Prevalence Percentage
Oxnard	1,669	4,703	2.8	1.6%
Ventura	745	2,221	3.0	2.3%
Simi Valley	538	1,996	3.7	2.0%
Camarillo	343	1,099	3.2	2.6%
Santa Paula	337	955	2.8	2.2%
Thousand Oaks	298	1,336	4.5	2.2%
Port Hueneme	169	591	3.5	2.1%
Moorpark	146	535	3.7	1.9%
Fillmore	138	412	3.0	1.7%
Newbury Park	102	386	3.8	1.7%

*** Analysis included only the top 10 primary diagnoses associated with all medical visits within a 12-month period.**
Source: Claims from Professional, Encounters, and All Plan Data feed from July 2023 – June 2024.

Key findings:

- Oxnard is the city with the highest number of visits related to low back pain, unspecified, with 4,703 visits and 1,669 unique members or 1.6% of their total member population having had a visit with this primary diagnosis.
- Ventura and Simi Valley are next with 2,221 visits and 1,996 visits respectively.
- Of the top 10 cities, Newbury Park has the fewest visits for this primary diagnosis, with 386 visits between 102 unique members or 1.7% of their total population having had a visit for this diagnosis.

Conclusion Statement:

In conclusion, Oxnard has the highest visit count and unique member count. However, Camarillo has a higher prevalence of visits with 2.6% of their membership or 343 unique members having this as a primary diagnosis.

Table 10: Top 10 Most Common Primary Diagnoses by Total Visits

Reason for Visits	Total Members	Total Visits
Essential (primary) hypertension	10,391	24,980
Illness, unspecified	5,118	24,440

Reason for Visits	Total Members	Total Visits
Routine child health examination without abnormal findings	17,589	24,409
Type 2 diabetes mellitus without complications	7,946	23,802
Low back pain that is unspecified	4,771	15,106
Unspecified chest pain	9,241	14,924
Obstructive sleep apnea	3,169	14,400
Unspecified abdominal pain	8,394	13,395
Unspecified acute upper respiratory infection (URI)	9,818	12,938
End-stage renal disease (ESRD)	871	12,639

*** Analysis included only the top 10 primary diagnoses associated with all medical visits within a 12-month period.**
Source: Claims from Professional, Encounters, and All Plan Data feed from July 2023 – June 2024.

Key findings:

- Essential (primary) hypertension is the most common primary diagnosis affecting the total membership population.
- Illness, unspecified is second with 24,440 visits.
- Routine child health examination without abnormal findings is third with 24,409 visits.

Conclusion Statement:

There are a variety of health conditions or primary diagnoses affecting the total membership population. When drilling down further into geographic areas we can see higher prevalence of occurrence where a more targeted approach can be introduced. There are some conditions like ESRD that have a low member count but have a high total visit count within a 12-month period, highlighting the need for higher levels of care.

Analysis of Needs:

- Chronic conditions such as hypertension, Type 2 diabetes, and disorders of lipid metabolism are common among GCHP membership.
  - » The Complex Case Management (CCM) Program, which is part of the PHM strategy, proactively outreaches to members with diabetes, cardiovascular disease, and/or hypertension who are identified through risk stratification monthly to enroll them in CCM.
  - » GCHP has partnered with Wellth, a company that uses behavioral science and behavioral economics, to incentivize members to engage in healthy behaviors; the program focused on members with chronic conditions is part of the PHM strategy. Wellth looks holistically at members' (not individual conditions) health needs in their care journey and ensures members can earn financial incentives for building healthy behaviors that lead to long-term improved health outcomes. This includes incentivizing daily behaviors like taking medications, healthy meals,

checking blood glucose or blood pressure as well as one-time annual health screenings (getting A1c checked, annual wellness visits, etc.).
    - **Wellth is also providing free blood pressure cuffs for members diagnosed with hypertension so they can monitor their blood pressure on a regular basis.**
  - The GCHP Chronic Disease Management Program provides members with chronic diseases health education on how to control and manage their symptoms. Classes are available in both English and Spanish.
  - GCHP has teamed up with Solera to offer a diabetes prevention program to members that includes health education on how to make healthier choices and lower risk for Type 2 diabetes available in both English and Spanish.
  - GCHP has a curated health library available through a partnership with Healthwise that provides membership with access to a myriad of health education materials to help learn how to manage their chronic conditions.
- Behavioral health related chronic conditions such as anxiety, depression and major depression are common among GCHP membership.
  - The GCHP Care Management (CM) Program utilizes the state Department of Health Care Services (DHCS) screening tools for mental health services to determine if a member needs access to non-specialty (mild-moderate) or specialty mental health services (Ventura County Behavioral Health).
    - **Adult Screening Tool for Medi-Cal Mental Health Services**
    - **Youth Screening Tool for Medi-Cal Mental Health Services**
    - **Members that screen positive for mild-moderate mental illness are referred to Carelon by CM staff.**
    - **Specialty mental health referrals are made on behalf of the member to Ventura County Behavioral Health.**
  - CM also works with Carelon, GCHP's non-specialty mental health provider, to provide follow-up after an emergency room (ER) visit for mental illness or substance use to ensure that members receive all necessary services and supports; this program is part of the PHM strategy. In addition, CM staff contact the member's primary care provider to ensure that they receive follow-up care within 30 days of their ER visit.
  - GCHP's Non-Specialty Mental Health Services (NSMHS) delegate, Carelon, completes PHQ-9s (an evidenced based depression screening) for members with mild-to-moderate distress. Services include outpatient therapy and medication management and applied behavioral analysis.
  - Medi-Cal beneficiaries with Serious Mental Illness / Serious Emotional Disturbance in need of more intensive treatment, such as wraparound day treatment, or inpatient care, are treated through Ventura County Behavioral Health.
- GCHP organized two impactful health fairs in Oxnard and Santa Paula in 2024 to support the residents of Ventura County. The fairs focused on providing essential health care screenings, resources, and education to address common gaps in care, which are crucial for improving health outcomes. GCHP was able to offer screenings for HbA1c, breast cancer, chlamydia, blood pressure, fluoride varnish, and flu vaccines. Incentives were provided as a way to encourage participation and help residents take proactive steps toward managing their health.

Social Determinants of Health

Introduction and Methodology

SDoH assessed for GCHP members are tobacco use, substance use, homelessness, and transportation needs. Tobacco and substance use are identified from Johns Hopkins ACG Expanded Diagnostic Cluster data; transportation needs are assessed through utilization data from GCHP's transportation provider; and homelessness is estimated based upon address within the GCHP member enrollment data. In 2024, GCHP began collecting social determinants through the health risk assessment (HRA) by surveying adults on their housing status, food insecurity, alcohol and drug use, transportation needs, employment, incarceration, and veteran status. For the 2025 population needs assessment, GCHP will incorporate HRA data by race, ethnicity, language and age band into this report. GCHP is also exploring incentivizing providers to expand their use of Z-codes to identify members with social needs that may affect their health.

Tobacco Use

Tobacco use can cause or exacerbate a wide range of adverse health conditions such as cancer, respiratory infections, and asthma. Of the total GCHP membership, 10,999 members, or 4.4% of the total membership population, have been identified as tobacco users compared to 2.7% of adults who smoke in Ventura County.

Table 11: Tobacco Use by Race

Tobacco Use	N=10,099	
Race	Unique Member Count	Percentage
White	3,739	34.0%
Some Other Race	4,015	36.5%
Unknown	2,685	24.4%
Black or African American	253	2.3%
Asian	205	1.9%
Native Hawaiian or Other Pacific Islander	67	0.6%
Alaskan Native or American Indian	35	0.3%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Table 12: Tobacco Use by Ethnicity

Tobacco Use	N=10,099	
Ethnicity	Unique Member Count	Percentage
Not Hispanic or Latino	4,299	39.1%
Hispanic or Latino	3,707	33.7%
Unknown	2,993	27.2%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Table 13: Tobacco Use by Language

Tobacco Use	N=10,099	
Language	Unique Member Count	Percentage
English	9,553	86.9%
Spanish	1,253	11.4%
Other	148	1.3%
Arabic	45	0.4%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Table 14: Tobacco Use by Age Band

Tobacco Use	N=10,099	
Age Band in Years	Unique Member Count	Percentage
21 - 64	9,179	83.5%
65+	1,506	13.7%
0 - 20	314	2.9%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings related to tobacco use:

- Table 11 shows that Whites make up 34.0% of all tobacco users, but only 15.4% of the total member population. Of the total White member population, 9.7% of Whites use tobacco second only to 9.9% of American Indian and Alaska Native members.
- Table 12 shows that Not Hispanic / Latino members make up 39.1% of all tobacco users but only 20.2% of the total member population. Of the total Not Hispanic / Latino member population, 8.5% of Not Hispanic / Latinos use tobacco followed by 6.6% of members with Unknown ethnicity.
- Table 13 shows that English-speaking members make up 86.9% of all tobacco users, but only 60.4% of the total member population. 12.1% of the total Arabic-speaking members use tobacco followed by 6.3% of English-speaking members.
- Table 14 shows that 21- to 64-year-old members make up 83.5% of all tobacco users but only 51.1% of the population. A large percentage of 0- to 20-year-olds in the member population are less likely to be tobacco users due to age restrictions on purchasing tobacco (38.7%) which shows only 0.3% of the total population age 0-20 are tobacco users.

