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AGENDA ITEM NO. 7
CORRECTED COPY

TO: Ventura County Medi-Cal Managed Care Commission

FROM: James Cruz, MD, Acting Chief Medical Officer
Kim Timmerman, MHA, CPHQ, Sr. Director of Quality Improvement

DATE: January 27, 2025

SUBJECT: Quality Improvement and Health Equity Committee 2025 First Quarter Report

SUMMARY:

The Department of Health Care Services ("DHCS") requires Gold Coast Health Plan ("GCHP") to implement an effective quality improvement system and to ensure that the governing body routinely receives written progress reports from the Quality Improvement and Health Equity Committee ("QIHEC").

The attached PPT report contains a summary of activities of the QIHEC and its subcommittees.

APPROVAL ITEMS:

- 2025 Quality Improvement and Health Equity Transformation Program Description
- 2025 Quality Improvement and Health Equity Transformation Work Plan

FISCAL IMPACT:

None

RECOMMENDATION:

Staff recommends that the Ventura County Medi-Cal Managed Care Commission approve the 2025 Quality Improvement and Health Equity Transformation Program Description and Work Plan as presented and receive and file the complete report as presented.

ATTACHMENTS:

1) Timmerman, K., (2025). Quality Improvement, Ventura County Medi-Cal Managed Care Commission, Quality Improvement and Health Equity Transformation Program Description and Work Plan, Presentation Slides.

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Integrity
Accountability
Collaboration
Trust
Respect

Quality Improvement and Health Equity Committee 2025 First Quarter Report

January 27, 2025

James Cruz, MD, Acting Chief Medical Officer
Kim Timmerman, Sr. Director Quality Improvement

Quality Improvement and Health Equity Transformation: Approval Items

- 2025 Quality Improvement and Health Equity Transformation Program Description
- 2025 Quality Improvement and Health Equity Transformation Work Plan

2025 QIHET Program Description Annual Updates

The Quality Improvement and Health Equity Transformation (QIHET) Program Description supports GCHP's mission to improve the health of our members through the provision of high-quality care and services.

The annual review of the QIHET Program Description serves to:

- Define and update processes for continuous quality improvement of clinical and non-clinical care and services, patient safety, health equity, and member experience.
- Ensure continued alignment with the Department of Health Care Services (DHCS) Quality Strategy and contractual requirements.
- Address requirements of the National Committee for Quality Assurance (NCQA) Health Plan and Health Equity Accreditation standards.

QIHET Program Description Key Updates

Enhancements to Address Health Disparities

- ❑ Assessment of committee members to ensure that community advisory bodies reflect the diversity of the Plan's community and membership
- ❑ Assessment of systems and activities that promote high quality and equitable services for members
- ❑ Assessment of resources dedicated to addressing health disparities

QIHET Program Description Key Updates

Program Organization, Oversight Resources and Evaluation

- Added new Member Advisory Committee
- Added the annual evaluation of the Culturally and Linguistically Appropriate Services (CLAS) Program Description and Work Plan
- Added new role and description: *Executive Director of Health Equity*
- Updated organization charts and the QIHETP resources

QIHET Program Description Key Updates

Quality Committees and Subcommittees

Updated committee role and membership

- Quality Improvement & Health Equity Committee
- Member Services Committee
- Grievances & Appeals Committee
- Utilization Management Committee
- Health Education & Cultural Linguistics Committee
- Credentials/Peer Review Committee
- Pharmacy & Therapeutics Committee
- NCQA Key Stakeholder Forum
- MCAS Operations Steering Committee
- Behavioral Health Quality Committee

Retired the Medical Advisory Committee

- Approval of Clinical Practice, Preventive Health, and UM Guidelines transitioned to the Credentials/Peer Review Committee

QIHET Program Description Key Updates

Key Functional Areas

Program descriptions updated for the following key functional areas:

- Population Health Management
- Care Management
- Utilization Management
- Behavioral Health
- Pharmacy Services
- Culturally and Linguistically Appropriate Services

2025 QIHET Work Plan Updates

- Serves as the roadmap to outline specific, measurable, timebound, and multidisciplinary objectives, activities and goals focused on improving key performance indicators.
- Integrates cross functional goals across the organization that comprise key activities to improve member care and service
- 51 focus areas reviewed
  - Updated goals and activities
  - Added 2025 completion dates

QIHET Work Plan Key Updates

Objective 1: Improve Quality & Safety of Clinical Care Services

- **Focus areas:** QIHET Structural Components, Population Health (PNA, Wellth, HRA), Clinical Guidelines, Care Management, Advance Prevention, Pharmacy, MCAS Measures (Behavioral Health, Cancer Prevention, Chronic Disease, Women's Health, Children's Health), DHCS Improvement Projects
- **Activities**: 32 continued from 2024 and 5 new added = 37

Objective 2: Improve Quality & Safety of Non-Clinical Care Services

- **Focus areas:** Culturally and Linguistically Appropriate Services (CLAS), Network Adequacy (Access, After Hours Availability, Provider Satisfaction), Facility Site Reviews, Credentialing/Re-Credentialing
- **Activities**: 8 continued from 2024

Objective 3: Improve Quality of Services

- **Focus areas:** Grievances & Appeals, Call Center Monitoring
- **Activities:** 2 continued from 2024

Objective 4: Assess and Improve Member Experience

- **Focus areas:** Consumer Assessment of Healthcare Providers and Services (CAHPS)
- **Activities:** 3 continued from 2024

Objective 5: Ensure Organizational Oversight of Delegated Activities

- **Focus areas:** Delegation oversight audits and corrective action caps as needed.
- **Activities:** All audit focus areas continued from 2024 with the addition of Population Health Management in 2025

➢ Status of planned activities updated in the QIHET Work Plan quarterly and reported to the Quality Improvement and Health Equity Committee (QIHEC) with periodic reports to Commission

Objective 1: Improve Quality & Safety of Clinical Care Services

	Measures / Activities	Goal	Department
1	2025 Quality Improvement & Health Equity Transformation (QIHET) Program Description	Update the 2025 QIHET Program Description	Quality Improvement
2	2025 QIHET Work Plan	Update the 2025 QIHET Work Plan	Quality Improvement
3	2024 QIHET Program and Work Plan Evaluation	Complete the 2024 QIHET Program and Work Plan Evaluation	Quality Improvement
4 ***New***	2025 Culturally and Linguistically Appropriate Services (CLAS) Program Description and Work Plan	Update the 2025 CLAS Program Description and Work Plan	Health Education / Cultural Linguistics
5 ***New***	2024 CLAS Work Program and Work Plan Evaluation	Complete the 2024 CLAS Program and Work Plan Evaluation	Health Education / Cultural Linguistics
6	2025 HEDIS® Compliance Audit™	Successfully complete and pass the annual HEDIS® Compliance Audit™ and receive reportable status for all measures.	Quality Improvement
7	Population Needs Assessment (PNA)	Maintain NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS.	Population Health
8	Wellth Program	Maintain and expand QI-focused programs with Wellth for Medi-Cal members 18+ years of age, taking at least one medication, and have multiple MCAS care gaps	Population Health
9 ***New***	Health Risk Assessment	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	Population Health
10	Utilization Management: Preventive Health, Clinical Practice, and UM Guidelines	Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including Diabetes and Asthma Clinical Practice Guideline (CPG), and UM Guidelines.	Utilization Management

Objective 1: Improve Quality & Safety of Clinical Care Services

	Measures	Goal	Department
11	Complex Case Management	Maintain and monitor a standardized Turn Around (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements	Care Management
12	Case Management: Care Gap Closure	Implement strategies to close care gaps for MCAS measures	Care Management
13	Tobacco Cessation	Increase rate of tobacco cessation counseling and utilization of tobacco cessation medication in members identified as tobacco users	Health Education / Cultural Linguistics
14	Initial Health Appointment (IHA)	Increase rates of Initial Health Appointment (IHA) completion by providers	Quality Improvement
15	Opioid Utilization Monitoring	Monitor member opioid utilization via pharmacy claims from Medi-Cal Rx and monitor for any trends where the utilization exceeds more than a 5% increase from prior quarter.	Pharmacy
16	Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days (FUM)	Increase the FUM-30 rate to exceed the DHCS MPL (50th percentile).	Behavioral Health
17	Behavioral Health: Follow-Up After Emergency Department Visit for Substance Use – 30 Days (FUA)	Increase the FUA-30 rate to exceed DHCS MPL (50th percentile).	Behavioral Health
18	2023-2026 PIP Non-Clinical Topic: Percentage of Provider Notifications for Members with SUD/SMH Diagnoses within 7 Days of an ED Visit	Improve the percentage of provider notifications for members with substance use disorder (SUD) and/or specialty mental health (SMH) diagnoses following or within 7 days of emergency department (ED) visit.	Quality Improvement
19	2024-2025 DHCS/IHI Behavioral Health Collaborative	DHCS / IHI / VCBH Collaborative focused on improving the existing navigator workflows at the county-run hospital (Ventura County Medical Center) to improve outcomes for individuals who visit the ED for an FUA and FUM condition.	Behavioral Health

Objective 1: Improve Quality & Safety of Clinical Care Services

	Measures	Goal	Department
20	Breast Cancer Screening (BCS)	Increase the percentage of members 50-74 years of age who had a mammogram to screen for breast cancer to meet or exceed the DHCS HPL (90th percentile)	Quality Improvement Health Education/ Cultural Linguistics
21	Cervical Cancer Screening (CCS)	Increase percentage of members 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90th percentile)	Quality Improvement
22	Colorectal Cancer Screening (COL)	Increase the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer to meet the Medicare 50th percentile	Quality Improvement
23	Asthma Medication Ratio (AMR)	Increase the AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a ≥ 0.50 ratio of controller medications to total asthma medications to exceed the DHCS MPL (50th percentile)	Quality Improvement Pharmacy
24 ***New***	Asthma Medication Ratio (AMR)	2025 DHCS Lean Quality Improvement and Health Equity Improvement Project: Implement multi-disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio measure	Quality Improvement
25	Health Equity Controlling Blood Pressure (CBP)	Increase the percentage of members with hypertension who are 21-44 years of age and have a blood pressure rate of <140/90 to exceed the DHCS MPL (50th percentile).	Quality Improvement Population Health
26	Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD-Poor Control	Decrease the percentage of members with diabetes who are 18-75 years of age and have GSD > 9.0% to meet the DHCS HPL (90th percentile).	Quality Improvement
27	Chlamydia Screening in Women (CHL)	Increase the rate of chlamydia screening in members 16 to 24 years of age to meet or exceed the 75th national Medicaid percentile established by NCQA.	Quality Improvement Health Education / Cultural Linguistics
28	Prenatal and Postpartum Care (PPC)	Increase the percentage of members with live birth deliveries who completed timely prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement

Objective 1: Improve Quality & Safety of Clinical Care Services

	Measures	Goal	Department
29	Childhood Immunization Status – Combo 10 (CIS-10)	Increase the percentage of members who completed all Combo-10 immunizations by their 2nd birthday to exceed the 75th national NCQA Medicaid percentile	Quality Improvement
30	Immunization Status for Adolescents – Combo 2 (IMA-2)	Increase the percentage of members who completed all IMA-2 immunizations by their 13th birthday to exceed the 75th national NCQA Medicaid percentile	Quality Improvement
31	Developmental Screening in the First Three Years of Life (DEV)	Increase the percentage of members screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding, or on, their first, second or third birthday, by 3% compared to prior measurement year	Quality Improvement
32	Lead Screening in Children (LSC)	Increase the percentage of members who had one or more capillary or venous blood lead tests for lead poisoning by their 2nd birthday to meet the 75th national NCQA Medicaid percentile	Quality Improvement
33	Topical Fluoride Varnish (TFL)	Increase the percentage of members, ages 1 through 20, who received at least two topical fluoride applications during the measurement year to exceed the DHCS MPL (50th percentile)	Quality Improvement
34	Well-Child Visits in the First 30 Months of Life (W30)	Increase the percentage of members who had well-child visits with a PCP to exceed the DHCS MPL (50th percentile)	Quality Improvement
35	Child and Adolescent Well-Care Visits (WCV)	Increase the percentage of members, 3-21 years of age, who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year to exceed the DHCS MPL (50th percentile)	Quality Improvement
36	2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members	Improve the performance rate for Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) among the Hispanic/Latinx population	Quality Improvement
37	2024-2025 DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits	Quality Improvement

Objective 2: Improve Quality & Safety of Non- Clinical Care Services

	Measures	Goal	Department
38	Cultural and Linguistic Needs & Preferences	• Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules to include Diversity, Equity, and Inclusion (DEI) training program as per DHCS (APL 23-025) that encompasses sensitivity, diversity, cultural competence and cultural humility, and health equity • HECL Department shall conduct Cultural and Linguistic (C&L)/DEI trainings with threeNetwork Provider offices per quarter. • HECL Department shall report on the number of C&L fulfilment and benchmarks quarterly to QIHEC	Health Education / Cultural Linguistics
39	Primary and Specialty Care Access	Ensure primary and specialty care access standards met for minimum of 80% of providers	Provider Network Operations
40	Network Adequacy	Assess and improve network adequacy as demonstrated by availability of practitioners	Provider Network Operations
41	After Hours Availability	Conducts surveys to ensure members are able to reach a provider after hours	Provider Network Operations
42	Provider Satisfaction	Field provider survey and develop action plan(s) to improve areas of low performance	Provider Network Operations

Objective 2: Improve Quality & Safety of Non- Clinical Care Services

	Measures	Goal	Department
43	Facility Site Review Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements	Quality Improvement
44	Physical Accessibility Review Surveys (PARS)	Complete Physical Accessibility Reviews (PARs) 100% on time	Quality Improvement
45	Credentialing/Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners/ providers to provide care to members	Provider Network Operations

Objective 3: Improve Quality of Services

	Measures	Goal	Department
46	Grievances and Appeals	Monitor all member grievances and appeals to identify trending issues. Communicate trends to relevant departments to develop actionable plans aimed at addressing highly reported concerns and improve the overall member experience	Grievances and Appeals
47	Call Center Monitoring	Meet call center benchmarks to ensure members have timely access to call center staff and implement interventions on any deficient benchmarks. (1) ASA: 30 seconds or less; (2) Abandonment Rate: 5% or less; (3) Phone Quality Results: ≥ 95%	Member Services

Objective 4: Assess and Improve Member Experience

	Measures	Goal	Department
48	CAHPS: Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and to monitor and improve CAHPS scores	Quality Improvement
49	CAHPS: Access to Specialty Care	Improve access to specialty care for adults and children	Operations Strategy/External Affairs Quality Improvement
50	CAHPS: Improve CAHPS Scores	Improve CAHPS scores based on MY 2024 CAHPS outcomes, including Getting Care Quickly and Getting Needed Care	Operations Strategy/External Affairs Quality Improvement

Objective 5: Delegation Oversight

	Measures	Goal	Department
51	Delegation Oversight • Credentialing • Quality Improvement • Utilization Management • Member Experience • Claims • Call Center • Cultural and Linguistics • Transportation (NEMT/NMT) • Population Health Management	100% of all audits completed at least annually with corrective action plans (CAPs) closed timely	Compliance

Questions?

Recommendation:

Approve the 2025 Quality Improvement and Health Equity Transformation Program Description and Work Plan

Thank you

GOLD COAST HEALTH PLAN
~~2024~~ 2025 QUALITY IMPROVEMENT & HEALTH EQUITY TRANSFORMATION PROGRAM

Table of Contents

I. BACKGROUND

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

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

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

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

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

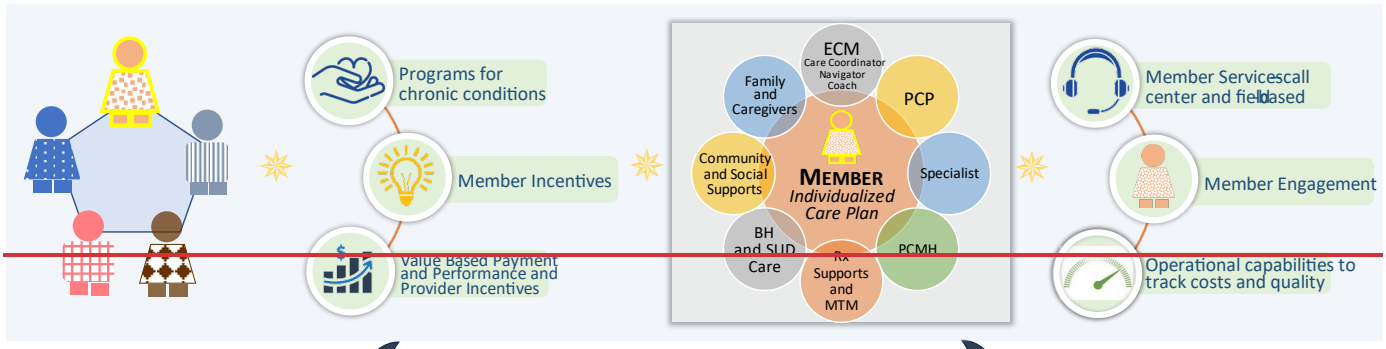
Values
The QIHET Program supports the organization's values of:

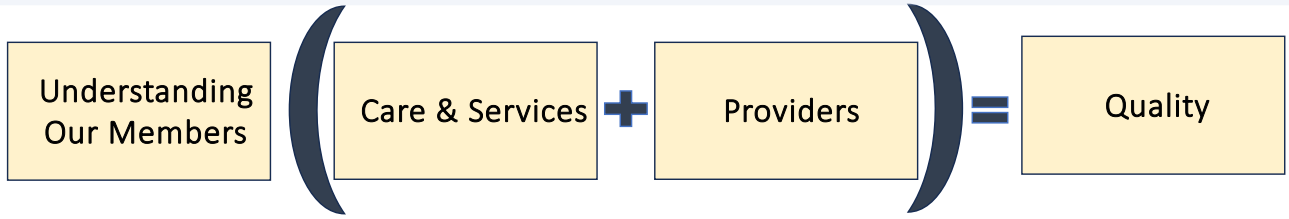
- Integrity: Achieving the highest quality of standards of professional and ethical behavior, with transparency in all business and community interactions
- Accountability: Taking responsibility for our actions and being good stewards of our resources
- Collaboration: Working together to empower our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

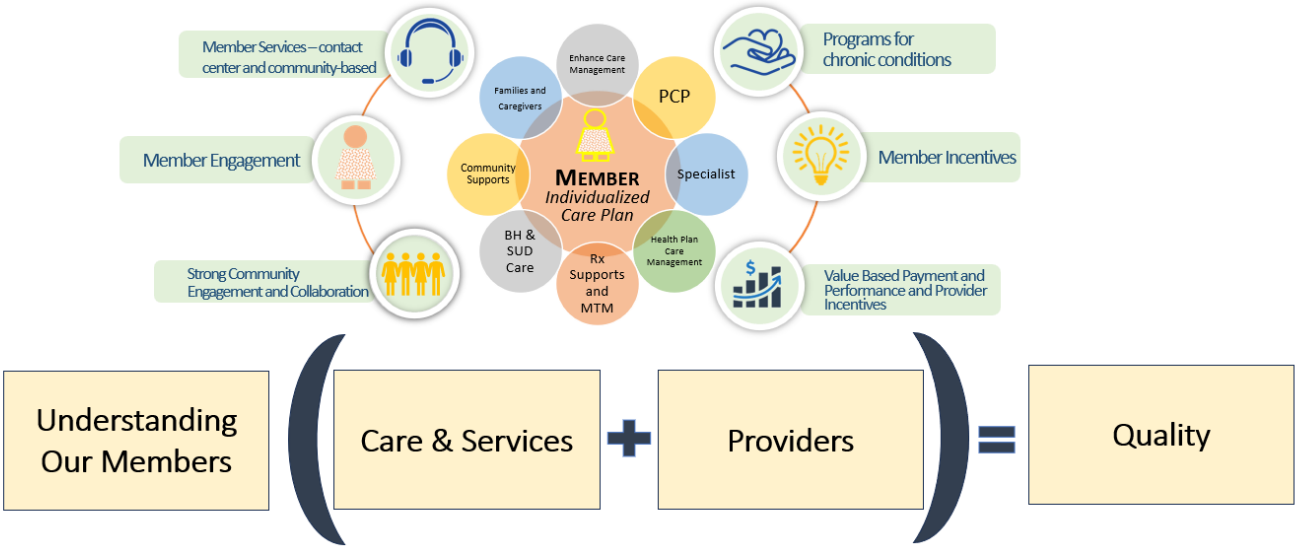
Model of Care
Our Model of Care is built to meet the unique needs of our members and our community through deep understanding of needs and preferences. By, providing the care and services to meet those needs and preferences through internal programs and partnerships with providers and community-based service delivery organizations, we achieve high quality of care and services, as measured by

the DHCS Managed Care Accountability Set (MCAS), the National Committee of Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), the Centers for Medicare and Medicaid (CMS) Core Measures for Medicaid, the Consumer aAssessment of Health Plans and Systems (CAHPS®) as well as other standard quality measures.

Model of Care: Greater than the sum of its parts







III. PURPOSE AND SCOPE

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

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

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

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

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

Quintuple Aim

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

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

The QIHET Program consists of the following elements:

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

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

The scope of the QI process encompasses the following:

1. Quality and safety of clinical care services including, but not limited to:

- Preventive services for children and adults
- Primary Care
- Specialty care, including behavioral health services
- Emergency services
- Inpatient services
- Ancillary services
- Chronic disease management
- Care Management
- Population Health
- Prenatal/perinatal care
- Family planning services
- Medication management
- Coordination and Continuity of Care

- Long-Term Care

2. Quality of nonclinical services including, but not limited to:

   - Accessibility
   - Availability
   - Member and Provider Satisfaction
   - Grievance and Appeal Process
   - Cultural and Linguistically Appropriate Services
   - Network Adequacy
   - Health Equity
   - Community Supports

3. Patient safety initiatives including, but not limited to:

   - Facility site reviews/Medical record review/Physical Accessibility Review Surveys
   - Credentialing of practitioners/organizational providers
   - Peer review
   - Sentinel event monitoring
   - Potential Quality Issues (PQIs)
   - Provider Preventable Condition (PPC) monitoring
   - Health education
   - Utilization management
   - Transitional Care Services

4. A QI focus which represents

   - All care settings
   - All types of services
   - All demographic groups

IV. AUTHORITY AND RESPONSIBILITY

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

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

To address the scope of the Plan's QIHET Program goals and objectives, the structure consists of the Quality Improvement and Health Equity Committee (QIHEC) supported by ~~ten~~ nine subcommittees that meet at least quarterly:

~~1. Medical Advisory Committee (MAC)~~
~~2.~~1. Utilization Management Committee (UMC)
~~3.~~2. Health Education & Cultural Linguistics Committee (HE/CL)
~~4.~~3. Credentials/Peer Review Committee (C/PRC)
~~5.~~4. Member Services Committee (MSC)
~~6.~~5. Grievance & Appeals Committee (G&A)
~~7.~~6. Pharmacy & Therapeutics (P&T) Committee
~~8.~~7. NCQA Key Stakeholder Forum
~~9.~~8. MCAS Operations Steering Committee
~~10.~~9. Behavioral Health Quality Subcommittee

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

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

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

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

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

V. QIHET PROGRAM GOALS AND OBJECTIVES

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

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

The QIHET Program goals include:

- Develop and maintain QIHET resources, structure, and processes that support the

organization's commitment to equitable and quality health care for our culturally and linguistically diverse members.

- Coordinate, monitor and report QIHET activities.
- Develop effective methods for measuring and reporting the outcomes of care, including health disparities and services provided to members.
- Identify opportunities and make improvements based on measurement, validation, and interpretation of data.
- Continuously improve the quality, equity, appropriateness, availability, accessibility, coordination, and continuity of both physical and mental/behavioral healthcare services to members across the continuum of care.
- Provide culturally and linguistically appropriate services.
- Measure and enhance member satisfaction with the quality of care and services provided by our network providers.
- Maintain compliance with state and federal regulatory requirements.
- Ensure effective credentialing and re-credentialing processes for practitioners/providers that comply with state, federal and accreditation requirements.
- Ensure network adequacy and member access to primary and specialty care and ethnic and cultural concordance.
- Provide oversight of delegated entities to ensure compliance with GCHP standards as well as State and Federal regulatory requirements.