Substance Use

According to the National Institute on Drug Abuse, people with substance use issues usually have one or more associated health issues, which could include mental health conditions, lung or heart disease, stroke, cancer, or mental health conditions. Of the total GCHP membership, 12,374 members, or 5%, have been identified as substance users. In Ventura County, there were 20.7 emergency room visits per 10,000 population 18+ years from 2020-2022. Ventura County residents 18-34 years, male, and White or Black/ African American were more likely to be hospitalized for substance abuse.

Table 15: Substance Use by Race

Substance Use	N=12,374	
Race	Unique Member Count	Percentage
Some Other Race	5,670	45.8%
White	3,522	28.5%
Unknown	2,799	22.6%
Black or African American	228	1.8%
Asian	89	0.7%
American Indian and Alaska Native	33	0.3%
Native Hawaiian and Other Pacific Islander	33	0.3%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Table 16: Substance Use by Ethnicity

Substance Use	N=12,374	
Ethnicity	Unique Member Count	Percentage
Not Hispanic or Latino	5,445	44.0%
Hispanic or Latino	3,905	31.6%
Unknown	3,024	24.4%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Table 17: Substance Use by Language

Substance Use	N=12,374	
Language	Unique Member Count	Percentage
English	10,547	85.2%
Spanish	1,772	14.3%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Table 18: Substance Use by Age Band

Substance Use	N=12,374	
Age Band in Years	Unique Member Count	Percentage
21 - 64	9,955	80.5%
65+	1,294	10.5%
0 - 20	1,125	9.1%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings related to substance use:

- Table 15 shows that members of Some Other Race make up 45.8% of all substance users but account for 64.0% of the total member population. Only 3.6% of members of Some
- Other Race are substance users compared to 9.4% of American Indian and Alaska Natives and 9.2% of Whites.
- Table 16 shows that members of Hispanic / Latino ethnicity make up 44.0% of all substance users but account for 61.5% of the total member population. Only 3.6% of Hispanic / Latino members are substance users compared to 7.8% of Not Hispanic / Latinos and 6.6% of members with unknown ethnicity.
- Table 17 shows that English-speaking members make up 85.2% of all substance users but only 60.4% of the total member population. Of the total English-speaking member population, 7.0% of English speakers are substance users followed by 1.9% of Spanish-speaking members.
- Table 18 shows that 21- to 64-year-old members make up 80.5% of all substance users but 51.1% of the population. 0- to 20-year-olds in the member population are less likely to be substance users, with only 1.1% of the total population in this age group as substance users.

Homelessness or Housing Instability

Housing instability has a direct impact on health outcomes and health care utilization. Of the total GCHP membership, 6,658 members, or 2.7%, have been identified through member enrollment data as lacking a permanent address and are either homeless or experiencing housing instability.

Table 19: Top 10 Chronic Conditions of Members Experiencing Homelessness or Housing Instability

Homelessness or Housing Instability	N=6,658	
Chronic Conditions	**Unique Member Count**	**Percentage**
Anxiety, neuroses	1,039	15.6%
Hypertension, without major complications	1,006	15.1%
Substance use	759	11.4%
Disorders of lipid metabolism	654	9.8%
Depression	571	8.6%
Major depression	496	7.4%
Obesity	479	7.2%
Asthma, without status asthmaticus	425	6.4%
Nonspecific signs and symptoms	414	6.2%
Degenerative joint disease	354	5.3%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings Related to Homelessness and Chronic Conditions:

- Compared to the general GCHP member population, members who are either homeless or experiencing housing instability are more likely to have anxiety / neuroses (15.6% versus 11.3%), hypertension, without major complications (15.1% versus 13.8%), depression (8.6% versus 5.3%), major depression (7.4% versus 5.7%), and asthma, without status asthmaticus (6.4% versus 5.5%).
- Substance use is the third most common chronic condition among members who are either homeless or experiencing housing instability, but this condition does not show up in the top 10 chronic conditions for the general membership.

Transportation Utilization

Transportation is a key determinant in access to health care. Of the total GCHP member population, 3,876 members (approximately 1.6%) accessed transportation services at some point in 2022 through Ventura Transit Systems, GCHP's transportation provider. Transportation days refers to the number of days that transportation was provided to a member; one transportation day includes the trip back and forth to a medical appointment.

Table 20: Transportation Days by Top Five Reasons for Ride and Age Group

Reason for Transportation Need	Under 18 Yrs.	18-64 Yrs.	65+ Yrs.	Total Transportation Days
Dialysis	87	53,422	55,182	108,691
Substance Use Disorder	0	50,504	8,422	58,926
Specialist	1,951	31,109	17,020	50,080
PCP	160	3,094	1,682	4,936
Mental Health	169	3,795	634	4,598

Source: Claims for service by Ventura Transit Service, 2023.

Key findings Related to Transportation:

- Dialysis was the No. 1 reason for requesting transportation by GCHP membership with the highest number of transportation days for those 65+ years.
- Substance use disorder was the number two reason for requesting transportation by GCHP membership with the highest number of transportation days for those 18 to 64 years of age.

Analysis of Needs:

GCHP offers Enhanced Care Management (ECM) to members that addresses clinical and non-clinical needs of high-need individuals through the coordination of services and comprehensive care management. ECM provides members with a dedicated lead care manager who will coordinate care for health and health-related social needs. ECM offers seven types of services to help a member manage and improve their health:

1. Outreach and engagement
2. Comprehensive assessment and care management planning
3. Enhanced coordination of care
4. Health promotion
5. Comprehensive transitional care
6. Member and family supports
7. Coordination of and referral to community and social support services

To be eligible for ECM, members must be enrolled in GCHP and meet at least one of the ECM populations of focus definitions described below:

1. Individuals Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experiencing Homelessness
2. Individuals Experiencing Homelessness: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness
3. Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly "High Utilizers")
4. Individuals with Serious Mental Health and/or SUD Needs
5. Individuals Transitioning from Incarceration
6. Adults Living in the Community and At Risk for LTC Institutionalization
7. Adult Nursing Facility Residents Transitioning to the Community
8. Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition
9. Children and Youth Involved in Child Welfare
10. Birth Equity Population of Focus

In addition, GCHP offers a wide range of community support services. These services help address members' health-related social needs, help them live healthier lives, and avoid higher, costlier levels of care. The following services are available to members through GCHP:

- **Housing Navigation** - If a member is experiencing homelessness or is at risk of experiencing homelessness, they may receive help to find, apply for and secure permanent housing.
- **Housing Deposit** - Members may also receive assistance with housing fees, such as security deposits and setting up utilities, like gas and electricity.
- **Housing Tenancy & Sustainability** - Once housing is secured, members may receive support to maintain your tenancy, such as coordination with landlords to address issues, assistance with annual housing recertification process, and connecting to local resources to prevent eviction.
- **Personal Care and Homemaker Services** - Members may receive in-home support such as bathing or feeding, meal preparation, grocery shopping, and someone to go with them to medical appointments if they require assistance with Activities of Daily Living Instrumental Activities of Daily Living.
- **Caregiver Services (Respite Services)** - Short-term relief for caregivers. Members may receive caregiver services in their home or in an approved facility on an hourly, daily, or nightly basis as needed.

- **Recuperative Care (Medical Respite)** - After hospitalization, if a member is without stable housing and still needs to heal from an injury or illness, they may receive short-term residential care, also called recuperative care.
- **Medically Supportive Food / Medically Tailored Meals** - Members may receive deliveries of nutritious, prepared meals and healthy groceries to support their health needs. They may also receive vouchers for healthy food and/or nutrition education.
- **Home Modifications** - Physical changes can be made to a member's home to improve their health, safety, and independence. Changes include ramps and grab-bars, doorway widening if they use a wheelchair, stairlifts, or making bathrooms wheelchair accessible.
- **Asthma Remediation** - Physical modifications can be made in a member's home to avoid acute asthma episodes due to environmental triggers like mold. Modifications can include filtered vacuums, dehumidifiers, air filters, and ventilation improvements.
- **Nursing Facility Transition / Diversion** - Assist individuals to live in the community and/or avoid institutionalization when possible.

Transportation Benefit

GCHP's transportation services are a vital resource for ensuring that members can access their health care appointments, especially for those facing mobility challenges, financial constraints, or lack of reliable transportation. These services help remove a significant barrier to care, promoting better health outcomes by ensuring that members can attend necessary appointments without worrying about transportation logistics. These are the two types of transportation services offered:

1. **Nonemergency Medical Transportation (NEMT)**
   a. **Eligibility:** Available for members who need extra assistance or a specialized vehicle due to medical or physical needs.
   b. **Service:** NEMT provides transportation to and from medical appointments in vehicles equipped to accommodate those with special needs (e.g., wheelchair-accessible vans).
3. **Nonmedical Transportation (NMT)**
   a. **Eligibility:** Available for members who do not require specialized medical transport and are capable of riding in a car, taxi, or bus.
   b. **Service:** NMT offers general transportation for medical appointments via regular vehicles (e.g., cars, taxis, buses).

Tobacco Cessation Resources

GCHP's Health Education team is taking a comprehensive approach to support its members in making healthier lifestyle choices, especially around issues like tobacco use and substance misuse. Offering resources and support in these areas is crucial for improving overall health outcomes, particularly in the context of chronic conditions and long-term wellness. Here's a summary of how GCHP is addressing these health concerns:

- **Mailed to Members:** Tobacco cessation resources are mailed directly to members, providing them with valuable information and tools to quit smoking or using tobacco products.

- **Inserted in Health Education (HE) Packets:** These materials are included in GCHP's educational packets, such as *Healthy Connections, Pregnancy & Postpartum*, ensuring that members receive important information during regular communications.
- **Available at Health Fairs:** At health fairs, members can access tobacco cessation resources in person, which is an opportunity for more direct interaction and support.
- **HRA (Health Risk Assessment) Follow-up:** After completing a Health Risk Assessment (HRA), GCHP follows up with members who report using alcohol, tobacco, prescription, or nonprescription drugs. The follow-up process helps identify those who may need additional support, referrals, or resources.

Member Incentive Program

GCHP's member incentive program is an excellent way to encourage members to engage in preventive care and ensure they stay on top of their health. By offering gift cards for completing these important screenings and vaccinations, GCHP is making it easier for individuals and families to access health care and take proactive steps toward wellness. Here's a summary of the preventative care incentives being offered:

1. **Mammograms**
   a. **Eligibility:** Members ages 40-74
   b. **Incentive:** $50 gift card
2. **Cervical Cancer Screening (Pap Test)**
   a. **Eligibility:** Members ages 21-64
   b. **Incentive:** $50 gift card
3. **HPV Vaccine**
   a. **Eligibility:** Members ages 9-13 (for second dose of vaccine)
   b. **Incentive:** $25 gift card
4. **Child and Adolescent Well-Care Visits**
   a. **Eligibility:** Members ages 3-21
   b. **Incentive:** $25 gift card
5. **Lead Screening**
   a. **Eligibility:** Members ages 0-2
   b. **Incentive:** $25 gift card
6. **Flu Shots**
   a. **Eligibility:** Members ages 6 months to 2 years
   b. **Incentive:** $25 gift card

These findings were reviewed and discussed with the PHM Workgroup. The PHM Workgroup found the services and programs included to reflect the current needs of the population.

Needs of Children and Adolescents

Introduction

GCHP assesses the needs of members 0–20 years of age (children and adolescents). There are 96,346 unique members meeting this definition in our overall population, which accounts for 38.7% of the total member population.

Methodology

The report includes the Johns Hopkins ACG Expanded Diagnostic Clusters and frequency of outpatient visits for children up to 20 years old, attributing each member to the age groups based on their age as of June 2024. The top 10 medical and behavioral health diagnoses and groups are identified through the aggregation of the raw data provided in this report. The needs of members are identified based on these diagnoses.

Table 21: Top 10 Most Prevalent Chronic Conditions for 0-20 Year Olds

Chronic Condition	Unique Member Count	Percentage
Gingivitis	8,205	8.5%
Obesity	7,248	7.5%
Developmental disorder	6,830	7.1%
Asthma, without status asthmaticus	6,197	6.4%
Anxiety, neuroses	5,664	5.9%
Disorders of lipid metabolism	3,619	3.8%
Autism Spectrum Disorder	3,544	3.7%
Attention deficit disorder	2,774	2.9%
Depression	2,625	2.7%
Major depression	2,521	2.6%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- Gingivitis is the most common chronic condition among members 0-20 years, affecting 8.5% of the child and adolescent population.
- Gingivitis ICD10 coding went live October 1, 2023, with more to come in 2025.
- Obesity is second most common in terms of chronic conditions, affecting 7.5% of the 0–20-year member population.
- Developmental disorder is the third most common chronic condition among these members, affecting 7.1% of the member population.
- Six of the top ten chronic conditions are mental health related chronic conditions including anxiety / neuroses, major depression, and depression.

Table 22: Top 10 Most Common Primary Diagnoses by Children and Adolescents

0-20 years old	N=96,346	
Reason for Visit	**Unique Member Count**	**Prevalence Percentage**
Encounter for routine child health examination without abnormal findings	16,915	17.6%
Acute upper respiratory infection, unspecified	6,432	6.7%
Cough, unspecified	3,448	3.6%
Acute pharyngitis, unspecified	2,427	2.5%
Fever, unspecified	2,370	2.5%
Unspecified abdominal pain	2,263	2.3%
Viral infection, unspecified	2,036	2.1%
Encounter for immunization	2,033	2.1%
Obesity, unspecified	1,231	1.3%
Constipation, unspecified	1,210	1.3%

*** Analysis included only the top 10 primary diagnoses associated with all medical visits within a 12-month period.**
Source: Claims from Professional, Encounters, and All Plan Data feed from July 2023 – June 2024.

Key findings:

- Preventive care is the most common reason for visits among children and adolescents (0- 20 years old), representing 17.6% of members within this age group having a visit with this primary diagnosis.
- Acute upper respiratory infections are the second most common reason, accounting for 6.7% of the total member population in this age group having a visit with this primary diagnosis.
- Vaccine-related encounters are also frequent causes for visits, accounting for 2.1% of total members in this age group.

Conclusion Statement:

Preventive care is the top medical visit reason for children and adolescents, highlighting a focus on proactive health measures within this age group. As stated previously, while this suggests that preventive care efforts are particularly strong, GCHP is currently meeting minimum performance level for well-child

visits for 0-30 months of life for the 2024 measurement year and has some significant work to do to address adolescent well-child visits.

Analysis of Needs:

- The third most common chronic condition among children and adolescents is developmental disorders.
  - The CM program works with Tri-Counties Regional Center to ensure children with developmental disorders are receiving the services and support they need.
  - When a child is diagnosed with a developmental disorder, CM staff notifies their primary care provider to facilitate care coordination.
  - The CM program also works to ensure that children with special health care needs are connected with pediatric specialists based upon their age and diagnosis as well as referring them to California Children's Services to facilitate expanded coverage.
- The fourth most common chronic condition among children and adolescents is asthma, without status asthmaticus.
  - GCHP offers Asthma Remediation as a community support benefit to members. Physical modifications can be made in a member's home to avoid acute asthma episodes due to environmental triggers like mold. Modifications can include filtered vacuums, dehumidifiers, air filters, and ventilation improvements.
- Although preventive care is the top reason for visits in the child and adolescent population, GCHP is still not meeting minimum performance level for child and adolescent well visits.
  - GCHP offers a member incentive of $25 for members 3-21 years of age to complete a well-child visit within the calendar year.
  - GCHP is also exploring partnerships with providers, school districts, and other agencies to bring wellness and prevention opportunities to where children and adolescents congregate such as schools or after-school programs.
- Behavioral health related chronic conditions such as anxiety, depression and major depression are common among children and adolescent members.
  - The GCHP Care Management (CM) Program utilizes the state Department of Health Care Services (DHCS) screening tools for mental health services to determine if a member needs access to non-specialty (mild-moderate) or specialty mental health services (Ventura County Behavioral Health).
    - **Adult Screening Tool for Medi-Cal Mental Health Services**
    - **Youth Screening Tool for Medi-Cal Mental Health Services**
    - **Members who screen positive for mild-moderate mental illness are referred to Carelon by CM staff.**
    - **Specialty mental health referrals are made on behalf of the member to Ventura County Behavioral Health.**
  - CM also works with Carelon, GCHP's non-specialty mental health provider, to provide follow-up after an emergency room (ER) visit for mental illness or substance use to ensure that members receive all necessary services and supports; this program is part of the PHM strategy. In addition, CM staff contact the member's primary care provider to ensure that they receive follow-up care within 30 days of their ER visit.