The Program Objectives include the following:

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

VI. QIHET PROGRAM METHODOLOGY

GCHP utilizes industry-standard quality improvement tools such as the Plan-Do-Study-Act (PDSA) Cycle methodology, Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis, Fishbone Diagrams, etc. ~~which is an improvement process tool used by the Institute for Health Care Improvement's (IHI) Model for Improvement and adopted by the Department of Health Care Services (DHCS) as the standardized process for~~to test~~ing~~ the effectiveness of interventions aimed at improving the quality of care and services. ~~PDSA cycles~~Overall, GCHP focuses on identifying and measuring improvement opportunities by utilizing small-scale studies to test the effectiveness of interventions that can be modified or expanded to achieve continuous improvement.

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

The indicators may reflect the following parameters of quality:

- Structure, process, or outcome of care
- Administrative and care systems within healthcare services to include:
  - Acute and chronic condition management including care management and population health activities
  - Utilization and risk management
  - Credentialing
  - Member experience/satisfaction
  - Care and provider experience
  - Member grievances and appeals
  - Practitioner accessibility and availability
  - Plan accessibility
  - Member safety
  - Preventive care
  - Behavioral/mental health
  - Health disparities and inequities
  - Social drivers of health

MCAS/HEDIS®/CMS Core Set for Medicaid measures and CAHPS® amongst other quality metric

results ~~that~~ are integrated in the QIHET Program and may be adopted as performance indicators for clinical improvement. The CAHPS® survey is utilized as one of the tools for assessing member satisfaction.

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

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

Health Equity

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

Gold Coast Health Plan is committed to diversity, equity, and inclusion (DEI) to maintain high-quality, equitable, and affordable healthcare for all Medi-Cal members, their families and their community. Therefore, Gold Coast Health Plan's QIHET Program will continue to focus on community health, improving health equity by work we do within the health plan and ~~,~~ with our provider and community-based partners. Lifting the health of our community, lifts the health of our members and reduces the inequities that exist today as well as addresses the structural barriers to equity in the future. GCHP develops programs and interventions using the foundational architecture of community health, health equity, and quality improvement theory which drive system transformation and innovation. In order to do so, Gold Coast Health Plan's ~~2024~~ 2025 QIHET Program includes a focus on whole-person care through partnerships with members, providers, community-based organizations, schools, public health agencies, outside counties, and other health care systems. Specifically, improving member SOGI and RELD data, analyzing health care utilization and performance metrics, and engaging members and the community for recommendations and input in the development of policies and interventions to address disparities. Additionally, Gold Cost Health Plan prioritizes improving access to services and developing community support strategies for at-risk populations and those populations experiencing health disparities with an emphasis on children's preventive care, maternal health outcomes, and behavioral health.

Inclusion, Diversity, and Non-Discrimination

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

Assessment of Equitable Access to Covered Services

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

- Review of member complaints and grievances including those related to culturally and linguistically appropriate level of care.
- Timely access to language assistance services for all medical and non-medical services
- Provision of written materials in threshold language and non-threshold languages upon

request, alternative formats, auxiliary aids, and services for members with visual impairments or other disabilities to ensure effective communication.

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

~~*Culturally and Linguistically Appropriate Services*~~

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

~~Culturally and linguistically appropriate services include:~~

- ~~Provision of education and training to GCHP leadership and staff in culturally and linguistically appropriate policies and practices on an ongoing basis.~~
- ~~Ensuring the competence of individuals providing language assistance, specifically recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.~~
- ~~Offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and non-clinical services.~~
- ~~Informing all members of the availability of language assistance services clearly and in their preferred language, verbally and in writing.~~
- ~~Providing easy-to-understand print and multimedia materials and signage in the GHCP's threshold languages.~~

- ~~Collection and maintenance of accurate and reliable demographic data to inform service delivery.~~
- ~~Assessment of community health resources to implement services responsive to identified CLAS needs.~~

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

VIII. PROGRAM ORGANIZATION, OVERSIGHT, RESOURCES, AND EVALUATION

ORGANIZATION AND OVERSIGHT

CHIEF MEDICAL OFFICER

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

CHIEF INNOVATION OFFICER

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

~~CHIEF HEALTH EQUITY OFFICER~~Executive Director of Health Equity

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

QIHET PROGRAM RESOURCES

Multidisciplinary Staff

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

Support for improvement initiatives related to population health, behavioral health, care management, utilization/risk management, culturally and linguistically appropriate services, and

other clinical process improvement and outcome measures are provided by Health Services, Population Health, Health Education/Cultural Linguistics, Information Technology, and QI staff.

Quality initiatives related to service including member satisfaction and those related to complaints and appeals are supported by Member Services and Grievance and Appeals staff.

Quality initiatives related to provider network and provider communication areis supported by Provider Network Operations staff.

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

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

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

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

Further description of the QIHET Program's multidisciplinary resources and responsibilities are included in Attachment 1.2024 2025 QIHETP Resources.

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

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

Sources of Data
GCHP utilizes tools and resources that provide standards, benchmarks, guidelines, best practices, and measurement and evaluation methodologies to assist in guiding our improvement strategies. These resources include:

- *National initiatives, ~~and~~ measurement sets, and benchmarks* such as Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Healthcare Effectiveness Data and Information Set (HEDIS®), Centers for Medicare and Medicaid (CMS) Core Set for Medicaid, and Quality Compass®
- *Government issued laws, regulations and guidance* including those from DHCS, CMS, the U.S. Preventive Services Taskforce (USPSTF), and National Institutes of Health (NIH)
- *Healthcare Quality Improvement Organizations* such as the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), the National Association for Healthcare Quality (NAHQ), ~~and~~ the Agency for Healthcare Research and Quality (AHRQ), and Health Services Advisory Group (HSAG)
- *The Guide to Community Preventive Services (The Community Guide);* a collection of evidence-based findings of the Community Preventive Services Task Force established by the U.S. Department of Health and Human Services (DHHS)

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

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

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

~~Department's Principal Data Analyst,~~ and GCHP's QI HEDIS Data Master. The engine ingests the following data sources to calculate measure rates:

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

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

QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION (QIHET) PROGRAM AND CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) PROGRAM EVALUATIONS

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

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

- A description of completed and ongoing ~~QIHETP~~ activities that address quality, equity, and safety of both physical and mental/behavioral healthcare provided to GCHP members, including trended measures and an analysis of barriers to success.
- A description of completed and ongoing ~~QIHETP~~ activities that address service quality and the experience of care for GCHP members, including trended measures and an analysis of barriers to success.
- Analysis and evaluation of the overall effectiveness of the QIHET and CLAS Programs (QIHEC committee and sub-committee structures, QI program resources, practitioner participation and leadership involvement), including progress toward influencing network-wide clinical practices, population health needs, health disparities, and addressing the cultural and linguistic needs of GCHP members.
- Recommendation for restructure or changes to the QIHET and CLAS Programs for the subsequent year to improve effectiveness as appropriate.

IX. ANNUAL QIHET WORK PLAN

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

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

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

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

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

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

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

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

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

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

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

- Potential Quality Issue Investigation

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

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

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

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

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

X. QUALITY COMMITTEES AND SUBCOMMITTEES

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

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

committee and are signed and dated within the same reasonable timeframe. Committee meeting minutes shall be submitted to DHCS quarterly, or as requested.

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

i. Quality Improvement and Health Equity Committee (QIHEC)

The QIHEC is the principal organizational unit that has been delegated authority to monitor, evaluate, and report to the VCMMCC by the VCMMCC on all component elements of the GCHP Quality Improvement and Health Equity Transformation Program. The QIHEC shall have a minimum of 8 voting members and be chaired by the GCHP Chief Medical Officer (CMO) in collaboration with the ~~Chief Health Equity Officer~~Executive Director of Health Equity (HEO) and facilitated by the Sr. QI Director.

Membership consists of the chairs of the ~~10~~ 9 QIHEC Subcommittees, and at least one Commissioner, and at least one practicing physician in the community, and a behavioral health care practitioner.

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

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

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

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

An annual QIHET Report is submitted to the VCMMCC addressing:

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

- Success in improving patient care and outcomes, health equity, and provider performance.
- Opportunities for improvement.
- Overall effectiveness of quality monitoring and review activities or specific areas that require remedial action as indicated in the annual report issued by the state's External Quality Review Organization (EQRO).
- Effectiveness in performing quality and health equity management functions. ~~and~~
- Reporting and achievement of goals and objectives through quality and health equity monitoring and improvement programs.
- Presentation of the QIHET Work Plan including recommendations for revision identified as a result of the review.

QIHEC Objectives:

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

QIHEC Responsibilities:

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

QIHEC Membership:

- Chief Medical Officer ~~& Co-Chief Health Equity Officer~~ (Chair)
- Chief Innovation Officer ~~& Co-Chief Health Equity Officer~~
- Executive Director of Health Equity

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

QIHEC Reporting Structure:

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

Meeting Frequency:

The QIHEC meets at a minimum ~~quarterly~~ six times per year.

~~ii. Medical Advisory Committee (MAC)~~

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

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

~~*Scope:*~~

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

- ~~Clinical Practice and Preventive Healthcare Guidelines (CPGs/PHGs)~~
- ~~Provider Grievance Process~~
- ~~Provider Satisfaction~~

- ~~Provider Access/Availability Standards~~
- ~~Provider Contracting~~
- ~~Provider Materials/Communications~~
- ~~Clinical Programs and Service Delivery~~
- ~~Utilization Management~~
- ~~Pharmacy~~
- ~~Quality Improvement (including clinical studies, MCAS/HEDIS®/CMS Core Set Medicaid/CAHPS® survey outcomes)~~

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

~~*Membership:*~~

~~Membership is comprised of 6 to 10 fully credentialed and actively participating physicians representing the contracted provider community for GCHP's programs. The Chief Medical Officer and Co-Chief Health Equity Officer will serve as Chair and will ensure that the membership has adequate specialty representation. Efforts are made to rotate membership every two years; however, in order to ensure continuity of committee activity, membership may be extended.~~

~~*Meeting Frequency:*~~

~~The committee meets at a minimum on a quarterly basis.~~

~~iii.~~ii. Member Services Committee (MSC)

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

MSC Objectives:

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

MSC Membership:

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

Meeting Frequency:

The MSC meets quarterly at a minimum.

iv. Grievance and Appeals Committee (G&A)

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

G&A Committee Objectives:

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

G&A Committee Membership:

- Manager of Operations (Chair)
- Director of Operations ~~(Chair)~~
- Sr. Grievance and Appeals Specialist
- Chief Medical Officer or designee
- Sr. Medical Director
- Executive Director of Operations
- Sr. Director of Network Operations or designee
- Manager of Member Services or designee
- Sr. Director of Quality Improvement or designee
- Sr. Director of Care Management
- Sr. Director of Utilization Management

- Sr. Director of Compliance or designee
- Sr. Director of Health Education & Cultural Linguistics or designee
- Director of Pharmacy Services or designee

Meeting Frequency:

The committee meets quarterly.

v. Utilization Management Committee (UMC)

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

UMC Responsibilities:

Responsibilities include but are not limited to the following:

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

Membership:

- Chief Medical Officer ~~& Co-Chief Health Equity Officer (Chair)~~
- Chief Innovation Officer ~~& Co-Chief Health Equity Officer~~
- ~~Executive Directory of Health Equity~~
- Sr. Medical Director
- Sr. Director of Care Management
- Sr. Director of Utilization Management
- Managers of Care Management
- Managers of Utilization Management

- Director of Pharmacy Services
- Physician Reviewers
- Compliance Designee
- Sr. Director of Quality Improvement
- Carelon ~~(formerly Beacon)~~ Regional Chief Medical Officer Behavioral Health

Meeting Frequency:

The UMC meets quarterly at a minimum.

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

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

HE/CL Committee Responsibilities:

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

Membership:

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

Meeting and/or Reporting Frequency:

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

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

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

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

Committee Responsibilities:

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

- Review Type I Credentialing and Recredentialing practitioner/provider list. Type I files will be presented to the C/PRC on a list of Type 1 files as one group for informational purposes.
- Receive, review, and act on Type II practitioners/providers applying for Credentialing or Recredentialing.
- Review the quality-of-care findings resulting from GCHP's credentialing and quality monitoring and improvement activities.
- Act as the final decision maker in regard to the initial and subsequent credentialing of practitioners/providers based on clinical competency and/or professional conduct.
- Review member and provider clinical complaints, grievances, and issues involving clinical quality of care concerns and determine corrective action when necessary.
- Review the Credentialing and Recredentialing policies and procedures annually.
- Establish, implement, and make recommendations regarding policies and procedures.
- The C/PRC provides feedback and advice to the health plan on any aspect of health plan policy or operations affecting network providers or members including the adoption and approval of the following:
    - Clinical practice and preventiveon health care guidelines (CPGs/PHGs)
    - Utilization Management Criteria

Membership:

The C/PRC is a peer-review body that includes the Chief Medical Officer (CMO) and participating practitioners who span a range of specialties, including primary care (i.e., family practice, internal medicine, pediatrics, general medicine, geriatrics, etc.) and specialty care. It consists of 7-9 voting members who serve two-year terms which may be renewed (there are no term limits). Members are nominated by the CMO and approved by the VCMMCC.

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

Meeting Frequency:

The committee meets quarterly.

viii. Pharmacy & Therapeutics (P&T) Committee

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

Committee Responsibilities:

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

Membership:

- Director of Pharmacy Services (Chair) or designee
- Clinical Programs Pharmacist
- Chief Medical Officer
- Sr. Medical Director or Medical Director
- Physicians and pharmacists representing a variety of clinical specialties.

Meeting Frequency:

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

ix. NCQA Key Stakeholder Forum

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

NCQA Key Stakeholder Forum Scope:

- NCQA Health Plan Accreditation
- NCQA Health Equity Accreditation

NCQA Key Stakeholder Forum Objectives:

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

NCQA Key Stakeholder Forum Membership:

- Senior Project Manager (Chair)
- Chief Innovation Officer ~~& Co-Chief Health Equity Officer~~
- Chief Medical Officer ~~& Co-Chief Health Equity Officer~~
- Executive Director of Health Equity
- Chief Policy and Program Officer
- Chief Diversity Officer
- Executive Director, Operations
- Executive Director, Population Health
- Sr. Medical Director
- Sr. Director, Quality Improvement
- Sr. Director, Care Management
- Sr. Director, Utilization Management
- Sr. Director, Health Education & Cultural Linguistics
- Sr. Director, Compliance
- Sr. Director, Network Operations
- Director, Operations
- Director, Communications
- Director, Pharmacy
- Director, Behavioral Health & Social Programs
- Director, IT Infrastructure and Security Operations
- Sr. Manager, CM & Special Programs
- Sr. Manager, Population Health
- Manager, Quality Improvement
- QI Program Manager II
- Key business owners and/or departmental representatives from:
    - Human Resources
    - Pharmacy
    - Credentialing
    - Information Technology
    - Communications

- Health Education and Cultural Linguistic Services
- Population Health
- Provider Network Operations
- Quality Improvement
- Behavioral Health
- Utilization Management
- Case Management
- Compliance
- Operations
- Member Services

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

x. **MCAS Operations Steering Committee**

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

MCAS Operations Steering Committee Objectives:
The role of the MCAS Operations Steering Committee is to align and drive the organization's strategy and initiatives around MCAS, including but not limited to, prioritization, goals, work plans, and performance tracking. The MCAS Operations Steering Committee serves to ensure effective communication processes are in place to adequately track progress toward work plan activities, provide a platform for candid discussions around barriers to achieving MCAS goals, and create pathways for escalation of performance issues, operational/financial/ regulatory risks, and fleeting opportunities.

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

MCAS Operations Steering Committee Membership:
- Chief Innovation Officer ~~& Co-Chief Health Equity Officer (Chair)~~
- Chief Medical Officer ~~& Co-Chief Health Equity Officer~~
- Chief Policy and Program Officer
- Chief Executive Officer, Ex Officio

- Sr. Director, Quality Improvement
- Executive Director of Health Equity
- Executive Director, Population Health ~~& Equity~~
- Executive Director, Operations
- Sr. Director, Care Management
- Sr. Director, Health Education/Cultural Linguistics
- Director, Behavioral Health & Social Programs
- Sr. Director, Network Operations
- Director, Pharmacy
- Clinical Programs Pharmacist
- Director, Medical Informatics
- Sr. Manager, Population Health
- Manager, Quality Improvement
- ~~RN Manager, Quality Improvement~~

~~*MCAS Steering Committee Reporting Structure:*~~
~~The MCAS Steering Committee reports to the QIHEC. The Chair of the MCAS Steering Committee ensures that quarterly reports are submitted to the Quality Improvement and Health Equity Committee (QIHEC).~~

Meeting Frequency:
The MCAS Operations Steering Committee meets at least monthly.

i. Behavioral Health Quality Committee

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

Behavioral Health Quality Subcommittee Objectives:
These meetings are utilized to ensure care coordination and continuity between medical and behavioral health care, to review quality reporting, develop and discuss quality improvement initiatives, and monitor progress towards addressing Member care needs.

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

Behavioral Health Quality Subcommittee Membership:
- GCHP Chief Medical Officer
- GCHP Senior Medical Director
- GCHP Director of Behavioral Health and Social Programs

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

~~*Behavioral Health Quality Subcommittee Reporting Structure:*~~
~~The Behavioral Health Quality Subcommittee reports to the QIHEC. The Chair of the MCAS Steering Committee ensures that quarterly reports are submitted to the Quality Improvement and Health Equity Committee (QIHEC).~~

Meeting Frequency:
The Behavioral Health Quality subcommittee meets at least monthly.

XI. QIHET PROGRAM KEY FUNCTIONAL AREAS

Population Health Management

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

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

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

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

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

For additional information regarding the PHM Program and Strategy, see Attachment 2. GCHP PHM Strategy 20245.

Care Management

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

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

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

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

provide the appropriate level of care. Care Management team documents care management activities in the Medical Management System.

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

For additional information regarding the Care Management Program, refer to Attachment 3. ~~2024~~ 2025 Care Management Program Description.

Utilization Management

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

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

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

For additional information regarding the UM Program, refer to the Attachment 4. ~~2024~~ 2025 Utilization Management Program Description.

Behavioral Health

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

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

For additional information regarding the BH Program, refer to Attachment 5. ~~2024~~ 2025 Behavioral Health Program Description.

For additional information regarding behavioral health quality, refer to Carelon's ~~2024~~ 2025 Quality Improvement Program Description.

Culturally and Linguistically Appropriate Services (CLAS) Program

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

Culturally and linguistically appropriate services include:

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

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

For additional information regarding the CLAS Program, see Attachment 6. 20245 Culturally and Linguistically Appropriate Services Program.

Pharmacy Services

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

Scope:

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

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

Pharmacy Services Objectives:

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

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

XII. DELEGATION OF QUALITY IMPROVEMENT

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

GCHP will evaluate the delegated entity's capacity to perform the delegated activities prior to

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

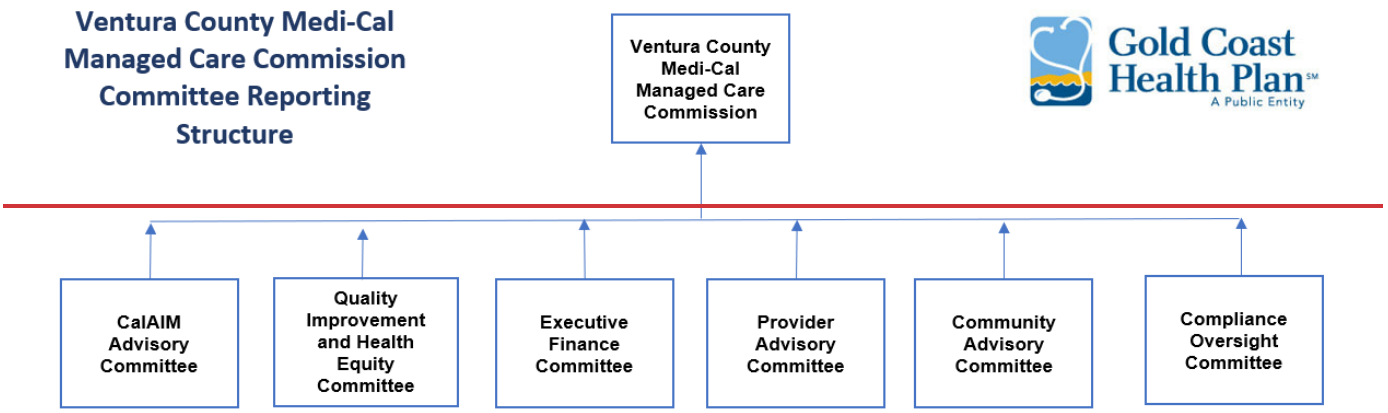
Any delegated functions are fully described in a mutually agreed upon signed and written formal delegation agreement between GCHP and each delegated entity and includes an effective date. All agreements clearly define GCHP's and the delegate's specific duties, responsibilities, activities, reporting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

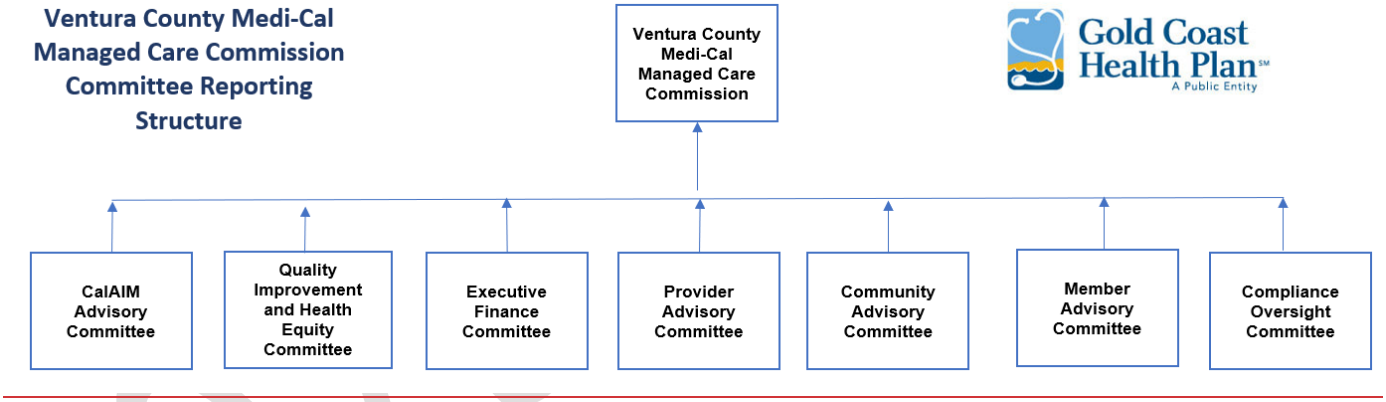
GCHP conducts ongoing oversight, evaluation, and monitoring of the delegate. At a minimum, an annual audit is conducted using an audit tool that is based upon current NCQA, DHCS, and GCHP standards and modified on an as-needed basis. In the event any deficiencies are identified through the oversight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

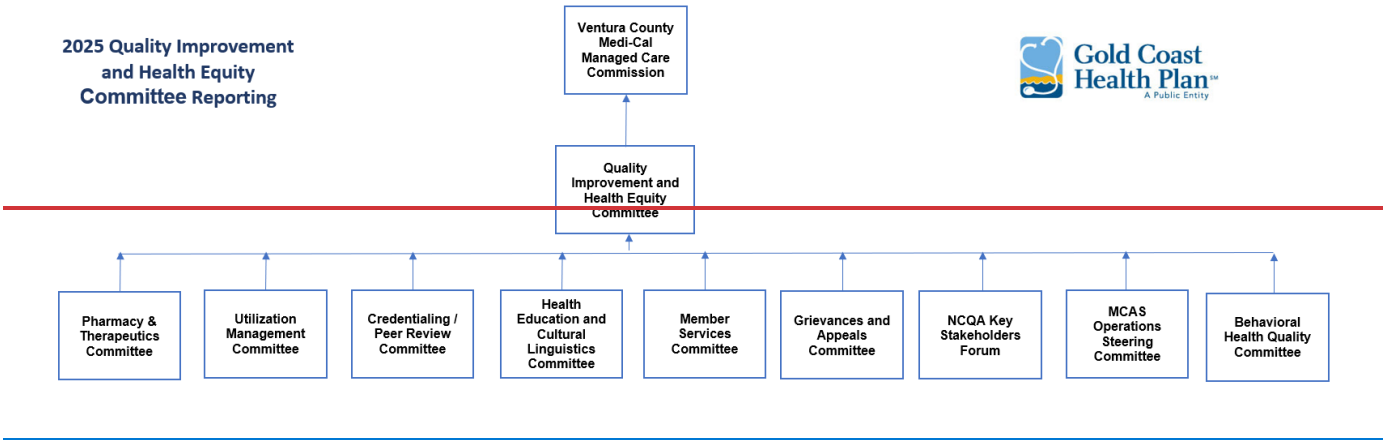
Delegated entities are required to submit at least semi-annual reports to GCHP according to the reporting schedule specified in the delegation agreement. Joint Operation Meetings (JOM) are held on a monthly or quarterly basis as a means of discussing performance measures and findings as needed. JOMs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