- In addition, CM works with Carelon to assist members who have been diagnosed with autism to connect members with appropriate providers for applied behavior analysis therapy.
- The Student Behavioral Health Incentive Program (SBHIP) is a three-year initiative in collaboration with local school districts that addresses the youth mental health crisis by providing prevention, early intervention, and treatment at schools through the wellness centers.

These findings were reviewed and discussed with the PHM Workgroup. The PHM Workgroup found the services and programs included to reflect the current needs of the population.

Needs of Persons with Disabilities

Introduction and Methodology

Persons with disabilities have particularly acute needs for care coordination and intense resource use (e.g., prevalence of chronic diseases). GCHP identified the population with disabilities by utilizing the disabled aid code from the GCHP member enrollment data as of June 2024 provided by the state Department of Health Care Services (DHCS). A total of 15,740 members were identified utilizing this methodology representing 6.3% of the total membership.

Table 23: Top Chronic Conditions Among Persons with Disabilities

Persons with Disabilities	N=15,740	
Chronic Conditions	**Unique Member Count**	**Prevalence Percentage**
Hypertension, without major complications	5,557	35.3%
Disorders of lipid metabolism	5,156	32.8%
Anxiety, neuroses	3,885	24.7%
Developmental disorder	3,213	20.4%
Obesity	2,796	17.8%
Degenerative joint disease	2,555	16.2%
Type 2 diabetes, with complication	2,442	15.5%
Autism Spectrum Disorder	2,386	15.2%
Major depression	2,382	15.1%
Nonspecific signs and symptoms	2,293	14.6%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- Hypertension without major complications is the most common chronic condition among persons with disabilities, affecting 35.3% of that population.

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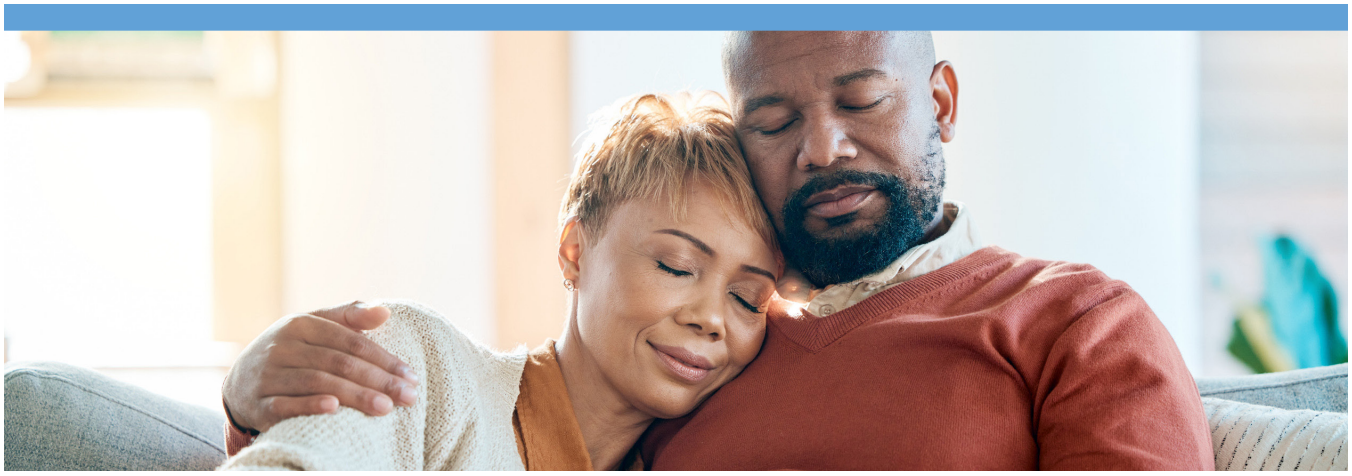
- Disorders of lipid metabolism is the second most common chronic condition among the population with disabilities, affecting 32.8% of that population.
- Anxiety neuroses is the third most common chronic condition affecting 24.7% of this population.

Analysis of Needs:

Every time a newly enrolled member is identified as a senior or person with disabilities, a program referral is generated for CM staff to outreach to the member. The CM staff works with the members to complete an initial intake screening to identify needs for services and support and/or enroll them in complex case management, a program included in the PHM strategy. These findings were reviewed and discussed with the PHM Workgroup. The PHM Workgroup found the services and programs included to reflect the current needs of the population.



Needs of Members with Persistent Mental Illness

Introduction and Methodology

Members with persistent mental illness have particularly acute needs for care coordination and intense resource use (e.g., prevalence of chronic diseases). These members were identified through use of Johns Hopkins ACG focusing on those members with chronic psychosocial conditions. Conditions included in the analysis can be found in Table 23 below. Utilizing this criterion, 45,457 members were identified with persistent mental illness, which makes up 18.3% of total membership.

Table 24: Psychosocial Conditions Used to Identify Persistent Mental Illness

Psychosocial Conditions	
Anxiety, neuroses	Post traumatic stress disorder
Attention deficit disorder	Psychologic signs and symptoms
Bipolar disorder	Psychological disorders of childhood
Depression	Psychosexual
Eating disorder	Psych-physiologic and somatoform disorders
Impulse control	Schizophrenia and affective psychosis
Major depression	Substance use
Personality disorders	

Source: Johns Hopkins ACG.

Table 25: Prevalence of Persistent Mental Illness

Persistent Mental Illness	N=45,457	
Chronic Conditions	Unique Member Count	Percentage
Anxiety, neuroses	28,788	63.3%
Major depression	14,674	32.3%
Depression	13,718	30.2%
Substance use	5,813	12.8%

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Persistent Mental Illness	N=45,457	
Chronic Conditions	Unique Member Count	Percentage
Attention deficit disorder	5,229	11.5%
Schizophrenia and affective psychosis	3,704	8.1%
Bipolar disorder	3,657	8.0%
Psychological disorders of childhood	1,919	4.2%
Post traumatic stress disorder	902	2.0%
Personality disorders	722	1.6%
Psychologic signs and symptoms	686	1.5%
Psych-physiologic and somatoform disorders	668	1.5%
Psychosexual	624	1.4%
Eating disorder	607	1.3%
Impulse control	270	0.6%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- Of the population with persistent mental illness, 63.3% have anxiety / neuroses. Ethnicity labeled Not Hispanic / Latino members account for 27.0% of those members who have anxiety / neuroses, but only 20.2% of total membership.
- Major depression and depression are the second and third most common persistent mental illness. English speakers make of 74.0% of members with major depression or depression but only 60.4% of total membership.
- Substance use is the fourth most common persistent mental illness, affecting 12.8% of the member population with persistent mental illness.

Table 26: Prevalence of Non-Psychosocial Chronic Conditions Among Members with Persistent Mental Illness

Persistent Mental Illness	N=45,457	
Non-Psychosocial Chronic Conditions	Unique Member Count	Percentage
Disorders of lipid metabolism	13,726	30.2%
Hypertension, without major complications	13,063	28.7%
Obesity	8,881	19.5%
Nonspecific signs and symptoms	5,811	12.8%
Degenerative joint disease	5,773	12.7%
Asthma, without status asthmaticus	5,244	11.5%
Type 2 diabetes, w/ complication	4,735	10.4%

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Persistent Mental Illness	N=45,457	
Non-Psychosocial Chronic Conditions	Unique Member Count	Percentage
Refractive errors	4,496	9.9%
Chronic liver disease	3,957	8.7%
Musculoskeletal disorders, other	3,720	8.2%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- Of those members with persistent mental illness, the most prevalent non-psychosocial chronic condition is disorders of lipid metabolism, affecting 30.2% of members with persistent mental illness.
- Hypertension without major complications is the second most common non-psychosocial chronic condition, affecting more than one-quarter of the membership with persistent mental illness.
- Obesity is the third most common non-psychosocial chronic condition of members with persistent mental illness.

Conclusion Statement:

Anxiety, depression, and other persistent mental health conditions affect more than 18% of the total GCHP membership, underscoring the importance of access to mental health services. This population is also experiencing co-occurring non-psychosocial conditions; control of these chronic conditions may be affected by their persistent mental illness, so care coordination efforts should be focused on this population to ensure improvement in health outcomes.

Analysis of Needs:

- Chronic conditions such as hypertension, obesity, asthma, Type 2 diabetes, and disorders of lipid metabolism are common among GCHP membership with persistent mental health conditions.
  - The Complex Case Management (CCM) Program, which is part of the PHM strategy, proactively outreaches to members with diabetes, cardiovascular disease, and/or hypertension who are identified through risk stratification monthly to enroll them in CCM.
  - GCHP has partnered with Wellth, a company that uses behavioral science and behavioral economics, to incentivize members to engage in healthy behaviors; the program focused on members with chronic conditions is part of the PHM strategy. Wellth looks holistically at members' (not individual conditions) health needs in their care journey and ensures members can earn rewards and incentives for building health behaviors that lead to long-term improved health outcomes. This includes incentivizing daily behaviors like taking medications, healthy meals, checking blood glucose or blood pressure as well as one-time annual health screenings (getting A1c checked, annual wellness visits, etc.).
    - **Wellth is also providing free blood pressure cuffs for members diagnosed with hypertension so they can monitor their blood pressure on a regular basis.**

  - » The GCHP Chronic Disease Management Program provides members with chronic diseases health education on how to control and manage their symptoms. Classes are available in both English and Spanish.
  - » GCHP has teamed up with Solera to offer a diabetes prevention program to members that includes health education on how to make healthier choices and lower risk for Type 2 diabetes available in both English and Spanish.
  - » GCHP has a curated health library available through a partnership with Healthwise that provides membership with access to a myriad of health education materials to help learn how to manage their chronic conditions.
- Behavioral health related chronic conditions such as anxiety, depression, and major depression are common among GCHP membership.
  - » GCHP offers Enhanced Care Management (ECM) to members as one way to address member needs with respect to SDoH and can provide care coordination to members with persistent mental illness. ECM provides members with a dedicated lead care manager who will coordinate care for health and health-related social needs. ECM care managers provide assistance to members by phone, in-person, or where they live; homeless individuals and substance users are included in the populations of focus for this benefit.
  - » CM works with Carelon, GCHP's non-specialty mental health provider, to provide follow-up after an emergency room (ER) visit for mental illness or substance use to ensure that members receive all necessary services and supports; this program is part of the PHM strategy. In addition, CM staff contact the member's primary care provider to ensure that they receive follow-up care within 30 days of their ER visit.

These findings were reviewed and discussed with the PHM Workgroup. The PHM Workgroup found the services and programs included to reflect the current needs of the population.

Needs of Members of Racial or Ethnic Groups

Introduction

GCHP uses direct data collection to assess the racial and ethnic needs of its population. Race and ethnicity data are collected directly from members at enrollment. Needs that may be relevant or specific to member experiences or cultures from identified racial or ethnic groups are identified below. Membership race / ethnicity profile and needs are presented at the first Quality Improvement Committee meeting after HEDIS® results are finalized.

Methodology

GCHP uses the Race / Ethnicity Stratified (RES) HEDIS® measures to aggregate data on member race / ethnicity and identify disparities. Only RES HEDIS® measures where at least two races or ethnicity groups had 30 or more members in the reporting population were included.

Table 27: Top 10 Chronic Conditions for Hispanic / Latino Members

Hispanic / Latino	N=152,968	
Chronic Conditions	**Unique Member Count**	**Prevalence Percentage**
Disorders of lipid metabolism	22,326	14.6%
Hypertension, without major complications	18,185	11.9%
Obesity	15,662	10.2%
Anxiety, neuroses	14,959	9.8%
Gingivitis	13,240	8.7%
Type 2 diabetes, with complication	8,678	5.7%
Asthma, without status asthmaticus	8,066	5.3%
Refractive errors	7,844	5.1%

Hispanic / Latino	N=152,968	
Chronic Conditions	Unique Member Count	Prevalence Percentage
Major depression	7,259	4.7%
Depression	7,020	4.6%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- Disorders of lipid metabolism is the leading chronic condition among Hispanic / Latino members, with a rate of 14.6% for the Hispanic / Latino member population compared to 15.4% for overall membership.
- Hypertension without major complications is present in 11.9% of Hispanic / Latino members making it the second most common chronic condition as compared to 13.8% for overall membership.
- Like the overall member population, three of the top ten chronic conditions among Hispanic / Latino members are mental health related chronic conditions including anxiety / neuroses, major depression, and depression.
- Obesity is the third most common chronic condition among Hispanic / Latino members, affecting 10.2% of the Hispanic / Latino population as compared to 9.3% of the overall member population.
- Gingivitis is the fifth most common chronic disease among the Hispanic / Latino membership affecting 8.7% of the Hispanic / Latino population versus 7.0% of the general population.

Conclusion Statement:

Hispanic / Latino members have similar needs in chronic disease management as the general membership. Chronic disease management programs that support members in controlling their conditions such as hypertension and diabetes and encourage healthy habits should be available to GCHP membership. Resources and programs to address behavioral health needs should also be prioritized.

Table 28: Top 10 Chronic Conditions for White Members

White	N=38,254	
Chronic Conditions	Unique Member Count	Prevalence Percentage
Anxiety, neuroses	6,679	17.5%
Hypertension, without major complications	6,676	17.5%
Disorders of lipid metabolism	6,663	17.4%
Major depression	3,679	9.6%
Depression	3,313	8.7%
Obesity	3,163	8.3%
Degenerative joint disease	3143	8.2%
Nonspecific signs and symptoms	2752	7.2%

White	N=38,254	
Chronic Conditions	Unique Member Count	Prevalence Percentage
Asthma, without status asthmaticus	2,405	6.3%
Refractive errors	2,069	5.4%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- Anxiety, neuroses is the leading chronic condition among White members, with a rate of 17.5% compared to 11.3% for overall membership.
- Hypertension without major complications is present in 17.5% of this population, making it the second most common chronic condition compared to 13.8% for overall membership.
- Similar to the overall member population, three of the top 10 chronic conditions among White members are mental health related chronic conditions including anxiety / neuroses, major depression, and depression.
- Disorders of lipid metabolism is the third most common chronic condition among White members, affecting 17.4% of the White population as compared to 15.4% of the overall member population.

Conclusion Statement:

White members have similar needs in chronic disease management as the general membership. Chronic disease management programs that support members in controlling their conditions such as hypertension and diabetes and encourage healthy habits should be available to GCHP membership. Resources and programs to address behavioral health needs should also be prioritized because rates of the top three behavioral health related chronic conditions are higher in the White member population.

Table 29: Top 10 Chronic Conditions for Black or African American Members

Black or African American	N=3,154	
Chronic Condition	Unique Member Count	Prevalence Percentage
Hypertension, without major complications	598	19.0%
Disorders of lipid metabolism	438	13.9%
Anxiety, neuroses	376	11.9%
Obesity	348	11.0%
Asthma, without status asthmaticus	279	8.8%
Major depression	217	6.9%
Depression	214	6.8%
Degenerative joint disease	207	6.6%
Type 2 diabetes, with complication	197	6.2%
Nonspecific signs and symptoms	187	5.9%

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- Hypertension without major complications is the leading chronic condition among Black or African American members, with a rate of 19.0% for the Black or African American member population compared to 13.8% for overall membership.
- Disorders of lipid metabolism are the second most common chronic condition groups among Black or African American members, affecting 13.9% of this population as compared to 15.4% of the overall member population.
- Anxiety / neuroses is present in 11.9% of Black or African American members making it the third most common chronic condition with a rate like the overall membership at 11.3%.
- Like the overall member population, three of the top 10 chronic conditions among Black or African American members are mental health related chronic conditions including anxiety / neuroses, major depression, and depression.

Conclusion Statement:

Black or African American members have similar needs in chronic disease management as the general membership but have higher rates of hypertension. Chronic disease management programs that support members in controlling their conditions such as hypertension and diabetes and encourage healthy habits should be available to GCHP membership. Resources and programs to address behavioral health needs should also be prioritized.

Table 30: Top 10 Most Common Primary Diagnoses for Hispanic / Latino Members

Hispanic / Latino	N=152,968	
Reason for Visit	**Unique Member Count**	**Prevalence Percentage**
Encounter for routine child health examination without abnormal findings	12,294	8.0%
Acute upper respiratory infection, unspecified	6,055	4.0%
Encounter for immunization	4,971	3.2%
Unspecified abdominal pain	4,760	3.1%
Essential (primary) hypertension	4,639	3.0%
Chest pain, unspecified	4,570	3.0%
Encounter for general adult medical examination without abnormal findings	4,540	3.0%
Cough, unspecified	4,405	2.9%
Type 2 diabetes mellitus without complications	4,367	2.9%
Encounter for screening mammogram for malignant neoplasm of breast	2,919	1.9%

***Analysis included only the top 10 primary diagnoses associated with all medical visits within a 12-month period.**
Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- Preventive care for children is the most common reason for visits among Hispanic / Latino members, representing 8.0% of the Hispanic / Latino population having a visit with this primary diagnosis.
- Acute upper respiratory infection, unspecified is the second most common primary diagnosis among the Hispanic / Latino population with 4.0% of members having a visit with this primary diagnosis.
- Other notable reasons for visits include preventive care for adults and mammogram screenings.