XIII. GOLD COAST HEALTH PLAN QUALITY COMMITTEE ORGANIZATIONAL CHART

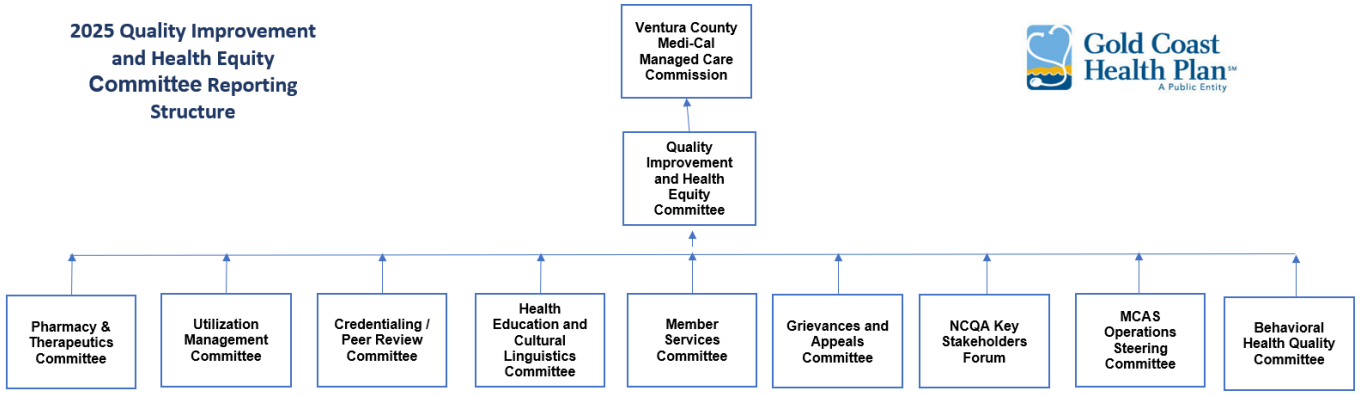
The following organizational chart shows the GCHP Quality Committees that advise the Ventura County Medi-Cal Managed Care Commission and their reporting relationships:





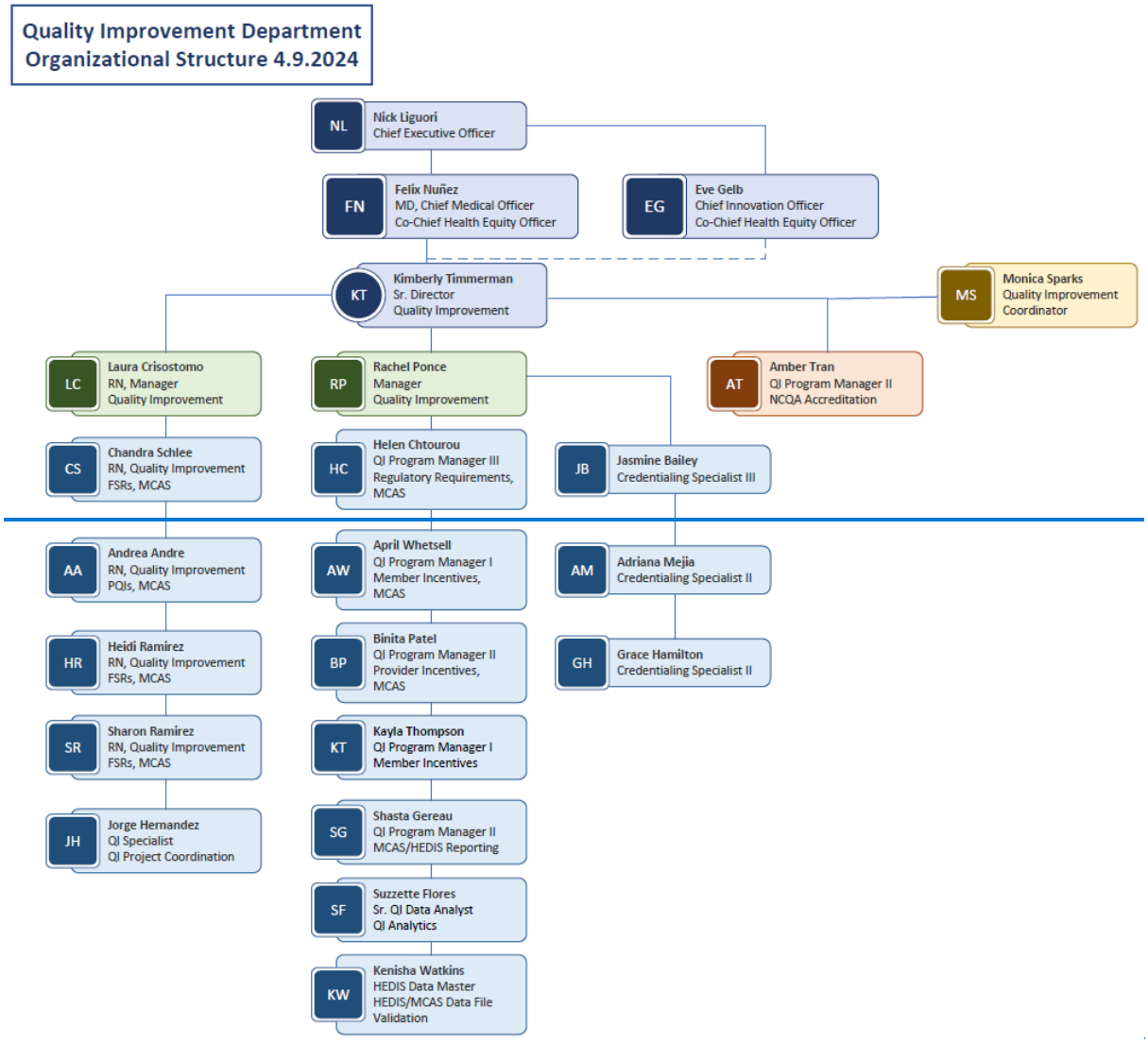


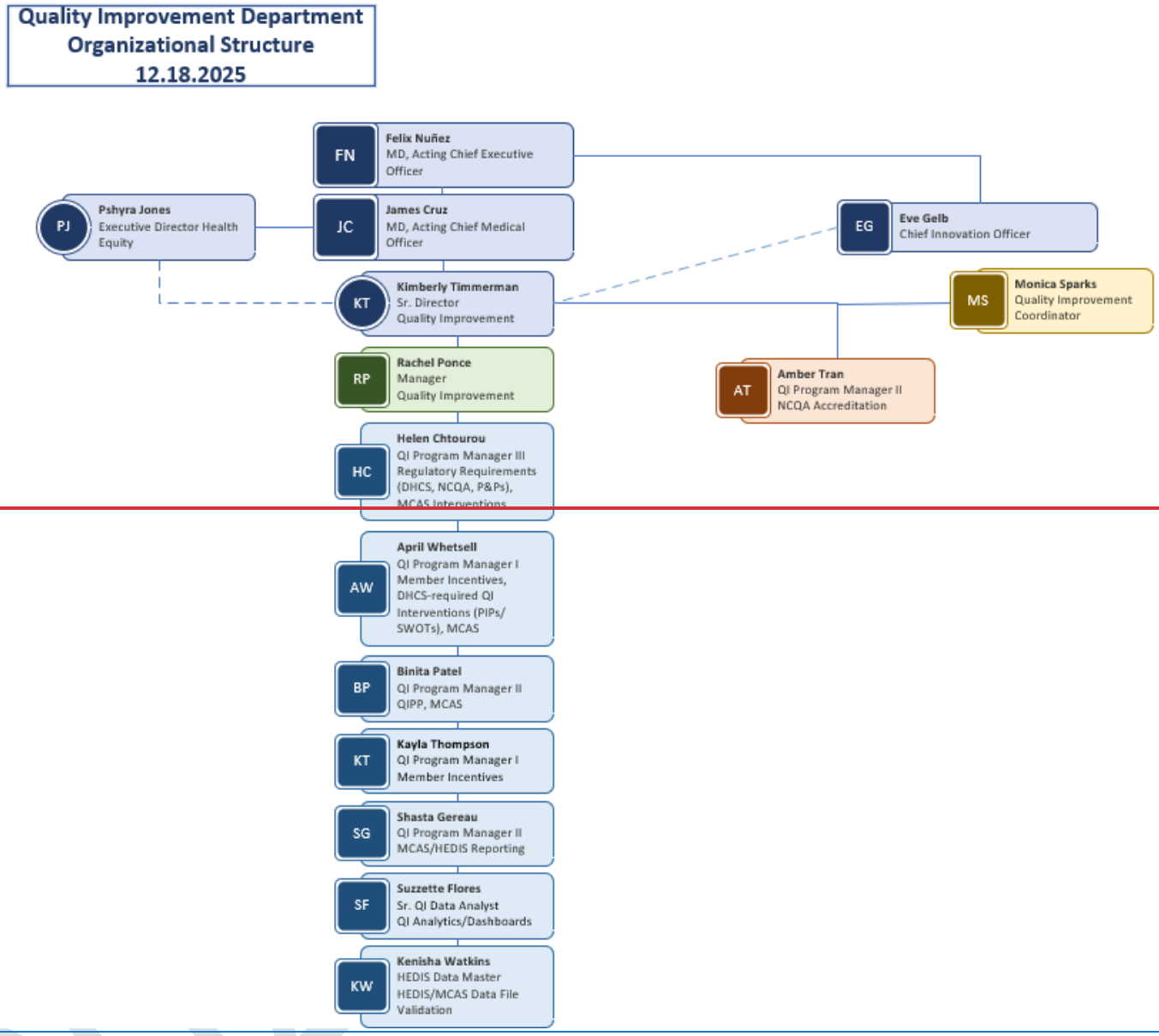
2025 Quality Improvement and Health Equity Committee Reporting Structure

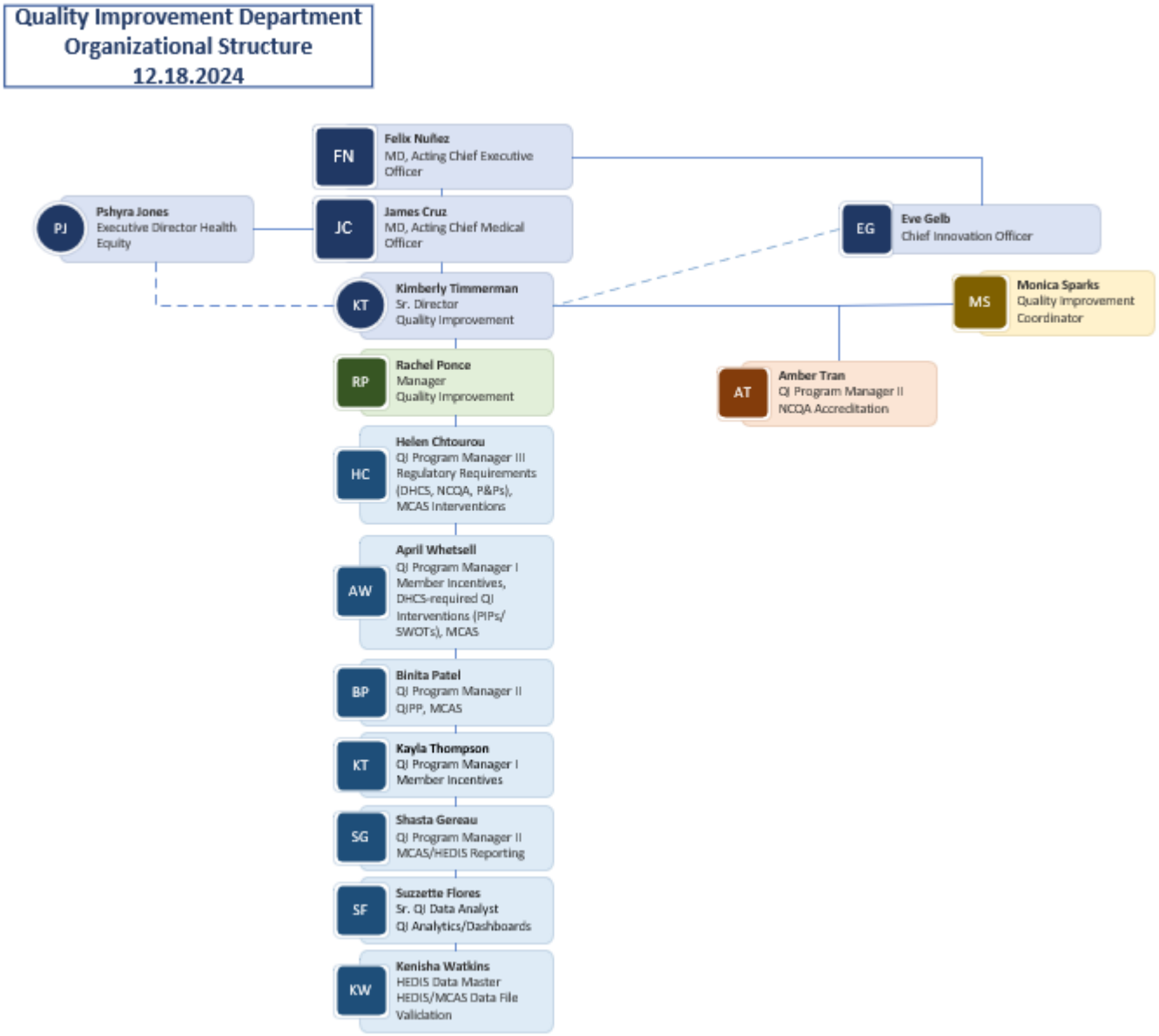


XIV. QUALITY IMPROVEMENT DEPARTMENT ORGANIZATIONAL CHART

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


Quality Improvement Department
Organizational Structure 4.9.2024
NL
Nick Liguori
Chief Executive Officer
FN
Felix Nuñez
MD, Chief Medical Officer
Co-Chief Health Equity Officer
EG
Eve Gelb
Chief Innovation Officer
Co-Chief Health Equity Officer
KT
Kimberly Timmerman
Sr. Director
Quality Improvement
MS
Monica Sparks
Quality Improvement
Coordinator
LC
Laura Crisostomo
RN, Manager
Quality Improvement
RP
Rachel Ponce
Manager
Quality Improvement
AT
Amber Tran
QI Program Manager II
NCQA Accreditation
CS
Chandra Schlee
RN, Quality Improvement
FSRs, MCAS
HC
Helen Chtourou
QI Program Manager III
Regulatory Requirements,
MCAS
JB
Jasmine Bailey
Credentialing Specialist III
AA
Andrea Andre
RN, Quality Improvement
PQIs, MCAS
AW
April Whetsell
QI Program Manager I
Member Incentives,
MCAS
AM
Adriana Mejia
Credentialing Specialist II
HR
Heidi Ramirez
RN, Quality Improvement
FSRs, MCAS
BP
Binita Patel
QI Program Manager II
Provider Incentives,
MCAS
GH
Grace Hamilton
Credentialing Specialist II
SR
Sharon Ramirez
RN, Quality Improvement
FSRs, MCAS
KT
Kayla Thompson
QI Program Manager I
Member Incentives
JH
Jorge Hernandez
QI Specialist
QI Project Coordination
SG
Shasta Gereau
QI Program Manager II
MCAS/HEDIS Reporting
SF
Suzzette Flores
Sr. QI Data Analyst
QI Analytics
KW
Kenisha Watkins
HEDIS Data Master
HEDIS/MCAS Data File
Validation


Quality Improvement Department
Organizational Structure
12.18.2025
FN
Felix Nuñez
MD, Acting Chief Executive Officer
PJ
Pshyra Jones
Executive Director Health Equity
JC
James Cruz
MD, Acting Chief Medical Officer
EG
Eve Gelb
Chief Innovation Officer
KT
Kimberly Timmerman
Sr. Director
Quality Improvement
MS
Monica Sparks
Quality Improvement Coordinator
RP
Rachel Ponce
Manager
Quality Improvement
AT
Amber Tran
QI Program Manager II
NCQA Accreditation
HC
Helen Chtourou
QI Program Manager III
Regulatory Requirements (DHCS, NCQA, P&Ps), MCAS Interventions
AW
April Whetsell
QI Program Manager I
Member Incentives, DHCS-required QI Interventions (PIPs/ SWOTs), MCAS
BP
Binita Patel
QI Program Manager II
QIPP, MCAS
KT
Kayla Thompson
QI Program Manager I
Member Incentives
SG
Shasta Gereau
QI Program Manager II
MCAS/HEDIS Reporting
SF
Suzzette Flores
Sr. QI Data Analyst
QI Analytics/Dashboards
KW
Kenisha Watkins
HEDIS Data Master
HEDIS/MCAS Data File Validation



XV. QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE MEETINGS FOR CALENDAR YEAR ~~2024~~2025

Dates:	
Tuesday	January 21, 2025
Tuesday	**March ~~19~~18, ~~2024~~2025**
Tuesday	~~June 11, 2024~~May 13, 2025
Tuesday	July 15, 2025
Tuesday	**September ~~17~~16, ~~2024~~2025**
Tuesday	~~December 3, 2024~~November 18, 2025
Location: GCHP Community Room 711 E. Daily Drive Suite 110, Camarillo CA 93010~~. Or~~ and via teleconference or web conference (with audio).	

XI. RESOURCES

Availability of QIHET Program to practitioners and members

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

- The ~~2024~~ 2025 Quality Improvement and Health Equity Transformation Program Description and Work Plan was approved by the Quality Improvement and Health Equity Committee on ~~May 7, 2024~~January 21, 2025.
- ~~The Quality Improvement and Health Equity Transformation Work Plan was approved by the Quality Improvement Committee March 19, 2024.~~
- The ~~2024~~ 2025 Quality Improvement and Health Equity Transformation Program Description and Work Plan were approved by Ventura County Medi-Cal Managed Care Commission (VCMMCC) on ~~May 20, 2024~~January 27, 2025.

References

- Gold Coast Health Plan Quality Improvement and Health Equity Committee Charter
- Gold Coast Health Plan Policy QI-002: Quality and Health Equity Performance Improvement Requirements
- Carelon's ~~2024~~ 2025 Quality Improvement Program Description
- Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 19-017: Quality and Performance Improvement Requirements
- GCHP DHCS Managed Care Contract ~~23-30242~~2024, Exhibit A, Attachment III
- HEDIS® - Healthcare Effectiveness Data and Information Set - a registered trademark of the National Committee for Quality Assurance (NCQA)
- CAHPS® - Consumer Assessment of Healthcare Providers and Systems - a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for Health Equity Accreditation
- DHCS Comprehensive Quality Strategy, February 2022
- DCHS California Advancing and Innovating Medi-Cal (CalAIM)
- National Quality Strategy, Agency for Healthcare Research and Quality (AHRQ)
- The Institute for Healthcare Improvement (IHI)
- Patient Protection and Affordable Care Act, Public Law No. 111-148, enacted March 23, 2010
- ~~Kohn KT, Corrigan JM, Donaldson MS. *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academy Press; 1999~~
- Title 42, Code of Federal Regulations, Section 438.240 Quality Assessment and Performance Improvement Program

Attachments

- Attachment 1. ~~2024~~ 2025 QIHETP Resources

- Attachment 2. ~~2024~~ 2025 GCHP PHM Strategy
- Attachment 3. ~~2024~~ 2025 Care Management Program Description
- Attachment 4. ~~2024~~ 2025 Utilization Management Program Description
- Attachment 5. 2025 Behavioral Health Program Description
- Attachment 6. 2025 Cultural and Linguistically Appropriate Services Program Description

GCHP Quality Improvement and Health Equity Transformation Program Resources

CHIEF MEDICAL OFFICER
The Chief Executive Officer (CEO) has appointed the Chief Medical Officer (CMO) as the designated physician to support the Quality Improvement and Health Equity Transformation (QIHET) Program ~~QIHET Program~~ by providing leadership, oversight and management of quality improvement and health equity activities.

The CMO in collaboration with the ~~Chief Health Equity Officer~~Executive Director of Health Equity (HEO) has the overall responsibility for the clinical direction of Gold Coast Health Plan's (GCHP)~~GCHP's~~ QIHET Program. The CMO in collaboration with the HEO ensures that the QIHET Program monitors the full scope of clinical services rendered, that services are rendered equitably, that identified problems are resolved, and corrective actions are initiated when necessary and appropriate.

The CMO serves on the following committees: Quality Improvement and Health Equity Committee (QIHEC), Credentialing/Peer Review Committee (C/PRC), Utilization Management Committee (UMC), Health Education/Cultural Linguistics Committee (HE/CL), Grievances and Appeals Committee (G&A), Pharmacy and Therapeutics Committee (P&T), and Member Services Committee (MSC). ~~QIHEC, C/PRC, UMC, HE/CL, G&A, P&T, and MSC, and MAC~~. The CMO in collaboration with the HEO works directly with all GCHP department heads and executive team members to achieve the goals of the QIHET Program. Further, as CMO and a member of the Quality Improvement and Health Equity Committee, the CMO ~~in collaboration with the HEO~~ annually oversees the approval of the clinical appropriateness of the Quality Improvement and Health Equity Transformation Program.

The CMO reports to the Chief Executive Officer. The CMO's job description also specifies that they have the ability and responsibility to inform the Chief Executive Officer, and if necessary, the Ventura County Medi-Cal Managed Care Commission (VCMMCC),~~VCMMCC~~, if at any time they believe their clinical decision-making ability is being adversely hindered by administrative or fiscal consideration.

CHIEF INNOVATION OFFICER
The Chief Innovation Officer (CIO) is responsible for driving the execution of wide-reaching, complex, and cross-functional work plans and performance improvement initiatives in partnership with the CEO and Executive Team. The CIO reports directly to the CEO.

The CIO is responsible for organization-wide coordination, collaboration, and integration by enhancing the practice of performance-focused activities, advancing the organization's capability to develop and execute goals and work plans, and to continuously track performance including a focus on quality improvement and health equity. The CIO serves to improve the execution and integration of complex, enterprise-wide strategic initiatives, including timely and meaningful engagement of the Executive and Leadership Teams in quality improvement and health equity activities.

The CIO serves on the QIHEC and works directly with GCHP department heads and executive team members to achieve transparency and communication; cross-functional coordination, collaboration, and integration; and meaningful engagement of management and staff in achievement of the goals set forth by the QIHET Program.

Executive Director of Health Equity ~~CHIEF HEALTH EQUITY OFFICER~~

The CEO has appointed the Executive Director of Health Equity ~~Chief Health Equity Officer~~ (HEO) as the designated executive authority to provide health equity expertise to support the QIHET

GCHP Quality Improvement and Health Equity Transformation Program Resources

Program by providing day to day oversight and management of quality improvement and health equity activities. The HEO reports directly to the Chief ~~Executive~~ Medical Officer.

The HEO in collaboration with the Chief Medical Officer (CMO) has the overall responsibility for the health equity direction of GCHP's QIHET Program. The HEO in collaboration with the CMO ensures that the QIHET Program monitors the full scope of clinical services rendered, that services are rendered equitably, that identified problems are resolved, and corrective actions are initiated when necessary and appropriate.

The HEO serves on the following committees: QIHEC~~, UM,~~and HE/CL~~, and CAC~~. The HEO in collaboration with the CMO works directly with all GCHP department heads and executive team members to achieve the goals of the QIHET Program. Further, as HEO and a member of the Quality Improvement and Health Equity Committee, the HEO in collaboration with the CMO, annually oversees the approval of the health equity appropriateness of the Quality Improvement and Health Equity Transformation Program.