Conclusion Statement:

Preventive care for children is the top medical visit reason for Hispanic / Latino members, highlighting a focus on proactive health measures within this ethnic group. However, only 30.0% of Hispanic / Latino members had a least one preventive care visit within a 12-month period.

Table 31: Top 10 Most Common Primary Diagnoses for White members

White	N=38,254	
Reason for Visit	**Unique Member Count**	**Prevalence Percentage**
Essential (primary) hypertension	2,028	5.3%
Chest pain, unspecified	1,668	4.4%
Encounter for general adult medical examination without abnormal findings	1,310	3.4%
Unspecified abdominal pain	1,272	3.3%
Shortness of breath	1,269	3.3%
Encounter for routine child health examination without abnormal findings	1,176	3.1%
Cough, unspecified	1,098	2.9%
Acute upper respiratory infection, unspecified	1,088	2.8%
Type 2 diabetes mellitus without complications	1,046	2.7%
Low back pain, unspecified	939	2.5%

***Analysis included only the top 10 primary diagnoses associated with all medical visits within a 12-month period.**
Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- Essential (primary) hypertension is the most common reason for medical visits among White members, accounting for 5.3% of visits.
- Chest pain, unspecified is the second most common reason, accounting for 4.4% of visits.
- Other notable reasons for visits include Type 2 diabetes, general adult medical examinations, low back pain, chest pain, unspecified abdominal pain, vaccine-related encounters, and shortness of breath, each ranging from 2.5% to 4.4% of visits.

Conclusion Statement:

White members frequently seek health care for essential (primary) hypertension as the most common primary diagnosis and chest pain, unspecified, as the second most common, highlighting the presence of chronic and acute illness.

Table 32: Top 10 Most Common Primary Diagnoses for Black or African American Members

Black or African American	N=3,154	
Reason for Visit	Unique Member Count	Prevalence Percentage
Essential (primary) hypertension	192	6.1%
Chest pain, unspecified	150	4.8%
Encounter for routine child health examination without abnormal findings	150	4.8%
Type 2 diabetes mellitus without complications	106	3.4%
Shortness of breath	103	3.3%
Unspecified abdominal pain	99	3.1%
Cough, unspecified	98	3.1%
Illness, unspecified	97	3.1%
Acute upper respiratory infection, unspecified	96	3.0%
Encounter for general adult medical examination without abnormal findings	95	3.0%

***Analysis included only the top 10 primary diagnoses associated with all medical visits within a 12-month period.**

Source: Johns Hopkins ACG Expanded Diagnostic Cluster based upon June 2024 enrollment.

Key findings:

- Essential (primary) hypertension is the most common reason for medical visits among Black or African American members, accounting for 6.1% of the total Black or African American member population.
- Routine child health examination is the third most common reason, accounting for 4.8% of the total Black or African American member population.
- Type 2 diabetes mellitus without complications is also frequent causes for visits, accounting for 3.4% of visits.
- Other notable reasons for visits include general adult medical examinations, chest pain, shortness of breath, unspecified abdominal pain each ranging from 3.0% to 4.8% of the total Black or African American member population having a visit with one of these as a primary diagnosis.

Conclusion Statement:

Black or African American members frequently seek health care for preventive care, reflecting an emphasis on preventive health measures, with a notable presence of chronic conditions and mental health concerns.

Table 33: HEDIS® Measure Compliance by Race / Ethnicity for Colorectal Cancer Screening (COL) MY23

Race	White			Black or African American			Hispanic or Latino		
Source	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
Eligible Population	5,989	0	5,989	363	0	363	11,038	0	11,038
Numerator	1,824	0	1,824	97	0	97	3,702	0	3,702
Rate	30.46	0	30.46	26.72	0	26.72	33.54	0	33.54
Audit Designation	R	R	R	R	R	R	R	R	R
Status	R	NA	R	R	NA	R	R	NA	R

Key findings:

- The eligible population for the HEDIS® measure is highest among the Hispanic / Latino group, with 11,038 individuals, followed by the White and Black or African American groups with 5,989 and 363 individuals, respectively.
- Compliance rates, as indicated by the measure rate, are highest for the Hispanic / Latino group at 33.54%, with the White group at 30.46% and the Black or African American group at 26.72%.
- The data is directly sourced for all racial/ethnic groups, with no indirect sources reported.
- The status for the reported HEDIS® measure is marked as 'R' (Required) for all the groups, with no applicable status marked as 'NA' (Not Applicable).

Conclusion Statement:

The HEDIS® measure compliance rates show that the Hispanic / Latino group has the highest compliance rate, while the Black or African American group, having the smallest eligible population, also has a lower compliance rate than the two other racial / ethnic groups. This suggests that Black or African Americans in the member population are getting screened at lower rates for measurement year 2023 compared to other groups.

Table 34: HEDIS® Measure Compliance by Race / Ethnicity for Controlling High Blood Pressure (CBP) MY23

Race	White			Black or African American			Hispanic or Latino		
Source	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
Collection Method	H	H	1,589	161	0	161	H	H	3,702
Eligible Population	1,589	0	46	3	0	3	4,607	0	11,038
Numerator	46	0	82	7	0	7	116	0	3,702
Denominator	82	0	56.10	42.86	0	42.86	2030	203	

Race	White			Black or African American			Hispanic or Latino		
Source	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
Rate	56.10	0	56.10	42.86	0	42.86	68.97	0	68.97
Audit Designation	R	R	R	R	R	R	R	R	R
Status	R	NA	R	NA	NA	NA	R	NA	R

Key findings:

- The HEDIS® measure of compliance for controlling high blood pressure (CBP) shows the highest rate among the Hispanic / Latino group at 68.97%.
- The White group's compliance rate is 56.10%, while the Black or African American group has a compliance rate of 42.86%.
- The eligible population size is considerably larger for the Hispanic / Latino group (4,607) compared to the white (1,589) and Black or African American (161) groups.
- Data collection is direct for all groups, and the status for the measure is marked as 'R' (required) across all racial and ethnic categories.

Conclusion Statement:

While the Hispanic / Latino group has the largest eligible population for the CBP measure, they also exhibit the highest compliance rate, indicating effective management of blood pressure within this group. The compliance rate for Black or African American members is low in this category, suggesting needed focused efforts on blood pressure control across this group. The data reflects a strong performance in managing high blood pressure, which is a critical component of cardiovascular health.

Table 35: HEDIS® Measure Compliance by Race / Ethnicity (PPC Timeliness Prenatal Care) MY23

Race	White			Black or African American			Hispanic or Latino		
Timeliness Prenatal Care									
Source	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
Collection Method	H	H	H	H	H	H	H	H	H
Eligible Population	169	0	169	17	0	17	1,685	0	1,685
Numerator	21	0	21	1	0	1	253	0	253
Denominator	24	0	24	1	0	1	272	0	272
Rate	87.50	0	87.50	100.00	0	100.00	93.01	0	93.01
Audit Designation	R	R	R	R	R	R	R	R	R

Race	White			Black or African American			Hispanic or Latino		
Timeliness Prenatal Care									
Source	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
Status	R	NA	R	NA	NA	NA	R	NA	R

Key findings:

- The White group has the third highest rate of timeliness in prenatal care at 87.50% compliant.
- The Black or African American group has a significantly lower numerator and denominator but met 100.00% compliance with the requirement.
- The Hispanic / Latino group has a higher denominator, and the rate of compliance is also high, at 93.01%.
- The eligible population for the measure is much larger for the Hispanic / Latino group (1,685) compared to the White (169) and Black or African American (17) groups.
- All data is sourced directly, and the audit designation and status are marked 'R' (required) across all racial and ethnic groups, indicating the mandatory nature of the measure.

Conclusion Statement:

The compliance rates for timeliness in prenatal care are particularly high for the White and Hispanic / Latino groups, indicating strong adherence to recommended prenatal care timelines within these groups. The Black or African American group has a much lower rate, which may point to potential barriers to accessing timely prenatal care that need to be addressed to ensure equitable health care.

Table 36: HEDIS® Measure Compliance by Race / Ethnicity (PPC Postpartum Care) MY23

Race	White			Black or African American			Hispanic or Latino		
Postpartum Care									
Source	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
Collection Method	H	H	H	H	H	H	H	H	H
Eligible Population	69	0	69	17	0	17	1,685	0	1,685
Numerator	21	0	21	1	0	1	253	0	253
Denominator	24	0	24	1	0	1	272	0	272
Rate	87.50		87.50	100.00		100.00	93.01		93.01
Audit Designation	R	R	R	R	R	R	R	R	R
Status	R	NA	R	NA	NA	NA	R	NA	R

Key findings:

- The HEDIS® measure compliance for postpartum care is highest among the Black or African American group, with a perfect rate of 100%.
- The compliance rate for the White group is 87.50%, while the Hispanic / Latino group has a rate of 93.01%.
- The eligible population is substantially larger for the Hispanic / Latino group (1,685) compared to the White (69) and Black or African American (17) groups.
- Data collection is solely direct across all groups, and the audit designation and status are marked 'R' (Required), indicating the necessity of compliance with this measure.