~~The CMO and CIO both serve as Co-Chief Health Equity Officers.~~

SENIOR MEDICAL DIRECTOR
The Senior Medical Director (MD) assists in the functions of the Health Services Department by collaborating with the Chief Medical Officer, Health Services Staff, Quality Improvement Department, Grievance and Appeals Department, and other GCHP staff. This collaboration allows the MD to oversee and carry out utilization management decisions, resolve clinical complaints and appeals and monitor clinical quality improvement programs. Key performance and quality of care indicators and criteria are established and reported to the QIHEC by the MD. The MD also serves on committees as directed by the CMO including the QIHEC, C/PRC, and UMC ~~and MAC~~.

Senior Director, Quality Improvement
The Sr. Director, Quality Improvement is responsible for working with sub-committee chairs and appropriate departments to ensure all quality and health equity monitoring activities, analyses, and improvement initiatives are in place. The Sr. Director, Quality Improvement works with the QIHEC, quality subcommittees, and leadership to educate all GCHP staff on the importance and role of quality improvement and health equity communication, analysis, and reporting. The Sr. Director, Quality Improvement is a mentor for all department heads and works with them to implement processes that will create efficient, high-quality, and equitable services.

The Sr. Director, Quality Improvement reports to the Chief Medical Officer (CMO) to ensure that the CMO is updated on any deficiencies and proposed improvement and equity activities. The CMO in collaboration with the HEO has overall responsibility for the clinical direction of GCHP's Quality Improvement and Health Equity Transformation Program (QIHETP).

Specific roles and responsibilities of the Sr. Director, Quality Improvement include but are not limited to:

- Ensuring that the annual QIHETP Description and Work Plan are created and reviewed by all appropriate areas.
- Working with all appropriate departments in the creation of the annual QIHETP Evaluation and analysis of results
- Ensuring QIHEC and VCMMCC approval of all QIHETP documents annually
- Guiding the collection of MCAS ~~for Medicaid~~ data as mandated by contractual requirements and assisting in the development of activities to improve care.
- Ensuring that appropriate principles of data collection and analysis are used by all departments when looking for improvement opportunities.

- Providing educational opportunities for GCHP staff ~~members key~~ to improving care, health equity, and service to better target improvement initiatives.

The Sr. QI Director oversees the GCHP QI Department under the direction of the CMO. The Sr. QI Director directly oversees the QI Department's ~~two~~1 ~~One~~ QI Manager~~s~~, ~~each overseeing~~who oversees various functions, 1 QI Program Manager focused on NCQA Accreditation, and 1 Quality Improvement Coordinator. ~~One QI Manager is a licensed RN overseeing 4 QI Registered Nurses and one QI Specialist.~~ The ~~second~~ QI Manager oversees a multidisciplinary team including 5 QI Program Managers, 1 Sr. Quality Improvement Data Analyst~~s~~, and the HEDIS Data Master~~, and 3 QI Credentialing Specialists.~~ .

The QI Department provides quality improvement subject matter expertise, oversight of quality improvement and health equity activities, data analytics, and support of other GCHP business units such as Population Health and Behavioral Health. Support of other business units includes but is not limited to guidance on QIHET metrics, identification of opportunities for improvement and QIHET priorities, member-level gap reports, and intervention determination and execution.

Additionally, the QI team is supported by a Principal Data Analyst residing in the IT Population Health Enablement Department, a Sr. IT Business Analyst residing in the IT Population Health Enablement Department, the Sr. Director Data Engineering, the Director of Business Solutions, and the Health Education and Cultural Linguistics Team. ~~**QI Manager – Clinical**~~

~~The Clinical QI Manager is a licensed Registered Nurse overseeing four QI Registered Nurses and one QI Specialist. The Clinical QI Manager reports directly to the Sr. Director, Quality Improvement and is responsible for oversight of clinical care quality and health equity including but not limited to:~~

- ~~Potential Quality of Care Investigations (PQI)~~
- ~~Facility Site Reviews (FSR)~~
- ~~Physical Accessibility Review Surveys (PARS)~~
- ~~Annual MCAS/HEDIS® medical record overreads~~
- ~~Quarterly Initial Health Assessment (IHA) medical record audits~~
- ~~Bi-annual pediatric lead screening (LSC) medical record audits~~
- ~~Dissemination of gaps reports for IHAs and LSC~~
- ~~Clinical Quality Improvement activities for identified areas of focus~~

QI Management

~~**QI Manager – Clinical**~~

~~The Clinical QI Manager is a licensed Registered Nurse overseeing four QI Registered Nurses and one QI Specialist. The Clinical QI Manager reports directly to the Sr. Director, Quality Improvement and is responsible for oversight of clinical care quality and health equity including but not limited to:~~

- ~~Potential Quality of Care Investigations (PQI)~~
- ~~Facility Site Reviews (FSR)~~
- ~~Physical Accessibility Review Surveys (PARS)~~
- ~~Annual MCAS/HEDIS® medical record overreads~~
- ~~Quarterly Initial Health Assessment (IHA) medical record audits~~
- ~~Bi-annual pediatric lead screening (LSC) medical record audits~~
- ~~Dissemination of gaps reports for IHAs and LSC~~

- ~~Clinical Quality Improvement activities for identified areas of focus~~

QI Manager ~~– Non-Clinical~~

The ~~Non-Clinical~~ QI Manager oversees a multidisciplinary team including five QI Program Managers, one Sr. Quality Improvement Data Analyst~~s~~, and a QI HEDIS Data Master~~, and three QI Credentialing Specialists~~. The ~~Non-Clinical~~ QI Manager reports directly to the Sr. Director, Quality Improvement and is responsible for oversight of quality improvement and health equity activities including but not limited to:

- Completion of the annual QIHETP Description and Work Plan
- Completion of the annual QIHETP Evaluation and results analysis
- Monitoring of quality improvement and health equity metrics
- Identification of opportunities and strategies for quality improvement and health equity
- Development and implementation of quality improvement and health equity activities
- Completion of the annual MCAS/HEDIS® Audit
- Monitoring and improvement of monthly data capture and processing activities for quality and health equity metrics reporting
- ~~Completion of all required Credentialing activities~~

QI Team

~~QI Registered Nurse (x4)~~

~~The QI Registered Nurse(s) is a licensed registered nurse completing clinical quality improvement activities. Each QI registered nurse completes various regulatory functions including FSRs, PQIs, PARS, and focused medical record audits. All QI Registered Nurses are responsible for clinical quality improvement and health equity activities as well as annual MCAS/HEDIS® medical record overreads. The QI Registered Nurse(s) directly reports to the Clinical QI Manager.~~

QI Program Manager (x5~~5~~)

The QI Program Manager(s) ~~is~~ are responsible for managing, leading, coordinating, and/or assisting with core QI projects and key accountabilities. These projects include performance improvement projects (PIPs/IPs), health initiatives, MCAS/HEDIS® reporting including vendor oversight, quality improvement and health equity interventions to improve quality outcomes or member satisfaction, dashboard monitoring, and reporting analyses. The QI Project Manager(s) directlyy report~~s~~ to the ~~Non-Clinical~~ QI Manager.

HEDIS Data Master (x1)

The HEDIS Data Master is accountable for engaging in and supporting data submission activities for the MCAS/HEDIS program including system and technical configurations, data validation and optimization, and management of strategic efforts to maximize MCAS/HEDIS results. The role has responsibilities that range from oversight of ensuring adequate claims and encounter data collection, maintaining data systems, as well as facilitating data transfer efforts. The HEDIS Data Master directly reports to the QI Manager.

Senior QI Data Analyst (x1)

The Sr. QI Data Analyst is responsible for providing analytical support for the QIHETP. The Sr. QI Data Analyst provides interpretation and analysis of quality improvement and health equity data to determine areas suitable for the implementation of a QIHETP and leads analytical efforts to determine effectiveness. They develop and produce reports that monitor and benchmark utilization and quality and health equity performance indicators, monitor for

adverse trends, and recommend modifications and corrective action. Additionally, the Sr. QI Data Analyst supports analyses requested by other departments such as Behavioral Health, Care Management, and Population Health. These analyses identify target populations, metrics for improvement, rate trends,~~,~~ amongst others. The Sr. QI Data Analyst(s) directly reports to the ~~Non-Clinical~~ QI Manager.

~~**Credentialing Specialist (x3)**~~
~~The Credentialing Specialist(s) is responsible for the compilation and verification of information for initial credentialing and re-credentialing of licensed independent practitioners and organizational providers, according to Health Plan and Accreditation Standards. The Credentialing Specialist(s) coordinates quality review information at the time of practitioner credentialing/re-credentialing with the Chief Medical Officer, Provider Network Operations, and the Credentialing/Peer Review Committee. The Credentialing Specialist(s) directly reports to the Non-Clinical QI Manager.~~

QI ~~Specialist~~ Improvement Coordinator (x1)
~~The Quality Improvement Specialist is responsible for coordinating quality improvement functions and activities including, but not limited to, coordination of departmental functions, maintenance of dashboards/tools; support for MCAS/HEDIS, DHCS audits, quality committees; and other regulatory mandates.~~

~~Quality Improvement Coordinator (x1)~~ The quality improvement coordinator is responsible for providing administrative ~~support~~ and clerical support to the QI Department as well as other quality improvement and health equity activities as necessary. The Quality Improvement Coordinator reports directly to the Sr. Director, Quality Improvement.

Information Technology (IT) Resources

Sr. Director Data Engineering

The Sr. Director of Data Engineering is responsible for implementing and managing data platforms and analytical capabilities across GCHP's technical ecosystem including MCAS/HEDIS data domains. The Sr. Director of Data Engineering manages the team of data engineers responsible for designing and building the data pipelines that generate the data files submitted to GCHP's HEDIS® certified software vendor, Inovalon. The Sr. Director of Data Engineering actively collaborates with QI leadership to guide technical solutions and data exchanges with GCHP partners. The Sr. Director of Data Engineering directly reports to the Executive Director of IT.

Director of Population Health Enablement and Analytics

The Director of Population Health Enablement and Analytics, plans, coordinates, and supervises all activities related to the design, development, and implementation of organizational information systems and software applications including those applicable to the QIHETP. In this role, they are responsible for oversight of the monthly creation of data files submitted to GCHP's HEDIS® certified software vendor, Inovalon. They provide subject matter expertise regarding the resolution of IT issues related to the design, development, and deployment of mission-critical information and software systems including those applicable to the QIHETP. The Director of Population Health Enablement and Analytics directly reports to the Executive Director of IT.

Principal Data Analyst

The Principal Data Analyst is responsible for the monthly creation of data files submitted to GCHP's HEDIS® certified software vendor, Inovalon. They perform data quality checks for each data source, resolve data integrity issues, and ensure that all required files are accurate when sent to and received by Inovalon. They also ensure that all required files are sent at appropriate intervals for calculation of both monthly prospective rate reporting as well as the annual MCAS/HEDIS® rate reporting. The Principal Data Analyst engages with the QI team to develop and document business requirements in collaboration with the QI HEDIS Data Master. The Principal Data Analyst directly reports to the IT Director of Population Health Enablement and Analytics.

~~**Sr. IT Business Analyst**~~

~~The Sr. IT Business Analyst is responsible for providing subject matter expertise and historical knowledge of the monthly creation of data files submitted to GCHP's HEDIS® certified software vendor, Inovalon. They ensure that all required files are accurate, sent to and received by Inovalon, and sent at appropriate intervals for calculation of both monthly prospective rate reporting as well as the annual MCAS/HEDIS® rate reporting. The Sr. IT Business Analyst directly reports to the IT Director of Population Health Enablement and Analytics.~~

Health Education/Cultural and Linguistics Staff

The Health Education/Cultural and Linguistics team establishes guidelines for ensuring quality health education materials are available to providers, members, and the communities. The team identifies the best distribution channel to present materials, adhering to a strict set of regulatory guidelines modified as necessary to ensure the collateral is compliant with all state regulations. The Health Education team develops health education materials in the right brand, style, and grade level, guiding the materials through the compliance and approval process.

Health Navigators provide support for the QIHET Program by performing focused outreach attempts to members using a variety of methods. Outreach campaigns are targeted based on review and analysis of available data by the QI team. Campaigns are modified as needed to support improvement. Campaigns may include outreach for services such as chronic conditions, tobacco cessation, and health promotion campaigns to close gaps in care for services related to preventive health. Beyond direct member telephonic outreach, the QIHET Program may also employ other methods of member outreach in our ongoing efforts to ensure members receive appropriate care. These include:

- Live outreach calls
- Text messaging
- Health tips targeted to specific populations or conditions
- Targeted member mailings
- Targeted provider communications
- Community events
- Member Newsletters

GOLD COAST HEALTH PLAN
2025 QUALITY IMPROVEMENT & HEALTH EQUITY TRANSFORMATION PROGRAM

Table of Contents

I. BACKGROUND

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

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

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

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

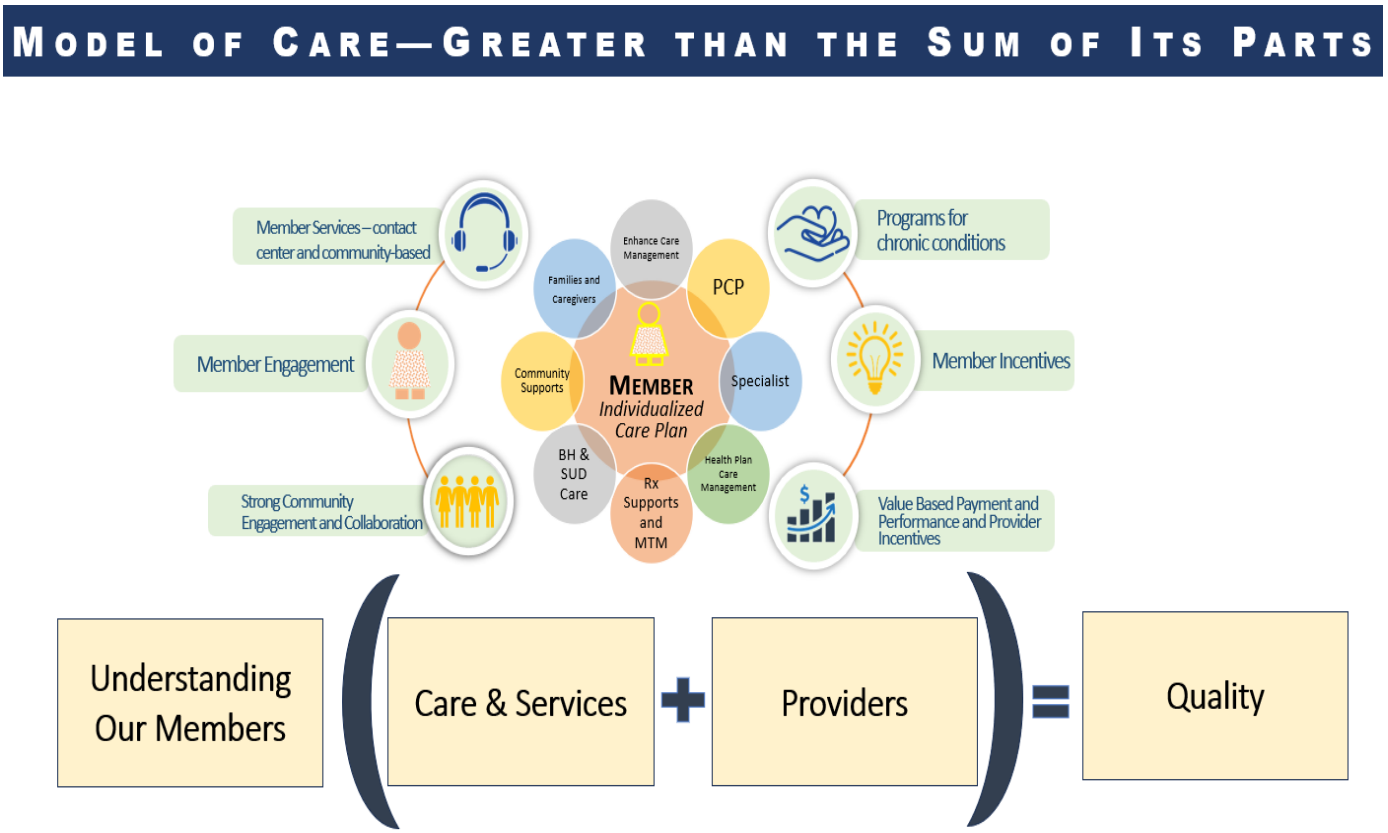
Vision
Compassionate care, accessible to all, for a healthy community.

Values
The QIHET Program supports the organization's values of:

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

Model of Care
Our Model of Care is built to meet the unique needs of our members and our community through deep understanding of needs and preferences. By providing the care and services to meet those needs and preferences through internal programs and partnerships with providers and community-based service delivery organizations, we achieve high quality of care and services, as measured by

the DHCS Managed Care Accountability Set (MCAS), the National Committee of Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), the Centers for Medicare and Medicaid (CMS) Core Measures for Medicaid, the Consumer Assessment of Health Plans and Systems (CAHPS®) as well as other standard quality measures.



III. PURPOSE AND SCOPE

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

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

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

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

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

Quintuple Aim

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

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

The QIHET Program consists of the following elements:

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

The Quality Improvement and Health Equity Transformation Program will ensure that all medically necessary covered services are available in a culturally and linguistically appropriate manner and

are accessible to all members regardless of race, color, national origin, ethnic group identification, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, medical condition, physical or mental disability, or identification with any other persons or groups identified in Penal Code 422.56.

The scope of the QI process encompasses the following:

1. Quality and safety of clinical care services including, but not limited to:

    - Preventive services for children and adults
    - Primary Care
    - Specialty care, including behavioral health services
    - Emergency services
    - Inpatient services
    - Ancillary services
    - Chronic disease management
    - Care Management
    - Population Health
    - Prenatal/perinatal care
    - Family planning services
    - Medication management
    - Coordination and Continuity of Care
    - Long-Term Care

2. Quality of nonclinical services including, but not limited to:

    - Accessibility
    - Availability
    - Member and Provider Satisfaction
    - Grievance and Appeal Process
    - Cultural and Linguistically Appropriate Services
    - Network Adequacy
    - Health Equity
    - Community Supports

3. Patient safety initiatives including, but not limited to:

    - Facility site reviews/Medical record review/Physical Accessibility Review Surveys
    - Credentialing of practitioners/organizational providers
    - Peer review
    - Sentinel event monitoring
    - Potential Quality Issues (PQIs)
    - Provider Preventable Condition (PPC) monitoring
    - Health education
    - Utilization management
    - Transitional Care Services

4. A QI focus which represents

    - All care settings
    - All types of services

- All demographic groups

IV. AUTHORITY AND RESPONSIBILITY

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

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

To address the scope of the Plan's QIHET Program goals and objectives, the structure consists of the Quality Improvement and Health Equity Committee (QIHEC) supported by nine subcommittees that meet at least quarterly:

1. Utilization Management Committee (UMC)
2. Health Education & Cultural Linguistics Committee (HE/CL)
3. Credentials/Peer Review Committee (C/PRC)
4. Member Services Committee (MSC)
5. Grievance & Appeals Committee (G&A)
6. Pharmacy & Therapeutics (P&T) Committee
7. NCQA Key Stakeholder Forum
8. MCAS Operations Steering Committee
9. Behavioral Health Quality Subcommittee

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

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

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

GCHP is governed by the twelve (12) member VCMMCC. Commission members are appointed for two- or four-year terms, and member terms are staggered. The VCMMCC is comprised of locally

elected officials, providers, hospitals, clinics, the Ventura County Healthcare Agency, and consumer advocates.

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

V. QIHET PROGRAM GOALS AND OBJECTIVES

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

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

The QIHET Program goals include:

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

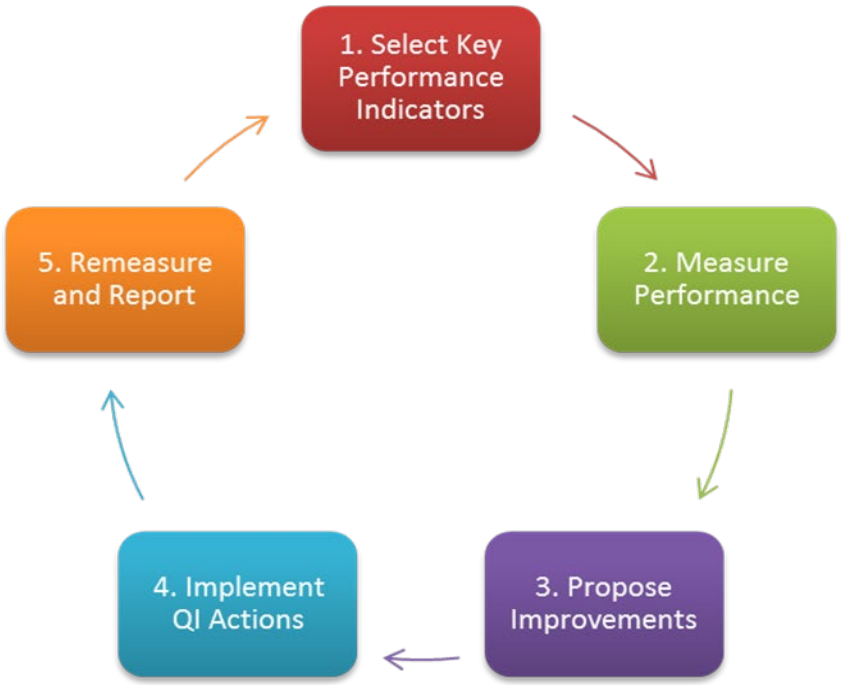
The Program Objectives include the following:

- To integrate the QIHET Program with other key operational functions of GCHP.
- To conduct an annual evaluation of the QIHET Program.
- To establish and conduct an annual review of quality, equity, and performance improvement projects (PIPs) related to significant aspects of clinical and non-clinical services.
- To identify opportunities for improvement through analysis of utilization patterns and through information collected from quality and performance metrics including the DHCS Managed Care Accountability Set (MCAS), the National Committee of Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), the Centers for Medicare and Medicaid (CMS) Core Measures for Medicaid, as well as other measure stewards.

- To leverage Sexual Orientation and Gender Identify (SOGI) and Race, Ethnicity, Language and Disability (RELD) data to advance health equity.
- To encourage feedback from members and providers regarding delivery of care and services and to use the feedback to evaluate and improve how care and services are delivered.

VI. QIHET PROGRAM METHODOLOGY

GCHP utilizes industry-standard quality improvement tools such as the Plan-Do-Study-Act (PDSA) Cycle methodology, Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis, Fishbone Diagrams, etc. to test the effectiveness of interventions aimed at improving the quality of care and services. Overall, GCHP focuses on identifying and measuring improvement opportunities by utilizing small-scale studies to test the effectiveness of interventions that can be modified or expanded to achieve continuous improvement.



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

The indicators may reflect the following parameters of quality:

- Structure, process, or outcome of care
- Administrative and care systems within healthcare services to include:
  - Acute and chronic condition management including care management and population health activities

- Utilization and risk management
- Credentialing
- Member experience/satisfaction
- Care and provider experience
- Member grievances and appeals
- Practitioner accessibility and availability
- Plan accessibility
- Member safety
- Preventive care
- Behavioral/mental health
- Health disparities and inequities
- Social drivers of health

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

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

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

Health Equity

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

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

Inclusion, Diversity, and Non-Discrimination

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

subcontractor providers are expected to render services to members they have accepted assignment for or have agreed to accept referrals and shall comply with the State and Federal civil rights laws. Providers shall not refuse services to any member based on the criteria above. GCHP follows up on all grievances alleging discrimination and takes appropriate action.