Conclusion Statement:

Compliance with postpartum care measures is exceptionally high across all groups, with the Black or African American group achieving complete compliance despite the small eligible population. This indicates that postpartum care is effectively prioritized and delivered across these racial and ethnic groups within the health care system evaluated.

Table 37: HEDIS® Measure Compliance by Race / Ethnicity for Well-Care Visits (WCV) MY23

Race	White			Black or African American			Hispanic or Latino		
Source	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
Eligible Population	7,918	0	7,918	789	0	789	62,415	0	62,415
Numerator	2,972	0	2,972	315	0	315	32,309	0	32,309
Rate	37.50	0	37.50	39.92	0	39.92	48.41	0	48.41
Audit Designation	R	R	R	R	R	R	R	R	R
Status	R	NA	R	R	NA	R	R	NA	R

Key findings:

- The rate of the HEDIS® measure for child and adolescent well-care visits (WCV) is highest among the Hispanic / Latino group at 48.41%.
- The White group's rate stands at 37.50%, while the Black or African American group has a rate of 39.92%.
- The eligible population is much larger for the Hispanic / Latino group (62,415) compared to the White (7,918) and Black or African American (789) groups.
- All data is sourced directly, and the audit designation and status are marked 'R' (Required), signifying the measure's mandatory reporting across all groups.

Conclusion Statement:

While the Hispanic / Latino group has the largest eligible population, they also have the highest compliance rate for well-care visits, indicating effective health engagement for children and adolescents

in this community. The rates for the White and Black or African American groups are lower, pointing to potential areas for improvement in healthcare delivery and engagement strategies for these populations.

Table 38: HEDIS® Measure Compliance by Race / Ethnicity

Race	COL	CBP	PPC (Timeliness)	PPC (Postpartum)	WCV
White	30.46%	56.10%	87.50%	87.50%	37.50%
Black or African American	26.72%	42.86%	100.00%	100.00%	39.92%
Hispanic / Latino	33.54%	68.97%	93.01%	93.01 %	48.41%

Key findings:

- The compliance rates for colorectal cancer screening (COL) are similar across all races, with the highest rate among Hispanic / Latino individuals (33.54%).
- For controlling high blood pressure (CBP), the Hispanic / Latino group has the highest compliance rate (68.97%), with the Black or African American group having a much lower rate at 42.86%.
- The Black or African American group shows the highest compliance for timeliness in prenatal care (PPC) and postpartum care (PPC) at 100.00%
- Child and adolescent well-care visits (WCV) have the highest compliance rate among the Hispanic / Latino group (48.41%).

Conclusion Statement:

The data demonstrates a generally equitable performance across racial and ethnic groups for most HEDIS® measures, with particularly strong results in postpartum care among Black or African American individuals and in hypertension control among Hispanic / Latino individuals. These results suggest targeted areas where health care delivery is effective and other areas where improvements could be made to ensure consistent care across all measures.

These findings were reviewed and discussed with the PHM Workgroup. The PHM Workgroup found the services and programs included to reflect the current needs of the population.

Provider Race and Ethnicity Summary

Introduction and Methodology

GCHP has access to provider submitted demographic data. Less than 20% of providers have reported their race / ethnicity. If providers submit their demographic data, we will be able to compare to the total membership population.

Table 39: Provider Race Stratification

Race	Unique Member Count	Percent of Race
American Indian or Alaska Native	5	0.1%
Asian	55	0.6%
Black or African American	6	0.1%
Decline to Answer	966	10.7%
Hawaiian or Other Pacific Islander	2	0.0%
Some other race	57	0.6%
Unknown	7,717	85.7%
White	194	2.2%

Source: GCHP Provider Demographic Data

Table 40: Provider Ethnicity Stratification

Ethnicity	Unique Member Count	Percent of Race
Decline to Answer	1,041	11.6%
Hispanic or Latino	28	0.3%
Not Hispanic or Latino	222	2.5%
Unknown	7,711	85.7%

Source: GCHP Provider Demographic Data

Key findings:

- The data is insufficient in determining the racial and ethnic background of providers who are serving GCHP members.

Conclusion Statement:

Over 80% of providers have not provided race or ethnicity background information and over 10% have declined to answer. There is no ability to compare the race or ethnicity background of providers to membership demographics.

These findings were reviewed and discussed with the PHM Workgroup. The PHM Workgroup found the services and programs included to reflect the current needs of the population.

Needs of Members with Limited English Proficiency

Introduction and Methodology

GCHP uses direct data collection to assess the needs of limited English proficiency groups. Spoken and written language data are collected directly from members at enrollment. GCHP utilizes the data to determine the needs of members whose primary language is a language other than English when threshold languages (spoken or written by ≥5% of the total population) are present.

Population Language Profile

Table 41: Membership Language Stratification

Language	Percent of Language	Unique Member Count
English	60.4%	150,442
Spanish	37.8%	93,976
Unknown	0.9%	2,159
Other	0.7%	1,714
Vietnamese	0.3%	632

Source: Membership based upon June 2024 active enrollment.

Key findings:

- The predominant language among members is English, making up 60.4% of the population with a raw count of 150,442 individuals.
- Spanish is the second most common language, representing 37.8% of the members, which translates to 93,976 individuals.
- A small minority, 0.7% or 1,174 members, speak 20 languages combined categorized as "Other."
- Vietnamese is the largest primary language spoken outside of English and Spanish, but still a small subset of the total member population at 0.3% or 632 unique members.

Conclusion Statement:

English and Spanish are the primary languages among members, while other languages are comparatively less common.

Table 42: Provider Language Stratification

Language	Percent of Language	Unique Member Count
Unknown	77.64%	6,487
Spanish	10.65%	890
Hindi	1.14%	95
Mandarin	1.09%	91
Other	9.48%	792

Source: GCHP Provider Submitted Demographic Data

Key findings:

- More than one-third of provider language data is null or unavailable. There are either data limitations or these providers only speak English.
- The second most common reported language is Spanish with 890 providers. We cannot make any assumptions that this is the total Spanish speaking population, because there are so many nulls.

Conclusion Statement:

There needs to be more data collected on providers to be able to identify English-only providers and providers who have not submitted their spoken languages.

Table 43: Top 10 Most Common Reasons for Visit by English Speaking members

English	N=150,442	
Reason for Visit	Unique Member Count	Prevalence Percentage
Encounter for routine child health examination without abnormal findings	9,827	6.5%
Acute upper respiratory infection, unspecified	6,514	4.3%
Essential (primary) hypertension	5,694	3.8%
Chest pain, unspecified	5,568	3.7%
Cough, unspecified	5,035	3.3%
Unspecified abdominal pain	4,874	3.2%
Encounter for general adult medical examination without abnormal findings	4,837	3.2%
Shortness of breath	3,880	2.6%
Type 2 diabetes mellitus without complications	3,709	2.5%

English	N=150,442	
Reason for Visit	Unique Member Count	Prevalence Percentage
Encounter for immunization	3,284	2.2%

***Analysis included only the top 10 primary diagnoses associated with all medical visits within a 12-month period.**
Source: Claims from Professional, Encounters, and All Plan Data feed from July 2023 – June 2024.

Key findings:

- Preventive care (routine child health examination) is the most common reason for visits among English-speaking members, accounting for 6.5% of the total member population having had a visit with this primary diagnosis. There are 54,657 members that are in the age group 0-20. This means that 18% of English-speaking members in this age group have had an encounter for routine child health examination.
- Acute upper respiratory infection is the second most common reason for medical visits at 4.3%.
- Chest pain and cough, unspecified, are other significant reasons for visits, with 3.7% and 3.3%, respectively.

Conclusion Statement:

English-speaking members predominantly seek preventive care, alongside attention for a spectrum of conditions from acute infections to chronic diseases, highlighting a varied health engagement profile.

Table 44: Top 10 Most Common Reasons for Visit by Spanish Speaking members

Spanish	N=93,976	
Reason for Visit	Unique Member Count	Prevalence Percentage
Encounter for routine child health examination without abnormal findings	6,993	7.4%
Encounter for immunization	3,786	4.0%
Type 2 diabetes mellitus without complications	3,360	3.6%
Essential (primary) hypertension	3,312	3.5%
Encounter for general adult medical examination without abnormal findings	2,828	3.0%
Unspecified abdominal pain	2,728	2.9%
Acute upper respiratory infection, unspecified	2,681	2.9%
Chest pain, unspecified	2,625	2.8%
Encounter for screening mammogram for malignant neoplasm of breast	2,309	2.5%
Cough, unspecified	2,291	2.4%

***Analysis included only the top 10 primary diagnoses associated with all medical visits within a 12-month period.**
Source: Claims from Professional, Encounters, and All Plan Data feed from July 2023 – June 2024.