Assessment of Equitable Access to Covered Services

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

- Review of member complaints and grievances including those related to culturally and linguistically appropriate level of care.
- Timely access to language assistance services for all medical and non-medical services
- Provision of written materials in threshold language and non-threshold languages upon request, alternative formats, auxiliary aids, and services for members with visual impairments or other disabilities to ensure effective communication.
- Conducting a Population Needs Assessment as defined by DHCS
- Provision of Cultural Competency Training for both providers and GCHP staff, and contract provider vendors. Conduct oversight of subcontract's Cultural Competency Training.
- Conducting surveys of members to determine if culture and language needs are met by providers
- Provision of diversity, equity, inclusion (DEI) training including sensitivity, communication skills, cultural competency/humility, and Seniors and Persons with Disabilities (SPD) sensitivity to network providers, subcontractors, and downstream subcontractors and GCHP staff
- Assessment of provider and provider staff members' linguistic capabilities
- Assessment of GCHP staff language capabilities for direct communication with members
- Conduct readability and suitability of member informing materials set by DHCS regulations
- Engage feedback and advice from the community advisory bodies regarding culturally and linguistically appropriate services and programs.
- Assessment of committee members to ensure that community advisory bodies reflect the diversity of the Plan's community and membership
- Assessment of systems and activities that promote high quality and equitable services for members
- Assessment of resources dedicated to addressing health disparities

VIII. PROGRAM ORGANIZATION, OVERSIGHT, RESOURCES, AND EVALUATION

ORGANIZATION AND OVERSIGHT

CHIEF MEDICAL OFFICER

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

CHIEF INNOVATION OFFICER

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

priorities, communications on goals/workplans/ priorities, Operating Reviews and Status Reports, and performance reporting to innovate the company.

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

QIHET PROGRAM RESOURCES

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

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

Quality initiatives related to service including member satisfaction and those related to complaints and appeals are supported by Member Services and Grievance and Appeals staff.

Quality initiatives related to provider network and provider communication are supported by Provider Network Operations staff.

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

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

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

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

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

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

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

Sources of Data
GCHP utilizes tools and resources that provide standards, benchmarks, guidelines, best practices, and measurement and evaluation methodologies to assist in guiding our improvement strategies. These resources include:

- National initiatives, measurement sets, and benchmarks such as Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Healthcare Effectiveness Data and Information Set (HEDIS®), Centers for Medicare and Medicaid (CMS) Core Set for Medicaid, and Quality Compass®
- Government issued laws, regulations and guidance including those from DHCS, CMS, the U.S. Preventive Services Taskforce (USPSTF), and National Institutes of Health (NIH)
- Healthcare Quality Improvement Organizations such as the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), the National Association for Healthcare Quality (NAHQ), the Agency for Healthcare Research and Quality (AHRQ), and Health Services Advisory Group (HSAG)
- The Guide to Community Preventive Services (The Community Guide); a collection of evidence-based findings of the Community Preventive Services Task Force established by the U.S. Department of Health and Human Services (DHHS)

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

- Enrollment and demographic data, including Race, Ethnicity, and Language and Disability (RELD) data and Sexual and Gender Identify (SOGI) data to advance health equity by identifying, addressing, and reducing health disparities among our patient population
- Claims and encounter data (utilization by diagnosis/procedure, provider, treatment/medications, site of care, etc.) to ensure members are receiving appropriate care and to mitigate gaps through sharing of this data with other organization business units (e.g. Population Health and Behavioral Health)
- Population health/Care management reports to assess support of members with complex or chronic medical and behavioral health conditions, and to evaluate coordination of care across the continuum of care
- Grievance and appeal data, including type of grievances, trends, and root cause analysis

- Ongoing tracking and trending of quality of care and serious reportable event (SRE) data to identify patient safety issues and assess provider qualifications
- Member and provider survey data to assess satisfaction with services and operations
- Credentialing process data to measure timeliness of application processing and quality of network providers
- Network adequacy/accessibility measurement data to assess provider availability and accessibility
- MCAS/HEDIS®/CMS Core Set for Medicaid data to assess the effectiveness of clinical care and services

HEDIS® Certified Software

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

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

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

QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION (QIHET) PROGRAM AND CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) PROGRAM EVALUATIONS

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

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

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

- A description of completed and ongoing activities that address service quality and the experience of care for GCHP members, including trended measures and an analysis of barriers to success.
- Analysis and evaluation of the overall effectiveness of the QIHET and CLAS Programs (QIHEC committee and sub-committee structures, QI program resources, practitioner participation and leadership involvement), including progress toward influencing network-wide clinical practices, population health needs, health disparities, and addressing the cultural and linguistic needs of GCHP members.
- Recommendation for restructure or changes to the QIHET and CLAS Programs for the subsequent year to improve effectiveness as appropriate.

IX. ANNUAL QIHET WORK PLAN

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

X. QUALITY COMMITTEES AND SUBCOMMITTEES

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

quality improvement and health equity activities by engaging with community stakeholders regarding QI activities, however each reports directly to the VCMCC.

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

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

i. Quality Improvement and Health Equity Committee (QIHEC)

The QIHEC is the principal organizational unit that has been delegated authority to monitor, evaluate, and report to the VCMMCC by the VCMMCC on all component elements of the GCHP Quality Improvement and Health Equity Transformation Program. The QIHEC shall have a minimum of 8 voting members and be chaired by the GCHP Chief Medical Officer (CMO) in collaboration with the Executive Director of Health Equity (HEO) and facilitated by the Sr. QI Director.

Membership consists of the chairs of the 9 QIHEC Subcommittees, and at least one Commissioner, and at least one practicing physician in the community, and a behavioral health care practitioner.

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

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

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

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

An annual QIHET Report is submitted to the VCMMCC addressing:

- Quality improvement and health equity activities such as:
  i. Utilization Reports
  ii. Review of the quality of services rendered

iii. MCAS/HEDIS®/CMS Core Set for Medicaid results
iv. Quality Improvement Projects and initiatives - status and/or results
v. Health Equity Projects and initiatives – status and/or results
vi. Satisfaction Survey Results
vii. Collaborative initiatives both internally and externally - status and/or results

- Success in improving patient care and outcomes, health equity, and provider performance.
- Opportunities for improvement.
- Overall effectiveness of quality monitoring and review activities or specific areas that require remedial action as indicated in the annual report issued by the state's External Quality Review Organization (EQRO).
- Effectiveness in performing quality and health equity management functions.
- Reporting and achievement of goals and objectives through quality and health equity monitoring and improvement programs.
- Presentation of the QIHET Work Plan including recommendations for revision identified as a result of the review.

QIHEC Objectives:

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

QIHEC Responsibilities:

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

QIHEC Membership:

- Chief Medical Officer (Chair)
- Chief Innovation Officer
- Executive Director of Health Equity

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

QIHEC Reporting Structure:

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

Meeting Frequency:

The QIHEC meets at a minimum six times per year.

ii. Member Services Committee (MSC)

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

MSC Objectives:

- Ensure GCHP members understand their health care system and know how to obtain care and services when they need them.
- Ensure GCHP members will have their concerns resolved quickly and effectively and have the right to voice complaints or concerns without fear of discrimination.
- Ensure GCHP members can trust that the confidentiality of their information will be respected and maintained.
- Have access to appropriate language interpreter services at no charge when receiving medical care.
- Ensure GCHP members can reach the Member Services Department quickly and be confident in the information they receive.
- Utilize the CAHPS® survey to identify service indicators for improvement.

- Ensure GCHP's Member Rights and Responsibilities are distributed and available to members and providers.
- Ensure that GCHP's member materials are developed in a culturally and linguistically appropriate format.
- Interface with other GCHP committees to improve service delivery to members.

MSC Membership:

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

Meeting Frequency:

The MSC meets quarterly at a minimum.

iv. Grievance and Appeals Committee (G&A)

The Grievance and Appeal Committee monitors expressions of dissatisfaction from members and providers. Information gathered is used to improve the delivery of service and care to Gold Coast Health Plan members.
G&A Committee Objectives:

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

G&A Committee Membership:

- Manager of Operations (Chair)
- Director of Operations
- Sr. Grievance and Appeals Specialist
- Chief Medical Officer or designee
- Sr. Medical Director
- Executive Director of Operations
- Sr. Director of Network Operations or designee
- Manager of Member Services or designee
- Sr. Director of Quality Improvement or designee

- Sr. Director of Care Management
- Sr. Director of Utilization Management
- Sr. Director of Compliance or designee
- Sr. Director of Health Education & Cultural Linguistics or designee
- Director of Pharmacy Services or designee

Meeting Frequency:

The committee meets quarterly.

v. Utilization Management Committee (UMC)

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

Responsibilities include but are not limited to the following:

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

Membership:

- Chief Medical Officer
- Chief Innovation Officer
- Sr. Medical Director
- Sr. Director of Care Management
- Sr. Director of Utilization Management
- Managers of Care Management

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

Meeting Frequency:

The UMC meets quarterly at a minimum.

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

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

HE/CL Committee Responsibilities:

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

Membership:

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

Meeting and/or Reporting Frequency:

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

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

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

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

Committee Responsibilities:

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

- Review Type I Credentialing and Recredentialing practitioner/provider list. Type I files will be presented to the C/PRC on a list of Type 1 files as one group for informational purposes.
- Receive, review, and act on Type II practitioners/providers applying for Credentialing or Recredentialing.
- Review the quality-of-care findings resulting from GCHP's credentialing and quality monitoring and improvement activities.
- Act as the final decision maker in regard to the initial and subsequent credentialing of practitioners/providers based on clinical competency and/or professional conduct.
- Review member and provider clinical complaints, grievances, and issues involving clinical quality of care concerns and determine corrective action when necessary.
- Review the Credentialing and Recredentialing policies and procedures annually.
- Establish, implement, and make recommendations regarding policies and procedures.
- The C/PRC provides feedback and advice to the health plan on any aspect of health plan policy or operations affecting network providers or members including the adoption and approval of the following:
    - Clinical practice and preventive health care guidelines (CPGs/PHGs)

- Utilization Management Criteria

Membership:

The C/PRC is a peer-review body that includes the Chief Medical Officer (CMO) and participating practitioners who span a range of specialties, including primary care (i.e., family practice, internal medicine, pediatrics, general medicine, geriatrics, etc.) and specialty care. It consists of 7-9 voting members who serve two-year terms which may be renewed (there are no term limits). Members are nominated by the CMO and approved by the VCMMCC.

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

Meeting Frequency:

The committee meets quarterly.

viii. **Pharmacy & Therapeutics (P&T) Committee**

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

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

Membership:

- Director of Pharmacy Services (Chair) or designee
- Clinical Programs Pharmacist
- Chief Medical Officer
- Sr. Medical Director or Medical Director
- Physicians and pharmacists representing a variety of clinical specialties.

Meeting Frequency:

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

ix. **NCQA Key Stakeholder Forum**

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

NCQA Key Stakeholder Forum Scope:

- NCQA Health Plan Accreditation
- NCQA Health Equity Accreditation

NCQA Key Stakeholder Forum Objectives:

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

NCQA Key Stakeholder Forum Membership:

- Senior Project Manager (Chair)
- Chief Innovation Officer
- Chief Medical Officer
- Executive Director of Health Equity
- Chief Policy and Program Officer
- Chief Diversity Officer
- Executive Director, Operations
- Executive Director, Population Health
- Sr. Medical Director
- Sr. Director, Quality Improvement
- Sr. Director, Care Management
- Sr. Director, Utilization Management
- Sr. Director, Health Education & Cultural Linguistics
- Sr. Director, Compliance
- Sr. Director, Network Operations
- Director, Operations
- Director, Communications
- Director, Pharmacy
- Director, Behavioral Health & Social Programs
- Director, IT Infrastructure and Security Operations
- Sr. Manager, CM & Special Programs
- Sr. Manager, Population Health
- Manager, Quality Improvement
- QI Program Manager II
- Key business owners and/or departmental representatives from:
    - Human Resources
    - Pharmacy
    - Credentialing
    - Information Technology
    - Communications
    - Health Education and Cultural Linguistic Services

- Population Health
- Provider Network Operations
- Quality Improvement
- Behavioral Health
- Utilization Management
- Case Management
- Compliance
- Operations
- Member Services

Meeting Frequency:

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

x. **MCAS Operations Steering Committee**

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

MCAS Operations Steering Committee Objectives:

The role of the MCAS Operations Steering Committee is to align and drive the organization's strategy and initiatives around MCAS, including but not limited to, prioritization, goals, work plans, and performance tracking. The MCAS Operations Steering Committee serves to ensure effective communication processes are in place to adequately track progress toward work plan activities, provide a platform for candid discussions around barriers to achieving MCAS goals, and create pathways for escalation of performance issues, operational/financial/ regulatory risks, and fleeting opportunities.

MCAS Operations Steering Committee Responsibilities:

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

MCAS Operations Steering Committee Membership:

- Chief Innovation Officer
- Chief Medical Officer

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

Meeting Frequency:

The MCAS Operations Steering Committee meets at least monthly.

i. Behavioral Health Quality Committee

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

Behavioral Health Quality Subcommittee Objectives:

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

Behavioral Health Quality Subcommittee Responsibilities:

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

Behavioral Health Quality Subcommittee Membership:

- GCHP Chief Medical Officer
- GCHP Senior Medical Director
- GCHP Director of Behavioral Health and Social Programs
- GCHP Behavioral Health Manager

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

Meeting Frequency:

The Behavioral Health Quality subcommittee meets at least monthly.

XI. QIHET PROGRAM KEY FUNCTIONAL AREAS

Population Health Management

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

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

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

The PHM program also works closely with our Community Relations and Care Management (CM) Departments to coordinate and provide self-administered test kit screenings for two MCAS

measures (GSD & CHL) at GCHP produced community health fairs. The PHM program is also launching a chronic disease management program targeting diabetic members. GCHP will continue to improve the depth and breadth of services available to our members as we learn more about their needs and characteristics through a data-driven, quality improvement approach.

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

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

Care Management

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

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

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

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

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

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

Utilization Management

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

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

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

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

Behavioral Health

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

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

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

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

Culturally and Linguistically Appropriate Services (CLAS) Program

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

Culturally and linguistically appropriate services include:

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

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

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

Pharmacy Services

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

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

- Utilization Management
- Quality Improvement

- Grievance and Appeals
- Provider Materials/Communications
- Clinical Programs and Services
- Member Services

Pharmacy Services Objectives:

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

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

XII. DELEGATION OF QUALITY IMPROVEMENT

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

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

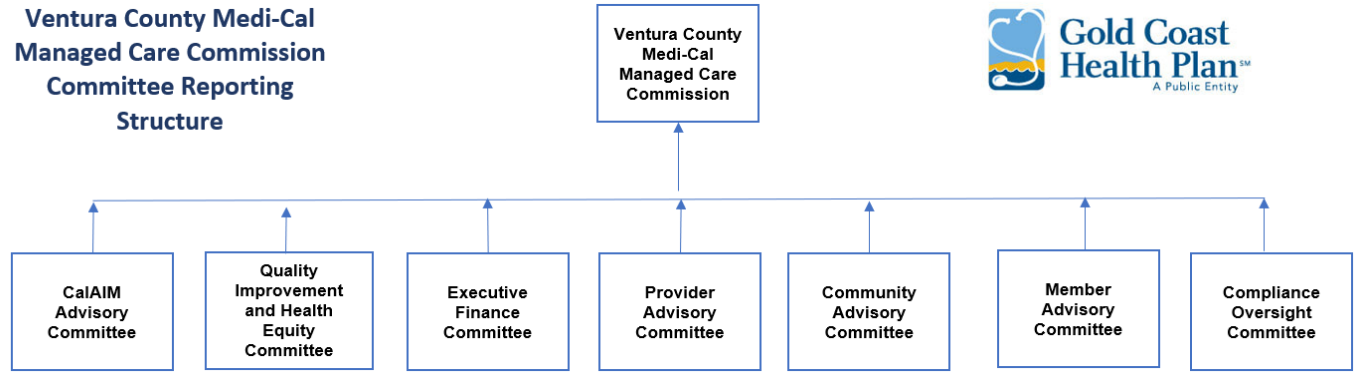
Any delegated functions are fully described in a mutually agreed upon signed and written formal delegation agreement between GCHP and each delegated entity and includes an effective date. All agreements clearly define GCHP's and the delegate's specific duties, responsibilities, activities, reporting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

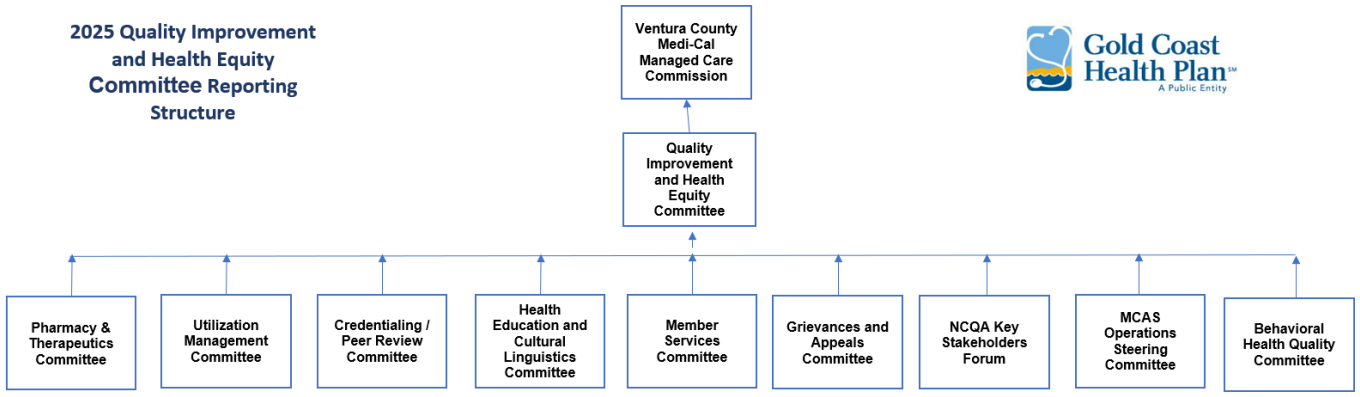
GCHP conducts ongoing oversight, evaluation, and monitoring of the delegate. At a minimum, an annual audit is conducted using an audit tool that is based upon current NCQA, DHCS, and GCHP standards and modified on an as-needed basis. In the event any deficiencies are identified through the oversight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

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

XIII. GOLD COAST HEALTH PLAN QUALITY COMMITTEE ORGANIZATIONAL CHART

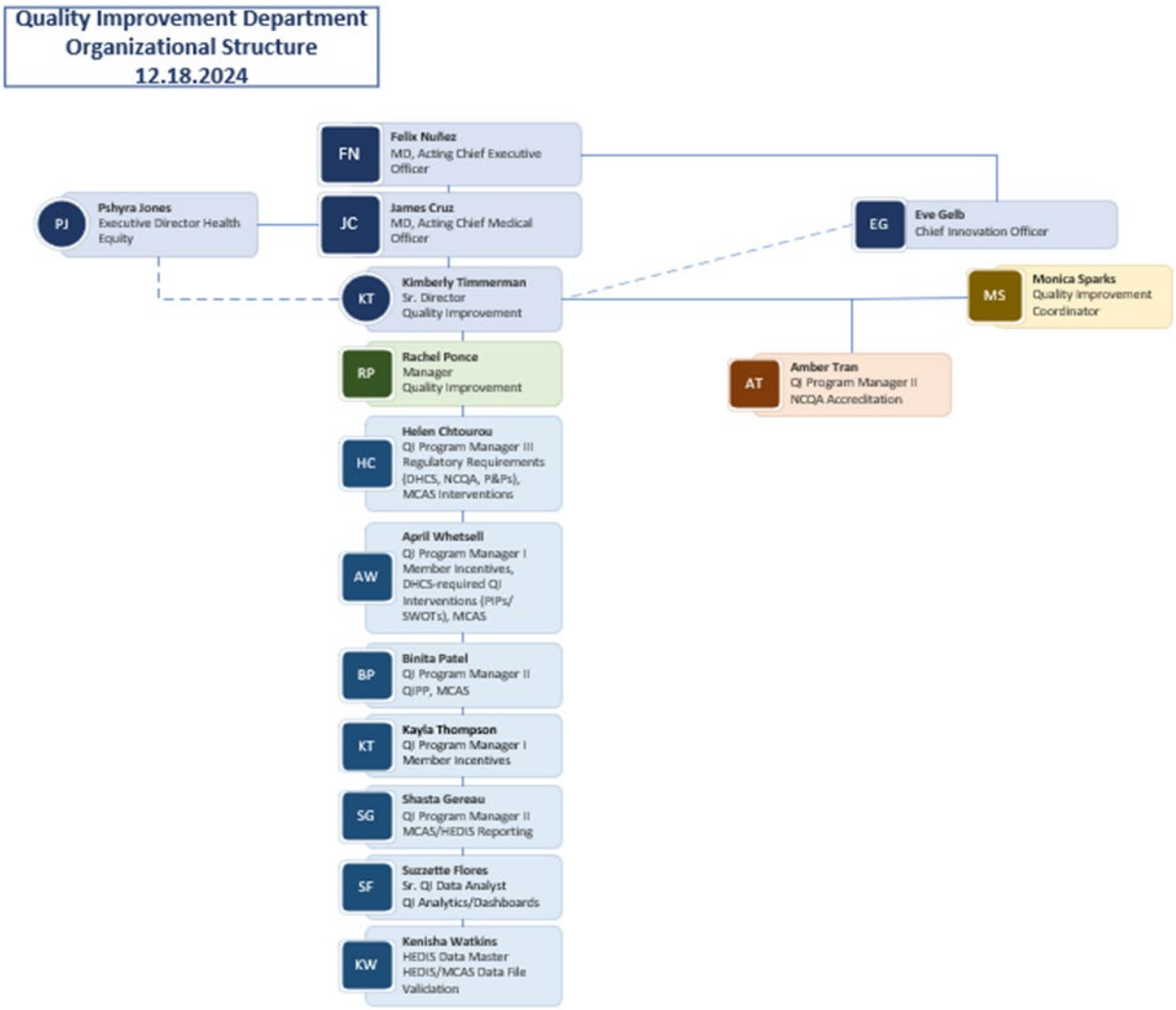
The following organizational chart shows the GCHP Quality Committees that advise the Ventura County Medi-Cal Managed Care Commission and their reporting relationships:





XIV. QUALITY IMPROVEMENT DEPARTMENT ORGANIZATIONAL CHART

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



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

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

XI. RESOURCES

Availability of QIHET Program to practitioners and members

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

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

References

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

Attachments

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

GCHP Quality Improvement and Health Equity Transformation Program Resources

CHIEF MEDICAL OFFICER
The Chief Executive Officer (CEO) has appointed the Chief Medical Officer (CMO) as the designated physician to support the Quality Improvement and Health Equity Transformation (QIHET) Program by providing leadership, oversight and management of quality improvement and health equity activities.

The CMO in collaboration with the Executive Director of Health Equity (HEO) has the overall responsibility for the clinical direction of Gold Coast Health Plan's (GCHP) QIHET Program. The CMO in collaboration with the HEO ensures that the QIHET Program monitors the full scope of clinical services rendered, that services are rendered equitably, that identified problems are resolved, and corrective actions are initiated when necessary and appropriate.

The CMO serves on the following committees: Quality Improvement and Health Equity Committee (QIHEC), Credentialing/Peer Review Committee (C/PRC), Utilization Management Committee (UMC), Health Education/Cultural Linguistics Committee (HE/CL), Grievances and Appeals Committee (G&A), Pharmacy and Therapeutics Committee (P&T), and Member Services Committee (MSC). The CMO in collaboration with the HEO works directly with all GCHP department heads and executive team members to achieve the goals of the QIHET Program. Further, as CMO and a member of the Quality Improvement and Health Equity Committee, the CMO annually oversees the approval of the clinical appropriateness of the Quality Improvement and Health Equity Transformation Program.

The CMO reports to the Chief Executive Officer. The CMO's job description also specifies that they have the ability and responsibility to inform the Chief Executive Officer, and if necessary, the Ventura County Medi-Cal Managed Care Commission (VCMMCC), if at any time they believe their clinical decision-making ability is being adversely hindered by administrative or fiscal consideration.

CHIEF INNOVATION OFFICER
The Chief Innovation Officer (CIO) is responsible for driving the execution of wide-reaching, complex, and cross-functional work plans and performance improvement initiatives in partnership with the CEO and Executive Team. The CIO reports directly to the CEO.

The CIO is responsible for organization-wide coordination, collaboration, and integration by enhancing the practice of performance-focused activities, advancing the organization's capability to develop and execute goals and work plans, and to continuously track performance including a focus on quality improvement and health equity. The CIO serves to improve the execution and integration of complex, enterprise-wide strategic initiatives, including timely and meaningful engagement of the Executive and Leadership Teams in quality improvement and health equity activities.

The CIO serves on the QIHEC and works directly with GCHP department heads and executive team members to achieve transparency and communication; cross-functional coordination, collaboration, and integration; and meaningful engagement of management and staff in achievement of the goals set forth by the QIHET Program.

Executive Director of Health Equity
The CEO has appointed the Executive Director of Health Equity (HEO) as the designated executive authority to provide health equity expertise to support the QIHET Program by providing day to day oversight and management of quality improvement and health equity activities. The HEO reports directly to the Chief Medical Officer.

The HEO in collaboration with the Chief Medical Officer (CMO) has the overall responsibility for the health equity direction of GCHP's QIHET Program. The HEO in collaboration with the CMO ensures

that the QIHET Program monitors the full scope of clinical services rendered, that services are rendered equitably, that identified problems are resolved, and corrective actions are initiated when necessary and appropriate.

The HEO serves on the following committees: QIHEC and HE/CL. The HEO in collaboration with the CMO works directly with all GCHP department heads and executive team members to achieve the goals of the QIHET Program. Further, as HEO and a member of the Quality Improvement and Health Equity Committee, the HEO in collaboration with the CMO, annually oversees the approval of the health equity appropriateness of the Quality Improvement and Health Equity Transformation Program.

SENIOR MEDICAL DIRECTOR

The Senior Medical Director (MD) assists in the functions of the Health Services Department by collaborating with the Chief Medical Officer, Health Services Staff, Quality Improvement Department, Grievance and Appeals Department, and other GCHP staff. This collaboration allows the MD to oversee and carry out utilization management decisions, resolve clinical complaints and appeals and monitor clinical quality improvement programs. Key performance and quality of care indicators and criteria are established and reported to the QIHEC by the MD. The MD also serves on committees as directed by the CMO including the QIHEC, C/PRC, and UMC.

Senior Director, Quality Improvement

The Sr. Director, Quality Improvement is responsible for working with sub-committee chairs and appropriate departments to ensure all quality and health equity monitoring activities, analyses, and improvement initiatives are in place. The Sr. Director, Quality Improvement works with the QIHEC, quality subcommittees, and leadership to educate all GCHP staff on the importance and role of quality improvement and health equity communication, analysis, and reporting. The Sr. Director, Quality Improvement is a mentor for all department heads and works with them to implement processes that will create efficient, high-quality, and equitable services.

The Sr. Director, Quality Improvement reports to the Chief Medical Officer (CMO) to ensure that the CMO is updated on any deficiencies and proposed improvement and equity activities. The CMO in collaboration with the HEO has overall responsibility for the clinical direction of GCHP's Quality Improvement and Health Equity Transformation Program (QIHETP).

Specific roles and responsibilities of the Sr. Director, Quality Improvement include but are not limited to:

- Ensuring that the annual QIHETP Description and Work Plan are created and reviewed by all appropriate areas.
- Working with all appropriate departments in the creation of the annual QIHETP Evaluation and analysis of results.
- Ensuring QIHEC and VCMMCC approval of all QIHETP documents annually.
- Guiding the collection of MCAS data as mandated by contractual requirements and assisting in the development of activities to improve care.
- Ensuring that appropriate principles of data collection and analysis are used by all departments when looking for improvement opportunities.
- Providing educational opportunities for GCHP staff to improving care, health equity, and service to better target improvement initiatives.

The Sr. QI Director oversees the GCHP QI Department under the direction of the CMO. The Sr. QI Director directly oversees the QI Department's 1 QI Manager, who oversees various functions, 1 QI Program Manager focused on NCQA Accreditation, and 1 Quality Improvement Coordinator. The QI

GCHP Quality Improvement and Health Equity Transformation Program Resources

Manager oversees a multidisciplinary team including 5 QI Program Managers, 1 Sr. Quality Improvement Data Analyst, and the HEDIS Data Master.

The QI Department provides quality improvement subject matter expertise, oversight of quality improvement and health equity activities, data analytics, and support of other GCHP business units such as Population Health and Behavioral Health. Support of other business units includes but is not limited to guidance on QIHET metrics, identification of opportunities for improvement and QIHET priorities, member-level gap reports, and intervention determination and execution.

Additionally, the QI team is supported by a Principal Data Analyst residing in the IT Population Health Enablement Department, a Sr. IT Business Analyst residing in the IT Population Health Enablement Department, the Sr. Director Data Engineering, the Director of Business Solutions, and the Health Education and Cultural Linguistics Team.

QI Management

QI Manager

The QI Manager oversees a multidisciplinary team including five QI Program Managers, one Sr. Quality Improvement Data Analyst, and a QI HEDIS Data Master. The QI Manager reports directly to the Sr. Director, Quality Improvement and is responsible for oversight of quality improvement and health equity activities including but not limited to:

- Completion of the annual QIHETP Description and Work Plan
- Completion of the annual QIHETP Evaluation and results analysis
- Monitoring of quality improvement and health equity metrics
- Identification of opportunities and strategies for quality improvement and health equity
- Development and implementation of quality improvement and health equity activities
- Completion of the annual MCAS/HEDIS® Audit
- Monitoring and improvement of monthly data capture and processing activities for quality and health equity metrics reporting

QI Team

QI Program Manager (x5)

The QI Program Manager(s) are responsible for managing, leading, coordinating, and/or assisting with core QI projects and key accountabilities. These projects include performance improvement projects (PIPs/IPs), health initiatives, MCAS/HEDIS® reporting including vendor oversight, quality improvement and health equity interventions to improve quality outcomes or member satisfaction, dashboard monitoring, and reporting analyses. The QI Project Manager(s) directly report to the QI Manager.

HEDIS Data Master (x1)

The HEDIS Data Master is accountable for engaging in and supporting data submission activities for the MCAS/HEDIS program including system and technical configurations, data validation and optimization, and management of strategic efforts to maximize MCAS/HEDIS results. The role has responsibilities that range from oversight of ensuring adequate claims and encounter data collection, maintaining data systems, as well as facilitating data transfer efforts. The HEDIS Data Master directly reports to the QI Manager.

Senior QI Data Analyst (x1)

The Sr. QI Data Analyst is responsible for providing analytical support for the QIHETP. The Sr. QI Data Analyst provides interpretation and analysis of quality improvement and health

equity data to determine areas suitable for the implementation of a QIHETP and leads analytical efforts to determine effectiveness. They develop and produce reports that monitor and benchmark utilization and quality and health equity performance indicators, monitor for adverse trends, and recommend modifications and corrective action. Additionally, the Sr. QI Data Analyst supports analyses requested by other departments such as Behavioral Health, Care Management, and Population Health. These analyses identify target populations, metrics for improvement, rate trends, amongst others. The Sr. QI Data Analyst(s) directly reports to the QI Manager.

QI Improvement Coordinator (x1)
The quality improvement coordinator is responsible for providing administrative and clerical support to the QI Department as well as other quality improvement and health equity activities as necessary. The Quality Improvement Coordinator reports directly to the Sr. Director, Quality Improvement.

Information Technology (IT) Resources

Sr. Director Data Engineering
The Sr. Director of Data Engineering is responsible for implementing and managing data platforms and analytical capabilities across GCHP's technical ecosystem including MCAS/HEDIS data domains. The Sr. Director of Data Engineering manages the team of data engineers responsible for designing and building the data pipelines that generate the data files submitted to GCHP's HEDIS® certified software vendor, Inovalon. The Sr. Director of Data Engineering actively collaborates with QI leadership to guide technical solutions and data exchanges with GCHP partners. The Sr. Director of Data Engineering directly reports to the Executive Director of IT.

Director of Population Health Enablement and Analytics
The Director of Population Health Enablement and Analytics, plans, coordinates, and supervises all activities related to the design, development, and implementation of organizational information systems and software applications including those applicable to the QIHETP. In this role, they are responsible for oversight of the monthly creation of data files submitted to GCHP's HEDIS® certified software vendor, Inovalon. They provide subject matter expertise regarding the resolution of IT issues related to the design, development, and deployment of mission-critical information and software systems including those applicable to the QIHETP. The Director of Population Health Enablement and Analytics directly reports to the Executive Director of IT.

Principal Data Analyst
The Principal Data Analyst is responsible for the monthly creation of data files submitted to GCHP's HEDIS® certified software vendor, Inovalon. They perform data quality checks for each data source, resolve data integrity issues, and ensure that all required files are accurate when sent to and received by Inovalon. They also ensure that all required files are sent at appropriate intervals for calculation of both monthly prospective rate reporting as well as the annual MCAS/HEDIS® rate reporting. The Principal Data Analyst engages with the QI team to develop and document business requirements in collaboration with the QI HEDIS Data Master. The Principal Data Analyst directly reports to the IT Director of Population Health Enablement and Analytics.

GCHP Quality Improvement and Health Equity Transformation Program Resources

Health Education/Cultural and Linguistics Staff

The Health Education/Cultural and Linguistics team establishes guidelines for ensuring quality health education materials are available to providers, members, and the communities. The team identifies the best distribution channel to present materials, adhering to a strict set of regulatory guidelines modified as necessary to ensure the collateral is compliant with all state regulations. The Health Education team develops health education materials in the right brand, style, and grade level, guiding the materials through the compliance and approval process.

Health Navigators provide support for the QIHET Program by performing focused outreach attempts to members using a variety of methods. Outreach campaigns are targeted based on review and analysis of available data by the QI team. Campaigns are modified as needed to support improvement. Campaigns may include outreach for services such as chronic conditions, tobacco cessation, and health promotion campaigns to close gaps in care for services related to preventive health. Beyond direct member telephonic outreach, the QIHET Program may also employ other methods of member outreach in our ongoing efforts to ensure members receive appropriate care. These include:

- Live outreach calls
- Text messaging
- Health tips targeted to specific populations or conditions
- Targeted member mailings
- Targeted provider communications
- Community events
- Member Newsletters

Gold Coast Health Plan℠
A Public Entity

~~2024 Quality Improvement & Health Equity Transformation Work Plan~~2025 Quality Improvement & Health Equity Transformation Work Plan

QIHEC Approved: January 21, 2025
Commission Approved: ~~TBD~~January 27, 2025

GOLD COAST HEALTH PLAN

Reference Guide

	Metric	Goal	Department
1	~~2024~~ 2025 Quality Improvement & Health Equity Transformation (QIHET) Program Description	Update the ~~2024~~ 2025 QIHET Program Description.	Quality Improvement
2	~~2024~~ 2025 Quality Improvement and Health Equity Transformation Work Plan	Update the ~~2024~~ 2025 QIHET Work Plan	Quality Improvement
3	~~2023~~ 2024 Quality Improvement and Health Equity Transformation Program and Work Plan Evaluation	Complete the ~~2023~~ 2024 QIHET Program and Work Plan Evaluation.	Quality Improvement
4	2025 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Description	Update the 2025 CLAS Program Description and Work Plan	Health Education & Cultural Linguistics
5	2024 CLAS Program and Work Plan Evaluation	Complete the 2024 CLAS Program and Work Plan Evaluation.	Health Education & Cultural Linguistics
~~4~~6	~~2024~~ 2025 HEDIS® Compliance Audit™	Successfully complete and pass the annual HEDIS® Compliance Audit™ and receive "reportable" status for all measures.	Quality Improvement
~~5~~7	Population Needs Assessment (PNA)	Maintain NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS. ~~NCQA compliant PNA is part of the Population Health Strategy Report submitted to DHCS.~~	Population Health
~~6~~8	Wellth Program	~~Implement~~ Maintain and expand a QI focused program with Wellth for full-scope Medi-Cal members who are 18+ years of age, are taking at least one medication and have multiple care gaps for which GCHP is held to the DHCS MPL (50th percentile).	Population Health
9	Health Risk Assessment	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	Population Health
~~7~~10	Utilization Management: Clinical Practice Guidelines	Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including the Diabetes and Asthma Clinical Practice Guidelines (CPG).	Utilization Management
~~8~~11	Complex Case Management	~~Develop and implement~~Maintain and monitor a standardized turn-around-time (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements.	Care Management
~~9~~12	Care Gap Closure	Implement strategies to close care gaps for MCAS measures.	Care Management
~~10~~13	Tobacco Cessation	Increase the rate of tobacco cessation counseling and utilization of tobacco cessation medication~~interventions~~ in members identified as tobacco users.	Health Education / Cultural Linguistics
~~11~~14	Initial Health Appointment (IHA)	Increase rates of Initial Health Appointment (IHA) completion by providers.	Quality Improvement
~~12~~15	Opioid Utilization Monitoring	Monitor member opioid utilization via pharmacy claims from Medi-Cal Rx and monitor for any trends where the utilization exceeds more than a 5% increase from the prior quarter. ~~in any category.~~	Pharmacy
~~13~~16	Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	Increase the FUM-30 rate to ~~meet or~~ exceed the DHCS MPL (50th percentile).	Behavioral Health

	Metric	Goal	Department
~~14~~17	Behavioral Health: Follow-Up After Emergency Department Visit for Substance Use – 30 Days	Increase the FUA-30 rate to ~~meet or~~ exceed DHCS MPL (50th percentile).	Behavioral Health
~~15~~18	2023-2026 PIP Non-Clinical Topic: Percentage of Provider Notifications for Members with SUD/SMH Diagnoses within 7 Days of an ED Visit	Improve the percentage of provider notifications for members with substance use disorder (SUD) and / or specialty mental health (SMH) diagnoses following or within 7 days of emergency department (ED) visit.	Quality Improvement
~~16~~19	2024-2025 DHCS/IHI Behavioral Health Collaborative	DHCS / IHI / VCBH Collaborative focused on improving the existing navigator workflows at the county-run hospital (Ventura County Medical Center) to improve outcomes for individuals who visit the ED for an FUA and FUM condition.	Behavioral Health
~~17~~20	Breast Cancer Screening (BCS)	Increase the percentage of ~~women~~ members 50-74 years of age who had a mammogram to screen for breast cancer to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement Health Education/ Cultural Linguistics
~~18~~21	Cervical Cancer Screening (CCS)	Increase percentage of ~~women~~ members 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
~~19~~22	Colorectal Cancer Screening (COL)	Increase the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer to meet the Medicare 50th percentile.~~Increase the percentage of members 45 to 75 year old who had an appropriate screening for colorectal cancer from 30.86% (2023 MY) to the minimum performance level (MPL) established by DHCS (50th percentile).~~	Quality Improvement
~~20~~23	Asthma Medication Ratio (AMR)	Increase the AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a ≥ 0.50 ratio of controller medications to total asthma medications to ~~meet or~~ exceed the DHCS MPL (50th percentile).	Quality Improvement Pharmacy
24	Asthma Medication Ratio (AMR)	Implement multi-disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio.	Quality Improvement
~~21~~25	Health Equity Controlling Blood Pressure (CBP)	Increase the percentage of members with hypertension who are 21-44 years of age and have a blood pressure rate of <140/90 to ~~meet or~~ exceed the DHCS MPL (50th percentile).~~Increase the CBP rate for members 21-44 years of age to meet or exceed the DHCS MPL (50th percentile).~~	Quality Improvement Population Health
~~22~~26	Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD-Poor Control	Decrease the percentage of members with diabetes who are 18-75 years of age and have GSD > 9.0% to meet the DHCS HPL (90th percentile).	Quality Improvement
~~23~~27	Chlamydia Screening in Women (CHL)	Increase the rate of chlamydia screening in members 16 to 24 years of age to meet or exceed the 75th national Medicaid percentile established by NCQA.	Quality Improvement Health Education / Cultural Linguistics
~~24~~28	Prenatal and Postpartum Care (PPC)	Increase the percentage of ~~women~~ members with live birth deliveries who completed timely prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
~~25~~29	Childhood Immunization Status – Combo 10 (CIS-10)	Increase the percentage of members~~, two years of age,~~ who completed all Combo-10 immunizations by their 2nd birthday to exceed the 75th national Medicaid percentile established by NCQA.	Quality Improvement

	Metric	Goal	Department
~~26~~30	Immunization Status for Adolescents – Combo 2 (IMA-2)	Increase the percentage of ~~adolescents~~ members who completed all IMA-2 immunizations by their 13th birthday to exceed the 75th national Medicaid percentile established by NCQA. ~~the NCQA established to DHCS MPL (50th percentile).~~	Quality Improvement
~~27~~31	Developmental Screening in the First Three Years of Life (DEV)	Increase the percentage of ~~children~~ members screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding, or on, their first, second or third birthday, by 3% compared to the prior measurement year.	Quality Improvement
~~28~~32	Lead Screening in Children (LSC)	Increase the percentage of ~~children~~ members who had one or more capillary or venous blood lead tests for lead poisoning by their 2nd birthday to meet the 75th national Medicaid percentile established by NCQA.	Quality Improvement
~~29~~33	Topical Fluoride Varnish (TFL)	Increase the percentage of members, ages 1 through 20, who received at least two topical fluoride applications during the measurement year to ~~meet or~~ exceed the DHCS MPL (50th).	Quality Improvement
~~30~~34	Well-Child Visits in the First 30 Months of Life (W30)	Increase the percentage of ~~children~~ members who had well-child visits with a PCP to ~~meet or~~ exceed the DHCS MPL (50th percentile)	Quality Improvement
~~31~~35	Child and Adolescent Well-Care Visits (WCV)	Increase the percentage of members, 3-21 years of age, who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year to meet or exceed the DHCS ~~HPL~~ MPL (~~90th~~ 50th percentile).	Quality Improvement
~~32~~36	2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members	Improve the performance rate for Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) among the Hispanic/Latinx population.	Quality Improvement
~~33~~37	2024-2025 DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits.	Quality Improvement
~~34~~38	Cultural and Linguistic Needs & Preferences	• By July 31, 2025~~4~~, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules ~~from four to seven which will~~to include Diversity, Equity, and Inclusion (DEI) training program as per DHCS (APL 23-025) that encompasses sensitivity, diversity, cultural competence and cultural humility, and health equity trainings. • By July 31, 2025~~4~~, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with ~~three~~ Network Provider offices per quarter. • By December 31, 2024~~5~~, GCHP's HECL Department shall report on the number of C&L fulfilment and benchmarks quarterly during the QIHEC meeting.	Health Education / Cultural Linguistics
~~35~~39	Primary and Specialty Care Access	Ensure primary and specialty care access standards met for minimum of ~~90~~80% of providers.	Provider Network Operation
~~36~~40	Network Adequacy	Assess and improve network adequacy as demonstrated by availability of practitioners.	Provider Network Operations
~~37~~41	After Hours Availability	Conducts surveys to ensure members are able to reach a provider after hours.	Provider Network Operations
~~38~~42	Provider Satisfaction	Field provider survey and develop action plan(s) to improve areas of low performance.	Provider Network Operations
~~39~~43	Facility Site Review Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements.	Quality Improvement

	Metric	Goal	Department
~~40~~	~~Facility Site Review Monitoring~~	~~Conduct facility site monitoring 100% on time to ensure safety practices.~~	~~Quality Improvement~~
~~41~~44	Physical Accessibility Review Surveys (PARS)	Complete Physical Accessibility Reviews (PARs) 100% on time.	Quality Improvement
~~42~~45	Credentialing/Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners/ providers to provide care to members.	~~Quality Improvement~~Provider Network Operations
~~43~~46	Grievances and Appeals	Monitor all member grievances and appeals to identify trending issues. Communicate these trends to relevant departments to develop actionable plans aimed at addressing highly reported concerns and improving the overall member experience~~Monitor all member grievances and appeals to review for trending issues that will be communicated to various departments to develop action plans to improve the member experience by focusing on highly reported issues.~~	Grievances and Appeals
~~44~~47	Call Center Monitoring	Meet call center benchmarks to ensure members have timely access to call center staff and implement interventions on any deficient benchmarks. (1) ASA: 30 seconds or less; (2) Abandonment Rate: 5% or less; (3) Phone Quality Results: ≥ 95%.	Member Services
~~45~~48	CAHPS: Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and to monitor and improve CAHPS scores.	Quality Improvement
~~46~~49	CAHPS: Access to Specialty Care	Improve access to specialty care for adults and children.	Operations Strategy/External Affairs Quality Improvement
~~47~~50	CAHPS: Improve CAHPS Scores	Improve CAHPS scores based on MY 2024 CAHPS outcomes, including ~~the DHCS Quality Withhold CAHPS scores focused on~~ Getting Care Quickly and Getting Needed Care~~Improve CAHPS Scores based on MY 2023 CAHPS outcomes.~~	Operations Strategy/External Affairs Quality Improvement
~~48~~51	Delegation Oversight	100% of all audits completed at least annually with corrective action plans (CAPs) closed timely.~~100% of all audits completed with corrective action plans (CAPs) closed timely~~	Compliance