Key findings:

- Preventive care (routine child health examination and immunizations) visit types are the first and second most common reasons for visits among Spanish-speaking members, accounting for 7.4% and 4.0% of their total membership having a visit with a preventive care primary diagnosis.
- Type 2 diabetes mellitus without complications is the third most common reason for medical visits at 3.6% of their total member population.
- Essential (primary) hypertension is common, with 3.5% of their total membership having a visit with this as a primary diagnosis.

Conclusion Statement:

Spanish-speaking members prioritize preventive care significantly, with a notable number of visits also focused on managing chronic conditions and acute medical issues. This points to a proactive approach to health maintenance within this language group.

Analysis of Needs

- Members who speak a foreign language may need offerings of case management telephonic outreach in their native language. This is completed by using interpreter services. Interpreter services translate case management calls for members in real time.
- Due to the volume of Spanish speaking members and case managed populations written materials for PHM services and programs can be provided in Spanish. GCHP's standard for single-page documents and resources is to print in English on one side and Spanish on the other.
- GCHP is looking into adopting a vendor for secured text messaging to interact with membership and expand PHM outreach modes to close this gap.

These findings were reviewed and discussed with the PHM Workgroup. The PHM Workgroup found the services and programs included to reflect the current needs of the population.

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Table 45: Effectiveness of Care

Measure / Data Element	Rate
Effectiveness of Care	
Childhood Immunization Status (CIS)	
Childhood Immunization Status - DTaP	74.45%
Childhood Immunization Status - IPV	88.81%
Childhood Immunization Status - MMR	85.16%
Childhood Immunization Status - HiB	86.13%
Childhood Immunization Status - Hepatitis B	90.02%
Childhood Immunization Status - VZV	85.64%
Childhood Immunization Status - Pneumococcal Conjugate	75.43%
Childhood Immunization Status - Hepatitis A	84.43%
Childhood Immunization Status - Rotavirus	65.45%
Childhood Immunization Status - Influenza	43.55%
Childhood Immunization Status - Combo 3	None
Childhood Immunization Status - Combo 7	None
Childhood Immunization Status - Combo 10	32.85%
Immunizations for Adolescents (IMA)	
Immunizations for Adolescents - Meningococcal	78.59%
Immunizations for Adolescents - Tdap	88.81%
Immunizations for Adolescents - HPV	42.58%
Immunizations for Adolescents - Combination 1	None
Immunizations for Adolescents - Combination 2	41.61%

Lead Screening in Children (LSC)	
Lead Screening in Children	69.87%
Breast Cancer Screening (BCS)	
Breast Cancer Screening	59.65%
Cervical Cancer Screening (CCS)	
Cervical Cancer Screening	61.31%
Colorectal Cancer Screening (COL)	
Colorectal Cancer Screening (Total)	32.04%
Chlamydia Screening in Women (CHL)	
Chlamydia Screening in Women (Total)	63.59%
Asthma Medication Ratio (AMR)	
Asthma Medication Ratio (Total)	46.80%
Controlling High Blood Pressure (CBP)	
Controlling High Blood Pressure	62.29%
Hemoglobin A1c Control for Patients With Diabetes (HBD)	
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	None
Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control	28.71%
Antidepressant Medication Management (AMM)	
Antidepressant Medication Management - Effective Acute Phase Treatment	64.27%
Antidepressant Medication Management - Effective Continuation Phase Treatment	45.03%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	23.57%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	21.92%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)	23.59%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)	12.49%
Follow-Up After Emergency Department Visit for Substance Use (FUA)	
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Total)	28.32%
Follow-Up After Emergency Department Visit for Substance Use - 7 days (Total)	17.01%

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Pharmacotherapy for Opioid Use Disorder (POD)	
Pharmacotherapy for Opioid Use Disorder (Total)	11.08%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.15%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	69.36%
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	41.70%
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	41.70%

Key findings:

- High immunization rates for children are reported for various vaccines, such as IPV, MMR, and Hepatitis B, with rates over 85%.
- Screening rates for various cancers are present but have room for improvement, with breast cancer screening at 59.65% and cervical cancer screening at 61.31%.
- Management of chronic conditions such as diabetes is an area of concern, with no data on optimal HbA1c control and 28.71% for poor HbA1c control.
- Mental health management shows varied engagement, with 64.27% for effective acute phase treatment in antidepressant medication management but lower follow-up rates post-emergency department visits for mental illness and substance use.

Conclusion Statement:

The data indicates strong performance in childhood immunizations and diabetes screening for people with schizophrenia or bipolar disorder. However, there is a significant need for enhanced focus on cancer screening programs and the management of chronic conditions, as well as strengthened follow-up care for mental health and substance use emergencies. This suggests that while certain areas of preventive care are well-addressed, others, particularly chronic condition management and mental health services, require targeted improvements.

Table 46: Access / Availability of Care

Measure / Data Element	Rate
Access / Availability of Care	
Adults' Access to Preventive / Ambulatory Health Services (AAP)	
Adults' Access to Preventive / Ambulatory Health Services (Total)	66.76%
Prenatal and Postpartum Care (PPC)	
Prenatal and Postpartum Care - Timeliness of Prenatal Care	91.97%
Prenatal and Postpartum Care - Postpartum Care	86.37%

Key findings:

- Adults' access to preventive and ambulatory health services is relatively high, with a total rate of 66.76%.
- Prenatal and postpartum care accessibility is very strong, with the timeliness of prenatal care at 91.97% and postpartum care at 86.37%.

Conclusion Statement:

The table reflects a robust level of access to preventive care for adults and exemplary rates of timely prenatal and postpartum care, suggesting effective healthcare service delivery in these areas.

Table 47: Utilization and Risk Adjusted Utilization

Measure / Data Element	Rate
Access / Availability of Care	
Well-Child Visits in the First 30 Months of Life (W30)	
Well-Child Visits in the First 30 Months of Life (First 15 Months)	47.38%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	68.14%
Child and Adolescent Well-Care Visits (WCV)	
Child and Adolescent Well-Care Visits (Total)	42.33%

Key findings:

- Well-child visits in the first 15 months of life are below 50%, at a rate of 47.38%.
- There is an increase in well-child visit rates in the second half of the first 30 months of life, with a rate of 68.14%.
- Child and adolescent well-care visits have a lower rate, at 42.33%.

Conclusion Statement:

The data shows that while there is an improvement in well-child visit rates as children age, overall utilization rates for well-care visits in both early childhood and adolescence could be improved, indicating a potential area for enhanced health care outreach and engagement strategies.

Table 48: Measures Reported Using Electronic Clinical Data Systems

Measure / Data Element	Rate
Measures Reported Using Electronic Clinical Data Systems	
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)	0.70%
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Total)	80.77%
Prenatal Immunization Status (PRS-E)	
Prenatal Immunization Status - Influenza	44.15%
Prenatal Immunization Status - Tdap	73.56%
Prenatal Immunization Status - Combination	39.95%
Prenatal Depression Screening and Follow-Up (PND-E)	
Prenatal Depression Screening and Follow-Up - Depression Screening	1.20%
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen	66.67%
Postpartum Depression Screening and Follow-Up (PDS-E)	
Postpartum Depression Screening and Follow-Up - Depression Screening	1.33%
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen	88.89%

Key findings:

- Depression screening for adolescents and adults is extremely low, with only 0.70% being screened. However, follow-up on those with a positive screen is high at 80.77%.
- Prenatal immunization rates for influenza and Tdap are 44.15% and 73.56% respectively, with the rate for receiving a combination of recommended vaccines at 39.95%.
- Prenatal depression screening is also low at 1.20%, but similar to depression screening, the follow-up on a positive screen is much higher at 66.67%.
- Postpartum depression screening is conducted at a rate of 1.33%, with a very high follow-up rate on positive screens at 88.89%.

Conclusion Statement:

The data indicates that while screening rates for depression during adolescence, adulthood, and the perinatal period are low, the follow-up care for those identified with depression is notably high. Prenatal immunization rates show a mixed picture, suggesting room for improvement in preventive care practices. The high follow-up rates, however, demonstrate a strong commitment to intervention once a risk is identified.

These findings were reviewed and discussed with the PHM Workgroup. The PHM Workgroup found the services and programs included to reflect the current needs of the population.

Gold Coast Health Plan℠
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Population Needs Assessment 2024

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