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update

Objective 1: Improve Quality and Safety of Clinical Care Services

1. Quality: ~~2024~~ 2025 Quality Improvement and Health Equity Transformation (QIHET) Program Description						
Quality	~~2024~~ 2025 QIHET Program Description	Update the ~~2024~~ 2025 QIHET Program Description.	1. Collaborate with business units to review and update the ~~2024~~ 2025 QIHET Program Description. 2. Prepare and submit for approval to Quality Improvement & Health Equity Committee (QIHEC). 3. Prepare and submit for approval to the Commission.	1. ~~01/01/24~~ ~~02/29/24~~11/18/24-01/15/25 2. ~~03/19/24~~01/21/25 3. ~~04/22/24~~01/27/25	• Sr. Director, Quality Improvement • QI Manager • QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
2. Quality: ~~2024~~ 2025 Quality Improvement and Health Equity Transformation Work Plan						
Quality	~~2024~~ 2025QIHET Work Plan	Update the ~~2024~~ 2025 QIHET Work Plan.	1. Collaborate with business units to review and update the ~~2024~~ 2025 QIHET Work Plan. 2. Prepare and submit for approval to the QIHEC. 3. Prepare and submit for approval to the Commission.	1. ~~01/01/24~~ ~~02/29/24~~11/18/24-01/15/24 2. ~~03/19/24~~01/21/25 3. ~~04/22/24~~01/27/25	• Sr. Director, Quality Improvement • QI Manager • QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
3. Quality: ~~2023~~ 2024 Quality Improvement and Health Equity Transformation Work Plan Evaluation						
Quality	~~2023~~ 2024 QIHET Work Plan and Program Evaluation	Complete the ~~2023~~ 2024 QIHET Work Plan and Program Evaluation.	1. Collaborate with business units to complete evaluation of the ~~2023~~ 2024 QIHET Work Plan. 2. Evaluate effectiveness of the quality improvement structure and resources. 3. Evaluate the QIHEC subcommittees are occurring according to each subcommittee's charter and cadence. 4. Conduct a~~A~~ssessment of Committee Members 5. Conduct a~~A~~ssessment of systems and activities 6. Conduct a~~A~~ssessment of resources dedicated to addressing disparities ~~3.~~7. Prepare and submit for approval to the QIHEC. 8. Prepare and submit for approval to the Commission.	1. 03/01/~~24~~25-06/30/~~24~~25 2. 03/01/~~24~~25-07/31/~~24~~25 3. 03/01/~~24~~25-07/31/~~24~~25 4. 07/31/25 5. 07/31/25 6. 07/31/25 ~~3.~~7. 09/~~17~~16/~~24~~25 8. 09/23/~~24~~25	• Sr. Director, Quality Improvement • QI Manager • QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
4. Health Equity: 2025 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Description						
Health Equity	2025 CLAS Program Description and Work Plan	Update the 2025 CLAS Program Description and Work Plan	1. Update the 2025 CLAS Program Description and Work Plan	1. 01/31/25	• Sr. Director, Health Education and Cultural Linguistics • Sr. Cultural and Linguistics Specialist • Sr. Health Navigator /Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
5. Health Equity: 2024 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Evaluation						
Health Equity	2024 CLAS Program and Work Plan Evaluation	Complete the 2024 CLAS Program and Work Plan Evaluation.	2. Complete evaluation of the 2024 CLAS Program and Work Plan Evaluation. 3. Evaluate effectiveness of the quality improvement structure and resources. 4. Conduct a~~A~~ssessment of Committee Members 5. Conduct a~~A~~ssessment of systems and activities 6. Conduct a~~A~~ssessment of resources dedicated to addressing disparities. 7. Prepare and submit for approval to the QIHEC. 8. Prepare and submit for approval to the Commission.	2. 03/01/25-06/30/25 3. 03/01/25-07/31/25 4. 07/31/25 5. 07/31/25 6. 07/31/25 7. 09/16/25 8. 09/23/25	• Sr. Director, Health Education and Cultural Linguistics • Sr. Cultural and Linguistics Specialist • Sr. Health Navigator /Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
6. Quality: 2025 HEDIS® Compliance Audit™						
Quality	2025HEDIS® Compliance Audit™	Successfully complete and pass the annual HEDIS® Compliance Audit™ and receive "reportable" status for all measures.	1. ROADMAP Submission 2. Non-Standard Supplemental Data Primary Source Validation 3. Preliminary rate review 4. Medical Record Review (MRR) Validation 5. Final rate review 6. Interactive Data Set Submission 7. Submit ROADMAP Management Representation Letter	1. 01/31/25 2. 03/28/25 3. 04/25/25 4. 05/23/25 5. 06/13/25 6. 06/13/25 7. 06/13/25	• Sr. Director, Quality Improvement • QI Manager • QI Program Manager II	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
4. Quality: 2024 HEDIS® Compliance Audit™						
Quality	2024 HEDIS® Compliance Audit™	Successfully complete and pass the annual HEDIS® Compliance Audit™ and receive "reportable" status for all measures.	1. ROADMAP Submission 2. Non-Standard Supplemental Data Primary Source Validation 3. Preliminary rate review 4. Medical Record Review (MRR) Validation 5. Final rate review 6. Interactive Data Set Submission 7. Submit ROADMAP Management Representation Letter	1. 01/31/24 2. 03/29/24 3. 04/12/24 4. 05/13/24 5. 05/31/24 6. 06/14/24 7. 06/14/24	• Sr. Director, Quality Improvement • QI Manager • QI Program Manager II	Annual Goal Met: Yes☒ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~5.~~7. Population Health: Population Needs Assessment (PNA)						
Population Health	Population Needs Assessment	Maintain NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS.	1. Develop and implement Population Health Management Strategic Objectives.	1. 12/31/254	• Sr. Manager of Population Health Management • ~~Sr. Director of Health Education and Cultural Linguistics~~ • Program Analyst of Population Health Management • Senior Healthcare Data Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: ~~o~~ ○ Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~6.~~8. Population Health: Wellth Program						
Population Health	Wellth Quality Improvement Program	~~Implement~~ Maintain and expand a QI focused program with Wellth for full-scope Medi-Cal members who are 18+ years of age, are taking at least one medication and have multiple care gaps for which GCHP is held to the DHCS MPL (50th percentile).	~~Enroll 3,800 members that qualify for the QI focused program.~~ ~~The PHM team will create an internal process for evaluating outcomes related to the Wellth Utilization versus QI Program to inform the phased implementation approach.~~ 1. The PHM team will continue to evaluate the outcomes associated with the Wellth QI program. ~~Decision point on whether to enroll additional 1,200 members in the Wellth Utilization or QI program.~~ ~~Decision point on whether to enroll additional 5,550 members in the Wellth Utilization or QI program.~~ 2. Implement a provider referral process. ~~2.~~3. Enroll additional members into Wellth QI program to a total of 10,500.	~~03/29/24~~ 1. ~~03/29/24~~ 01/06/25 - 12/31/25 2. ~~04/30/24~~ 2/28/25 3. ~~06/28/24~~ 3/31/25	• Sr. Manager of Population Health • Wellness and Prevention Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~7.~~9. Population: Health Risk Assessment						
Population Health	Health Risk Assessment (HRA)	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	~~1.~~ The PHM team will continue working with Carenet to conduct HRAs at a volume to match capacity for referrals. 2. Implement member HRA outreach via SMS through Carenet. 3. Transition HRA outreach from Carenet to the GCHP Call Center. 4. Enable HRA completion online via CRM.	1. 06/30/25 2. 03/31/25 3. 07/01/25 4. 3/31/25	• Sr. Manager of Population Health • Wellness and Prevention Manager	Annual Goal Met: Yes☒ No☐ Quarterly Updates: Continue Objective: Yes☐~~☒~~ No ☒~~☐~~ New objective added in 2025 Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~8.~~10. Utilization Management: Clinical Practice Guidelines						
Utilization Management	Preventive Health, Clinical Practice, and Utilization Management Guidelines~~Clinical Practice Guidelines~~	Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including the Diabetes and Asthma Clinical Practice Guidelines (CPG), and UM Guidelines.~~.~~	1. Review and approval by the ~~Medical Advisory Committee (MAC).~~Credentialing /Peer Review Committee (C/PRC) 2. Post guidelines on the GCHP website and distribute guidelines to appropriate practitioners, upon request. 3. Ensure alignment of PHG with Provider Manual and applicable policies.	1. ~~01/18/24,~~ ~~04/18/24,~~ ~~07/18/24,~~ ~~10/17/24~~03/06/25, 06/05/25, 09/04/25, 11/20/25 2. 01/01/2~~5~~4-12/31/2~~5~~4 3. 01/01/2~~5~~4-12/31/2~~5~~4	• Chief Medical Officer • Sr. Director Utilization Management • Sr. Director Quality Improvement	Annual Goal Met: Yes☐~~☒~~ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~9.~~11. Care Management: Complex Case Management						
Care Management (CM)	Complex Case Management (CCM)	~~Develop and implement~~Maintain and monitor a standardized turn-around-time (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements.	1. ~~Receive DHCS approval for policy HS-058 Care Management including Complex Case Management.~~ ~~2.~~1. Provide staff training as identified. ~~3.~~2. Review and revise staff auditing tools to align with NCQA and policy HS-058 Care Management including Complex Case Management guidelines associated with~~on~~ TAT for CCM. ~~4.~~3. Strategize with CM, QI, HS analyst on the development of metrics and benchmarks to capture CCM TAT. ~~5.~~4. Monitor CCM TAT dashboard and implement interventions for benchmarks not met.	1. ~~06/30/24~~ ~~2.~~1. 01/01/2~~5~~4-12/31/2~~5~~4 ~~3.~~2. ~~06/30/24~~01/01/2025 – 12/31/2025 ~~4.~~3. 01/01/2~~5~~4-12/31/2~~5~~4 ~~5.~~4. 03/01/2~~5~~4-12/31/2~~5~~4	• Director of CM • Sr. Manager, CM & Special Projects • CM Managers	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~10.~~12. Care Management: Care Gap Closure						
Care Management (CM)	Care Gap Closure	Implement strategies to close care gaps for MCAS measures.	~~1. Utilize the MCAS care gap dashboard to inform members of their care gaps.~~ ~~2.~~1. Continue to ~~I~~include utilization of the MCAS care gaps dashboard as part of the CM process. ~~3.~~2. Review and revise JAM's/resource tools/to align with care gap report utilization. ~~4.~~3. Review and revise staff auditing tools as identified. 4. Provide staff with learning opportunities related to MCAS care gap report, programs and activities. ~~as needed, utilization and impact to CM process.~~ 5. Strategize with QI and other departments as identified on the development of programs and activities to address identified care gaps.	1. 01/01/254-12/31/254 2. 04/01/524-12/31/254 3. 01/01/254-12/31/254 4. 01/01/254-12/31/254 ~~4.~~5. 01/01/254-12/31/254	• Director of CM • Sr. Manager, CM & Special Projects • CM Managers • QI Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~11.~~13. Advance Prevention: Tobacco Cessation						
Advance Prevention	Tobacco Cessation	Increase rate of tobacco cessation ~~interventions~~ counseling and utilization of tobacco cessation medication in members identified as tobacco users. **IHA benchmarks** • 100% of identified tobacco users receive counseling. • 32% of tobacco users receive cessation medication. **Admin benchmarks:** • ~~39~~45% of identified tobacco users receive counseling. • ~~13~~10% of tobacco users receive cessation medication.	1. Utilize DHCS methodology to identify tobacco users via data pulls for quarterly analysis and reporting. 2. Create and/or update provider and member education campaigns. 3. Measure tobacco cessation medication dispensing and cessation counseling quarterly via IHA medical record review and administrative data. 4. Report tobacco cessation medication dispensing and cessation counseling semi-annually.	1. 03/31/2~~5~~4 06/30/~~24~~ 2509/30/~~24~~ 25 12/31/2~~5~~4 2. 12/31/~~24~~25 3. 03/31/~~24~~ 2506/30/~~24~~ 25 09/30/~~24~~ 25 12/31/~~24~~25 4. 03/31/~~24~~25, 09/30/~~24~~25	• QI RN Manager • Sr. Director of Health Education and Cultural Linguistics • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~12.~~14. Advance Prevention: Initial Health Appointment (IHA)						
Advance Prevention	Initial Health Appointment	Increase rates of Initial Health Appointment (IHA) completion by providers.	1. Distribute new member lists to clinic/health system for member outreach to schedule the IHA visit. 2. Monitor claims data for timely IHA completion within 120 days by clinic system. 3. Conduct medical record audits by provider site and provide feedback on opportunities for improvement. 4. Provide ongoing trainings on the IHA and IHA Outreach Log.	1. 11th day of each month 2. 03/31/254, 06/30/~~24~~25, 09/30/~~24~~25, 12/31/~~24~~25 3. 01/01/~~24~~25-12/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25	• QI RN Manager • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~13.~~15. Pharmacy: Reduction in Potential Unsafe Opioid Prescriptions						
Pharmacy	Opioid Utilization Monitoring	Monitor member opioid utilization via pharmacy claims from Medi-Cal Rx and monitor for any trends where the utilization exceeds more than a 5% increase from the prior quarter ~~in any category~~.	1. Monitor the following statistics related to opioid utilization via pharmacy claims from Medi-Cal Rx in GCHP members: • Total number of unique users • Concurrent users of opioids and benzodiazepines • Concurrent users of opioids and antipsychotics • Number of high dose utilizers • Number of members who fill opioids at 3 or more pharmacies • Number of members who have opioids prescribed by 3 or more prescribers • ~~Concurrent users of opioids and naloxone~~ 2. Perform retrospective Drug Utilization Review (DUR) and implement Provider Interventions Related to Opioid Utilization as needed.	1. ~~03/20/24~~03/31/25, ~~06/11/24~~06/30/25, ~~09/17/24~~09/30/25, ~~12/03/24~~12/31/25 2. 01/01/~~24~~25-12/31/~~24~~25	• Director of Pharmacy Services • Clinical Programs Pharmacist	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~14.~~16. Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days						
Behavioral Health	Follow-Up After Emergency Department (ED)Visit for Mental Illness – 30 days. (FUM-30)	Increase the FUM-30 rate to ~~meet or~~ exceed the DHCS MPL (50th percentile).	1. Continuously improve and develop new innovative interventions that promote members' access to behavioral health care services. 2. Monitor Carelon Behavioral Health performance towards the established incentive measure targets within the fully executed contract to ensure adequate follow-up care after ED visit. 3. Improve data exchange to ensure more complete, accurate, and timely data to improve robust capture of follow-up visits. 4. Include in the Quality Incentive Provider Pool (QIPP) Program. 5. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 6. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 7. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 8. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions.	1. 12/31/254 2. 12/31/254 3. 12/31/254 4. 12/31/~~24~~25 5. 12/31/254 6. 08/15/~~24~~25 7. 01/31/~~24~~25-12/31/~~24~~25 8. 07/31/~~24~~25	• Director, Behavioral Health and Social Programs • Manager, Behavioral Health • QI Program Manager III • Executive Director, IT • Director of Medical Informatics • Sr. Program Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~15.~~17. Behavioral Health: Follow-Up After Emergency Department Visit for Substance Use – 30 Days						
Behavioral Health	Follow-Up After Emergency Department (ED)Visit for Substance Use – 30 days. (FUA-30)	Increase the FUA-30 rate to ~~meet or~~ exceed DHCS MPL (50th percentile).	1. Continuously improve and develop new innovative interventions that promote members' access to behavioral health care services. 2. Monitor Carelon Behavioral Health performance towards the established incentive measure targets within the fully executed contract to ensure adequate follow-up care after ED visit. 3. Improve data exchange to ensure more complete, accurate, and timely data to improve robust capture of follow-up visits with the HIE, diagnoses and ADT feeds. 4. Include in the Quality Incentive Provider Pool (QIPP) Program. 5. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 6. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 7. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 8. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions.	1. 12/31/254 2. 12/31/254 3. 12/31/254 4. 12/31/~~24~~25 5. ~~01/01/24~~ 12/31/254 6. 08/15/~~24~~25 7. 01/31/~~24~~25-12/31/~~24~~25 8. 07/31/~~24~~25	• Director, Behavioral Health and Social Programs • Manager, Behavioral Health • QI Program Manager III • Executive Director, IT • Director of Medical Informatics • Sr. Program Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Update Continue Objective: Yes☒ ~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~16.~~18. Behavioral Health: 2023-2026 PIP Non-Clinical Topic: Percentage of Provider Notifications for Members with SUD/SMH Diagnoses within 7 Days of an ED Visit						
Quality / DHCS	2023-2026 Non-Clinical PIP	Improve the percentage of provider notifications for members with substance use disorder (SUD) and / or specialty mental health (SMH) diagnoses following or within 7 days of emergency department (ED) visit.	1. Submit Modules as directed by DHCS/HSAG for approval. ~~1.~~2. Perform ongoing evaluation of the intervention and identify opportunities to improve. ~~2.~~3. Report updates/results to QIHEC	1. 09/01/~~24~~25 2. 09/~~17~~16/~~24~~25, ~~12/03/24~~11/18/25	• QI Program Manger III • Sr. Manager, CM & Special ~~Projects~~ • Director of Behavioral Health and Social Program • Clinical Care Manager III, LCSW • Sr. QI Data Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~17.~~19. Behavioral Health: 2024-2025 DHCS/IHI Behavioral Health Collaborative with VCBH						
Quality / DHCS	DHCS / IHI / VCBH Collaborative focused on improving the existing navigator workflows at the county-run hospital (Ventura County Medical Center) to improve outcomes for individuals who visit the ED for an FUA and FUM condition.~~DHCS /IHI~~	By June 30 2025, improved care coordination processes and data exchange will increase the rate of follow-up BH services by 5% for Ventura County Medi-Cal beneficiaries with BH-related ED visits.~~FUA/FUM~~	1. Implementation of Data Sharing Mechanism & Development of Data Use Framework 2. Enhancement of Care Coordination in ED and between Collaborating Entities 3. Improvement of Delivery System Processes ~~1. Launch collaboration project.~~ ~~2. Smart AIM~~ ~~3. Intervention determination~~	1. 01/01/25-06/30/25 2. 01/01/25-06/30/25 3. 01/01/01-06/30/25	• ~~BH~~ • ~~QI PM III~~ • GCHP staff ○ Director, Behavioral Health & Social Programs ○ Manager, Behavioral Health ○ Behavioral Health Specialist ○ Director, Medical Informatics ○ Senior Program Analyst ○ QI Manager ○ QI Program Manager III • VCBH Staff ○ Quality Improvement Manager ○ Sr. Program Administrator • Care Coordination Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~18.~~20. Cancer Prevention: Breast Cancer Screening (BCS)						
MCAS	Breast Cancer Screening	Increase the percentage of ~~women~~ members 50-74 years of age who had a mammogram to screen for breast cancer to meet or exceed the DHCS HPL (90th percentile).	1. Provide clinics/providers with the annual MY ~~2023~~ 2024. MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Evaluate effectiveness of the breast cancer screening member incentive program and identify program changes and enhancements, as applicable. 5. Expand and evaluate the effectiveness of the point-of-care (POC) member incentive program and identify program changes and enhancements as applicable. ~~• Nancy Reagan Breast Center~~ 6. Distribute provider member incentive awards annually. 7. ~~Fund~~ Promote and support access to mobile mammography services. 8. Conduct member outreach campaigns to increase preventive screenings and close care gap. 9. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 12/31/~~24~~25 5. 12/31/~~24~~25 6. 12/31/~~24~~25 7. 09/30/~~24~~25 8. 06/01/~~24~~25-12/31/~~24~~25 9. 01/01/~~24~~25-12/31/~~24~~25	• QI Manager • QI Program Manager 1 • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~☐~~ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			Relations Department) to implement interventions, promote best practices and increase awareness. 10. Include BCS in the Quality Incentive Provider Pool (QIPP) Program. 11. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	10. 12/31/~~24~~25 11. 01/01/~~24~~25-12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~19.~~21. Cancer Prevention: Cervical Cancer Screening (CCS)						
MCAS	Cervical Cancer Screening (CCS)	Increase percentage of ~~women~~ members 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90th percentile).	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Evaluate effectiveness of the cervical cancer screening member incentive program and identify program changes and enhancements, as applicable. 5. Expand and evaluate the effectiveness of the point-of-care (POC) member incentive program and identify program changes and enhancements as applicable. 6. Distribute provider member incentive awards annually. 7. Conduct member outreach campaigns to increase preventive screenings and close care gap. 8. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/31/~~25~~26 5. 12/31/~~24~~25 6. 12/31/~~24~~25 7. 04/01/~~24~~25-11/30/~~24~~25 8. 01/01/~~24~~25-12/31/~~24~~25	• QI Manager • QI Program Manager I • QI RN • Sr. Health Navigator & Health Education	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~☐~~ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			best practices and increase awareness. 9. Include CCS in the Quality Incentive Provider Pool (QIPP) Program core measures. ~~10. Explore grant opportunities to fund increased access to cervical cancer screenings.~~ ~~11.~~10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	9. 12/31/~~24~~25 ~~10. 04/01/24 12/31/24~~ ~~11.~~10. 01/01/~~2~~425-12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~20.~~22. Cancer Prevention: Colorectal Cancer Screening (COL)						
Advance Prevention	Colorectal Cancer Screening (COL-E)	Increase the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer ~~from 30.86% (2023 MY)~~ to meet the ~~minimum performance level (MPL) established by DHCS~~ Medicare ~~(~~50th percentile~~)~~.	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). ~~6. Launch educational member mailing campaign.~~ ~~7.~~6. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best practices and increase awareness. ~~8.~~ Partner with lab vendor to pilot home test kits. ~~Exact Sciences to promote Cologuard through member outreach campaigns, data sharing, and provider ordering efficiencies.~~	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~23~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 06/30/~~24~~25 7. 01/01/~~24~~25-12/31/~~24~~25 8. 12/31/~~24~~25	• QI Manager • QI RN • Sr. Director of Health Education, Cultural and Linguistic Services • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			~~9.~~7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	9. 12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~21.~~23. Chronic Disease Management: Asthma Medication Ratio (AMR)						
MCAS	Asthma Medication Ratio	Increase the AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a ≥ 0.50 ratio of controller medications to total asthma medications to ~~meet or~~ exceed the DHCS MPL (50th percentile).	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Retrospective Drug Utilization Review and Provider Interventions Related to Asthma Medication Use. 5. Explore development of community health workers (CHW) home visiting program in collaboration with Health Education. 6. Include ~~as a core measure~~ in the ~~expanded~~ Quality Incentive Provider Pool (QIPP) Program. 7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 8. Conduct member outreach campaigns to members identify with <50% asthma medication ration. 9. ~~for members identified as non-compliant.~~ Implement the asthma spacer member incentive program	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 09/30/~~24~~25 5. 09/30/~~24~~25 6. 12/31/~~24~~25 7. 12/31/2425 8. 09/30/25 9. 06/30/25	• Director of Pharmacy Services • Clinical Programs Pharmacist • QI Manager • QI Program Manager III • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			10. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best practices and increase awareness. 11. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). ~~7.~~12. ~~Create member health education flyer highlighting the importance of managing asthma.~~	10. 01/01/25-12/31/25 11. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
24. Chronic Disease Management: 2025 DHCS Lean Quality Improvement and Health Equity Improvement Project						
MCAS	Asthma Medication Ratio	Implement multi-disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio.	1. Submit lean quality improvement and health equity process form. 2. Submit Program form with SMART goals, run charts, and interventions. 3. Submit final progress form	1. 02/10/25 2. 06/10/25 3. 10/10/25	• QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☒ New objective added in 2025 Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~22.~~25. Chronic Disease Management: Health Equity Controlling Blood Pressure (CBP)						
MCAS	Controlling Blood Pressure	Increase the percentage of members with hypertension who are ~~CBP rate for members~~ 21-44 years of age and have a blood pressure rate of <140/90 to ~~meet or~~ exceed the DHCS MPL (50th percentile).	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Notify members and providers of the Medi-Cal Rx blood pressure cuff benefits. 7. Monitor and promote member utilization of the blood pressure cuff to improve self-monitoring and reporting of blood pressure. 8. Collaborate with Care Management to promote the blood pressure cuff benefit. 9. Utilize the Wellth to collect blood pressure data. 10. Conduct community health fairs to collect blood pressure data and	1. 08/15/~~24~~25 2. 01/01/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 03/31/~~24~~25 7. 03/01/~~23~~25-12/31/~~24~~25 8. 09/01/~~24~~25 9. 01/01/~~24~~25-12/31/~~24~~25 ~~9.~~10. 12/31/~~2~~425	• QI Manager • QI Program Manager II • QI RN • Manager, Care Management and Special Programs • Sr. Manager of Population Health • Wellness and Prevention Manager • HEDIS Data Master	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps: .

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			refer members with hypertension to care management. 11. Utilize the ~~e~~Chronic ~~d~~Disease ~~s~~Self-~~m~~Management ~~p~~Program to educate members with hypertension care gaps on self-management skills. 12. Include in the Quality Incentive Provider Pool (QIPP) Program. ~~core measures became optional.~~ 13. Evaluate improvements in data collection to capture BP through administrative data (e.g., EMR, HIE).	~~10.~~11. 12/31/~~2~~425 ~~11.~~12. 12/31/~~2~~425 ~~12.~~13. 12/31/~~2~~425		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~23.~~26. Chronic Disease Management: Glycemic Status Assessment for Patients with Diabetes (>9.0%) (GSD)						
MCAS	Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD-Poor Control	Decrease the percentage of members with diabetes who are 18-75 years of age and have GSD > 9.0% to meet the DHCS HPL (90th percentile).	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Launch program to distribute at-home HbA1c screenings kits. 7. Include in the Quality Incentive Provider Pool (QIPP) Program ~~core measures.~~ ~~8. Monitor and evaluate the provider grants to increase POC HbA1c machines at clinics.~~ ~~9.~~8. ~~Execute contracts for additional chronic condition programs for diabetes. (e.g. Arine, Wellth)~~ 9. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 01/01/~~24~~25-12/31/~~24~~25 7. 12/31/~~24~~25 8. ~~12/31/24~~25 9. 12/31/~~24~~25	• QI Manager • QI Program Manager III • QI RN • Sr. Director of Health Education, Cultural and Linguistic Services • Sr. Health Navigator & Health Education	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~☐~~ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			10. ~~Launch~~ Continue program to utilize test screenings • Health Fairs • Pop-Clinics 11. Complete data integration and testing for Arine diabetes management program (DMP), 12. Complete Arine platform requirements and configuration phases. 13. Complete Arine platform training for staff. 14. Launch Arine DMP. ~~10.~~15. Continue to promote Chronic Disease Self-Management Program to members with diabetes care gap and other co-morbidities.	10. 01/01/~~24~~25-12/31/~~24~~25 11. 9/1/25 12. 9/1/25 13. 9/13/25 14. 9/13/25 ~~10.~~15. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~24.~~27. Women's Health: Chlamydia Screening in Women (CHL)						
MCAS	Chlamydia Screening in Women	Increase the rate of chlamydia screening in members 16 to 24 years of age to meet or exceed the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with prospective MY ~~2024~~ 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 3. Identify low performing providers and conduct best practices presentations. ~~2.~~4. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. ~~3.~~5. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Community Relations Department, Planned Parenthood, VCPH, VCOE) to implement interventions to increase access to care, promote best practices and increase awareness. ~~4.~~6. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities Trainings for low performing providers. 7. Include in the Quality Incentive Provider Pool (QIPP) Program. ~~core measure.~~	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~23~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 04/30/~~24~~25 6. 06/30/~~23~~25 7. 12/31/~~24~~25	• QI RN Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~☐~~ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			~~5.~~8. ~~Launch~~ ~~Continue~~Evaluate programs to ~~distribute~~ utilize ~~at-home~~ chlamydia screenings test kits. • Health Fair • Home Test Kits ~~6.~~9. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	8. 01/01/25-12/31/~~24~~25 ~~8.~~9. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~25.~~28. Women's Health: Prenatal and Postpartum Care (PPC)						
MCAS	Prenatal and Postpartum Care	Increase the percentage of ~~women~~ members with live birth deliveries who completed timely prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile). • Members who received a prenatal care visit during the first trimester, on or before the enrollment start date, or within 42 days of enrollment. • Members who completed a postpartum exam completed with 7 to 84 days after a live-birth delivery.	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Conduct member outreach campaigns to increase postpartum screenings and close gaps in care. 7. Include in the Quality Incentive Provider Pool (QIPP) Program. 8. ~~Create~~ Continue providing report to improve early identification of members who are due for prenatal and postpartum visits. 9. ~~Launch~~ Evaluate effectiveness of the Doula Pilot Program, ~~Promotoras de Parto y Pos Parto, to increase prenatal and postpartum services for the Mixteco speaking population in Ventura County~~	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 03/01/~~24~~25-12/31/~~24~~25 7. 12/31/~~24~~25 8. 03/01/~~24~~25 9. 06/30/~~24~~25	• QI RN Manager • QI RN • HECL/Sr. Health Navigator & Health Educator • Population Health Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps: .

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			10. Provide Pregnancy and Postpartum packets with resources for providers to distribute to members.	~~9.~~10. 09/30/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~26.~~29. Children's Health: Childhood Immunization Status – Combo 10 (CIS-10)						
MCAS	Childhood Immunization Status – Combo 10	Increase the percentage of members ~~, two years of age,~~ who completed all Combo-10 immunizations by their 2nd birthday to exceed the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Community Relations Department, VCPH, VCOE, VFC) to implement interventions to increase access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Conduct member outreach campaigns to increase immunizations and close care gaps.	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 03/01/~~24~~25 – 11/30/~~24~~25 7. 12/31/~~24~~25	• QI RN Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps: .

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			7. Include in the Quality Incentive Provider Pool (QIPP) Program. ~~8. Schedule quarterly health fairs to offer and promote childhood immunizations.~~ 8. Flu vaccine workgroup to improve the CIS-10 rate 9. Evaluate effectiveness of the flu vaccine member incentive program. ~~9.~~10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	~~01/01/24 – 12/31/24~~ 8. 08/01/25 – 12/31/25 9. 01/31/26 ~~8.~~10. 12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~27.~~30. Children's Health: Immunizations for Adolescents – Combo 2 (IMA-2)						
MCAS	Immunizations for Adolescents – Combo 2 (IMA-2)	Increase the percentage of adolescents who completed all IMA-2 immunizations by their 13th birthday to ~~exceed to DHCS HPL~~ exceed the 75th national Medicaid percentile established by NCQA. ~~exceed the NCQA nationally established (90th percentile benchmark).~~	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Community Relations Department, VCPH, VCOE, VFC) to implement interventions, improve access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Conduct member outreach campaigns to increase immunizations and close care gap. 7. Evaluate effectiveness of the HPV immunization member incentive program and identify program changes/enhancements, as applicable. 8. Expand and evaluate the effectiveness of the POC member incentive program and identify	1. 08/15/~~24~~ 25 2. 01/31/~~24~~ 25- 12/31/~~24~~ 25 3. 07/31/~~24~~ 25 4. 01/01/~~24~~ 25- 12/31/~~24~~ 25 5. 01/01/~~24~~ 25- 12/31/~~24~~ 25 6. 03/~~01240~~ 125- 12/31/~~24~~ 25	• QI RN Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~☐~~ No☐ Next Steps: .

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			program changes/enhancements as applicable. 9. Include IMA-2 in the Quality Incentive Provider Pool (QIPP) Program. 10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	7. 12/31/~~24~~ 25 8. 12/31/~~24~~ 25 9. 12/31/~~24~~ 25 10. 01/01/~~24~~ 25- 12/31/~~24~~ 25		

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~28.~~31. Children's Health: Developmental Screening in the First Three Years of Life (DEV)						
MCAS	Developmental Screening in the First Three Years of Life	Increase the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding, or on, their first, second or third birthday, by 3% compared to the prior measurement year.	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Community Relations Department, Help Me Grow/First 5, ~~CHDP,~~ VCPH, VCOE) to implement interventions to improve access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 7. Include in the Quality Incentive Provider Pool (QIPP) Program ~~core measures.~~ 8. Conduct member outreach campaigns to increase preventive screenings and close care gap.	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~23~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 09/30/~~24~~25 6. 12/31/~~24~~25 7. 12/31/~~23~~25 8. 03/15/~~24~~25-11/30/~~24~~25	• QI RN Manager • QI Program Manager II • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~29.~~32. Children's Health: Lead Screening in Children (LSC)						
MCAS	Lead Screening in Children (LSC)	Increase the percentage of children who had one or more capillary or venous blood lead tests for lead poisoning by their 2nd birthday to meet the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Community Relations Department, Help Me Grow/First 5, ~~CHDP~~, CDR, CLPPP, VCPH, VCOE) to implement interventions, promote best practices and increase awareness. • ~~WIC text campaign~~ 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Compile and distribute lead screening gaps in care reports quarterly to providers (per DHCS APL 20-016). 7. Monitor provider compliance with lead screening requirements through medical record audits and issue PIPs for performance below 80% threshold.	1. 08/15/~~24~~25 2. 01/31/~~24~~25- 12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25- 12/31/~~24~~25 5. 01/01/~~24~~25- 12/31/~~24~~25	• QI RN Manager • QI Program Manger II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			8. Conduct member outreach campaigns to increase blood lead screenings and close care gap. 9. Evaluate effectiveness of the LSC ~~immunization~~ member incentive program and identify program changes/enhancements, as applicable. 10. Increase adherence to the DHCS APL (20-016) in the areas of anticipatory guidance and lead screening refusal forms. 11. ~~Monitor and evaluate the provider grants to increase POC lead screening machines at clinics~~. ~~12. Implement per test lead screening provider incentive of $25 for members 0-2 years age (available to providers who do not select LSC as an optional measure under QIPP)~~ ~~13.~~12. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	6. 05/31/~~24~~25, 12/31/~~24~~25 7. 03/15/~~24~~25- 11/30/~~24~~25 8. 03/01/~~24~~25- 12/31/~~24~~25 9. 12/31/~~24~~25 10. 12/31/~~24~~25 11. 12/31/~~24~~25 ~~12. 01/01/24- 12/31/24~~		

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
				~~13.~~12. 01/01/~~24~~25-12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~30.~~33. Children's Health: Topical Fluoride Varnish (TFL)						
MCAS	Topical Fluoride Varnish (TFL)	Increase the percentage of members, ages 1 through 20, who received at least two topical fluoride applications during the measurement year to ~~meet or~~ exceed the DHCS MPL (50th).	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Community Relations Department, Help Me Grow/First 5, ~~CHDP,~~ VCPH, VCOE, United Way) to implement interventions to improve access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Include as a core measure in the expanded Quality Incentive Provider Pool (QIPP) Program. ~~7. Explore grant opportunities to fund access to topical fluoride varnish.~~ 7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 12/31/~~24~~25 6. 12/31/~~24~~25 ~~7. 04/01/24-10/31/24~~ 7. 01/01/~~24~~25-12/31/~~24~~25	• QI RN Manager • QI Program Manager II • QI RN •	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			8. Work with vendors to administer topical fluoride varnish at health fairs.	8. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~31.~~34. Children's Health: Well-Child Visits in the First 30 Months of Life (W30)						
MCAS	Well-Child Visits in the First 30 Months of Life	Increase the percentage of children who had well-child visits with a PCP ~~to meet or~~ exceed the DHCS MPL (50th percentile) for the following sub-measures. • Well-child visits in the first 15 months of life: Increase the percentage of children with six or more well-care exams within the first 15 months of life. • Well-child visits between 15 and 30 months of age: Increase the percentage of 30-month-old children who had two or more well-child exams between 15 and 30 months of age.	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with monthly prospective MY ~~2024~~ 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Health Education, Population Health, Community Relations, Help Me Grow/First 5, CHDP, VCPH, VCOE, WIC) to implement interventions, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Conduct member outreach campaigns to increase well-child preventive care screenings and close gaps in care. 7. Include in the Quality Incentive Provider Pool (QIPP) Program ~~core measure.~~	1. 08/15/~~24~~25 2. 01/31/245-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 03/01/~~24~~25-11/30/~~24~~25 7. 12/31/~~24~~25	• QI Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			8. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	8. 01/01/~~24~~25-12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~32.~~35. Children's Health: Child and Adolescent Well-Care Visits (WCV)						
MCAS	Child and Adolescent Well-Care Visits	Increase the percentage of members, 3-21 years of age, who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year to meet or exceed the DHCS ~~HPL~~ MPL (~~90th~~-50th percentile).	1. Provide clinics/providers with monthly prospective MY ~~2024~~ 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 2. Provide clinics/providers with the annual MY ~~2023~~-2024 MCAS/HEDIS® rate reports. 3. Evaluate MY ~~2024~~-2025 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Health Education, Population Health, Community Relations Department, Help Me Grow/First 5, ~~CHDP~~, VCPH, VCOE, WIC) to implement interventions to increase access to care, promote best practices and increase awareness. 7. Create and/or update provider and member education campaigns that are culturally and linguistically	1. 07/31/~~24~~25 2. 01/01/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 01/01/~~24~~25-12/31/~~24~~25 7. 01/01/~~24~~25-12/31/~~24~~25	• QI Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			appropriate to address health disparities. 8. Evaluate effectiveness of the well care member incentive program and identify program changes/enhancements, as applicable. 9. Expand and evaluate the effectiveness of the point-of-care (POC) member incentive program and identify program changes/enhancements as applicable. 10. Distribute provider member incentive awards quarterly. 11. Conduct member outreach campaigns to increase preventive care screenings and close gaps in care. 12. Include in the Quality Incentive Provider Pool (QIPP) Program ~~core measures.~~ ~~Explore grant opportunities to fund increased access to well-care visits.~~ 13. ~~Create new teen flyer for members 18 years and older to promote taking charge of their own health.~~	8. 01/31/~~25~~25 9. 01/01/~~24~~25-12/31/~~24~~25 10. 12/31/~~24~~25 11. 03/01/~~24~~25–10/31/~~24~~25 12. 12/31/~~24~~25 13. ~~04/01/24-10/31/24~~		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~33.~~36. Children's Health: 2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members						
Quality / DHCS	2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members	Improve the performance rate for Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) among the Hispanic/Latinx population.	1. Submit Modules as directed by DHCS/HSAG for approval. 2. Report updates/results to QIHEC	1. 09/01/~~24~~25 2. 09/~~17~~16/~~24~~25, ~~12/03/24~~11/18/25	• QI Program Manager II	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~34.~~37. Children's Health: 2024-2025 DHCS/IHI Child Health Equity Collaborative						
Quality / DHCS	DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits.	1. Complete Interventions 4: Actor mapping & Community Partnership 2. Complete Intervention 5: Partnering for Effective Education and Communication ~~1. Launch collaboration project.~~ ~~2. Intervention determination~~	1. 01/16/2025 2. 01/16/2025-3/20/2025 ~~1. 09/01/24~~ ~~2. 04/01/24-12/31/24~~	~~• QI Program Manager II~~ ~~• QI RN~~ • QI Program Manager I • QI RN • Senior Health Navigator Manager, Community Relations	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
Objective 2: Improve Quality and Safety of Non-Clinical Care Services						
~~35.~~38. Cultural and Linguistic Needs & Preferences						
Improve Quality & Safety of Non-Clinical Care Services	Cultural and Linguistic Needs & Preferences	• By July 31, ~~2024~~2025, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules ~~from four to seven which~~to ~~will~~ include Diversity, Equity, and Inclusion (DEI) training ~~program~~program curriculum as per DHCS (APL 23-025) that encompasses sensitivity, diversity, cultural competence and cultural humility, and health equity trainings. • By July 31, ~~2024~~2025, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with three Network Provider offices per quarter. • By December 31, ~~2024~~2025, GCHP's HECL Department shall report on the	1. Develop an action plan to evaluate existing C&L/DEI training modules on the GCHP website and develop a process to increase C&L/DEI trainings. ~~modules from four to seven.~~ 2. Engage various departments on the C&L/DEI training modules and solicit feedback. 3. Engage Community-Based Organizations on the C&L/DEI training modules and solicit feedback. 4. Engage Members on the C&L/DEI training modules for Providers and solicit their recommendations to ensure the Providers trainings are inclusive of GCHP membership. 5. Identify three Providers to conduct three C&L/DEI trainings. 6. Evaluate C&L/DEI trainings and prepare summary report of findings. 7. Prepare QIC dashboard summarizing the total number of C&L/DEI trainings and services at the quarterly QIHEC meetings.	1. 01/01/~~24~~25-07/31/~~24~~25 2. 08/01/~~24~~25-12/31/~~24~~25 3. 12/31/~~24~~25 4. 12/~~2~~31/~~24~~225 5. 12/31/~~24~~25 6. 12/31/~~24~~25 7. 03/~~19~~118/~~24~~25, ~~06/11/2425~~05/13/25, 07/15/25, 09/~~17~~16/~~24~~25, ~~12/03/2425~~11/18/25	• Sr. Director of Health Education and Cultural Linguistics • Sr. C&L Specialist • Sr. Director, Network Operations • Manager, Provider Contracting & Regulatory	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~☐~~ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
		number of C&L fulfilment and benchmarks quarterly during the QIHEC meeting.				
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~36.~~39. Primary and Specialty Care Access						
Improve Quality & Safety of Non-Clinical Care Services	Primary and Specialty Care Access	Ensure standards met for minimum of ~~8~~90% of providers. **Primary Care Access** Members are offered: • Non-urgent primary care within 10 business days of request • Urgent care within 24 hours **Specialty Care Access** Members are offered: • Non-urgent specialty care appointment within 15 business days • Non-urgent ancillary services within 15 business days	1. Conduct survey and evaluate results. 2. Develop and implement corrective action plans when timely access standards not met. 3. Report quarterly performance to QIHEC. 4. Monitor complaints and PQIs relating to the member access for appointments and/or referrals and take action as appropriate.	1. ~~06/30/24~~09/30/2025 2. 01/01/25~~41~~-12/31/25~~4~~ 3. 03/21/25~~4~~, 06/13/25~~4~~, 09/19/25~~4~~, 12/05/25~~4~~ 4. 01/01/25~~4~~-12/31/25~~4~~	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Manager, Provider Relations • QI RN Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~37.~~40. Network Adequacy						
Improve Quality & Safety of Non-Clinical Care Services	Assess and improve network adequacy as demonstrated by availability of practitioners.	• PCP and Provider Ratios: o 1 PCP 1:2000 o Total Physicians 1: 1200 • Physician Supervision to Non-Physician Practitioner Ratios: o Nurse Practitioners 1:4 o Physician Assistants 1:4 • Network maintained PCP located within 10 miles or 30 minutes from members residence. • Network maintained DHCS Core specialists located within 30 miles or 60 minutes from members residence. • Develop process for network certification (with ratios). • Hospitals 15 miles or 30 minutes from members residence	1. Conduct ratio analysis for primary care and high-volume specialties ~~2. Identify gaps and implement corrective action plan(s).~~ ~~3.~~2. Monitor progress toward action plans to maintain or improve GeoAccess standards: Network maintained PCPs. ~~4.~~3. Monitor progress toward action plans to maintain or improve GeoAccess standards: Network maintained DHCS Core Specialists. ~~5.~~4. Develop process for network certification (with ratios). ~~6.~~5. Report biannual ratio analysis and annual GeoAccess findings to QIHEC.	1. 03/31/~~24~~25, 06/30/~~24~~25, 09/30/~~24~~25, 12/31/~~24~~25 ~~2. 03/31/24, 06/30/24, 09/30/24, 12/31/24 12/31/24~~ ~~3.~~2. 01/01/~~24~~25-12/31/~~24~~25 ~~4.~~3. 01/01/~~24~~25-12/31/~~24~~25 ~~5.~~4. 12/31/~~24~~25 ~~6.~~5. 03/21/~~24~~25, 06/13/~~24~~25, 09/19/~~24~~25, 12/05/~~24~~25	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Executive Director, Delivery System Operations and Strategies	Annual Goal Met: Yes☐ No☒ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~38.~~41. After Hours Availability						
Improve Quality & Safety of Non-Clinical Care Services	After Hours Availability	Conducts surveys to ensure members are able to reach a provider after hours.	1. Conduct surveys and evaluate results. 2. Develop and implement action plans when timely access standards are not met. 3. Report quarterly performance to QIHEC.	1. ~~06~~09/30/~~24~~25 2. 01/01/~~24~~25-12/31/~~24~~25 3. 03/21/~~24~~25, 06/13/~~24~~25, 09/19/~~24~~25, 12/05/~~24~~25	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Manager, Provider Relations • Executive Director, Delivery System Operations and Strategies	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~39.~~42. Provider Satisfaction						
Improve Quality & Safety of Non-Clinical Care Services	Provider Satisfaction Survey	Field provider survey and develop action plan(s) to improve areas of low performance.	1. Analyze results and identify opportunities for improvement. 2. Implement interventions as needed to improve satisfaction.	1. ~~06/30/24~~10/31/25 2. 01/01/~~24~~25-12/31/~~24~~25	• Sr. Director, Network Operations • Manager, Provider Relations • Sr. Manager, Provider Network Operations – Program & Policy • Executive Director, Delivery System Operations and Strategies	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~☐~~ No ☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~40.~~43. Facility Site Review Requirements						
Improve Member Safety	Facility Site Review Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements.	1. Complete and document Initial, Interim, and Tri-annual Facility Site Reviews 100 % timely. ~~2. Complete FSRs past due because of the public health emergency, in accordance with the DHCS plan.~~ 2. Issue and monitor corrective action plans (CAPs) as needed to facilitate clinic compliance and improvement on identified deficiencies. 3. Collaborate with PNO, legal, and CMO on sites not meeting requirements 4. Monitor member complaints/grievances and potential quality issues (PQIs) involving quality of care/safety concerns. ~~3.~~ ~~4.~~5. Submit biannual ~~reports~~ data to DHCS: ○ January – June ○ July – December	1. 01/01/2~~54~~-12/31/254 ~~2. 12/31/24~~ 2. 01/01/2~~54~~-12/31/254 3. 01/01/25-12/31/25 4. ~~3.~~ 01/01/25-12/31/25 ~~4.~~5. 07/31/~~24~~25, 12/31/~~24~~25	• QI RN Manager • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~Facility Site Review Monitoring~~						
~~Improve Member Safety~~	~~Facility Site Monitoring~~	~~Conduct facility site monitoring 100% on time to ensure safety practices.~~	~~1. Monitor FSR results and deficiencies, track, and trend.~~ ~~2. Monitor member complaints/grievances and potential quality issues (PQIs) involving quality of care/safety concerns.~~ ~~3. Issue CAPS and track improvements as needed.~~ ~~4.~~1. ~~Collaborate with PNO, legal, and CMO on sites not meeting requirements~~	~~1. 01/01/24 12/31/24~~ ~~2. 01/01/24 12/31/24~~ ~~3. 01/01/24 12/31/24~~ ~~4.~~1. ~~01/01/24 12/31/24~~	• ~~QI RN Manager~~ • ~~QI RN~~	~~Annual Goal Met: Yes☐ No☐~~ ~~Quarterly Updates:~~ ~~Continue Objective: Yes☒ No☐~~ ~~Next Steps:~~
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~41.~~44. Physical Accessibility Review Surveys (PARS)						
Improve Member Safety	Physical Accessibility Review Surveys	Complete Physical Accessibility Reviews (PARs) 100% on time.	1. Compile report for high volume/ancillary specialist visits for Seniors and Persons with Disabilities (SPD) population and submit PARS report to DHCS. 2. Complete and document PARS for identified high volume/ancillary specialist provider ~~sides.~~sites. 3. Complete and document PARS as indicated during the Initial and Periodic FSRs	1. 01/31/~~24~~25 2. 12/31/~~24~~5 3. 01/01/~~24~~25-12/31/~~24~~25	• QI RN Manager • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~42.~~45. Credentialing/Recredentialing						
Improve Member Safety	Credentialing / Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners/ providers to provide care to members.	1. Perform timely verification of all required credentialing elements to ensure current, accurate and complete files for credentialing decisions. 2. Perform timely recredentialing (within 36 months of last approval date). 3. Perform ongoing monitoring of sanctions and adverse events timely. 4. Collaborate with Symplr on software configuration and automation to achieve efficiency in the credentialing process.	1. 01/0125/~~24~~-12/31/2524 2. 01/01/2524-12/31/2524 3. 01/01/2524-12/31/2524 4. 01/01/2524-~~05~~12/3125/~~24~~	• Senior Director, Network Operations • Credentialing Specialist III • Credentialing Specialist II	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
Objective 3: Improve Quality of Service						
~~43.~~46. Grievances and Appeals						
Assess and improve member experience	Grievances and appeals	Monitor all member grievances and appeals to identify trending issues. Communicate these trends to relevant departments to develop actionable plans aimed at addressing highly reported concerns and improving the overall member experience. ~~Monitor all member grievances and appeals to review for trending issues that will be communicated to various departments to develop action plans to improve the member experience by focusing on highly reported issues.~~	~~1.~~ Conduct quarterly assessment of grievances and appeals. ~~2.~~ ~~3.~~1. ~~4.~~2. Identify opportunities for improvement. ~~5.~~3. Create and implement action plan for improvement	1. 03/31/254, 06/30/254, 09/30/254, 12/31/254 2. 01/01/254~~-~~ 12/31/254 3. 01/01/254~~-~~ 12/31/254	• Director of Operations • Operations Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~44.~~47. Call Center Monitoring						
Assess and improve member experience	Call Center Monitoring	Meet call center benchmarks to ensure members have timely access to call center staff and implement interventions on any deficient benchmarks. • ASA: 30 seconds or less • Abandonment Rate: 5% or less • Phone Quality Results: ≥ 95%	1. Report Member Services Telephone Access Analysis • Monitor Average Speed of Answer (ASA) • Monitor Abandonment Rate • Phone Quality Results 2. Identify opportunities for improvement based on data analysis.	1. 03/31/~~24~~25, 06/30/2~~5~~4, 09/30/2~~5~~4, 12/31/2~~5~~4 2. 01/01/2~~5~~4-12/31/2~~5~~4	• Director of ~~Operation~~Member Contact Center~~s~~ • Sr Operations Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
Objective 4: Assess and Improve Member Experience						
~~45.~~48. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys						
Assess and improve member experience	CAHPS Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and to monitor and improve CAHPS scores.	1. Submit Survey Sample Frame data to HSAG ~~1.~~2. Assess CAHPS scores.	1. 01/06/25 ~~1.~~2. ~~06~~07/~~30~~31/~~24~~25	• Sr. Director, Quality Improvement • QI Manager • QI Program Managers II, III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~46.~~49. Consumer Assessment of Healthcare Providers and Systems (CAHPS): Access to Specialty Care						
Assess and improve member experience	CAHPS: Access to Specialty Care	Improve access to specialty care for adults and children.	1. Develop intervention to improve access to specialty care. 2. Participate in the ACAP CAHPS Collaborative	1. 12/31/2025~~12/31/24~~ 2. 02/01/2025-12/31/2-025~~02/21/24-12/18/24~~	• Chief Innovation Officer • Executive Director, Delivery Systems, Operations and Strategies • Chief Member Experience and External Affairs Officer ~~Executive Director, Strategy and External Affairs~~ • ~~QI Program Manager I~~	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~47.~~50. Consumer Assessment of Healthcare Providers and Systems (CAHPS): Improve CAHPS Scores						
Assess and improve member experience	CAHPS: Improve CAHPS Scores	Improve CAHPS scores based on MY 2024 CAHPS outcomes, including Getting Care Quickly and Getting Needed Care~~Improve CAHPS Scores based on MY 2023 CAHPS outcomes.~~	1. Utilize Voice of the Member to create interventions based on areas of low performance.	1. 12/31/~~24~~25	• Chief Innovation Officer • Executive Director, Delivery Systems, Operations and Strategies • Chief Member Experience and External Affairs Officer ~~Executive Director, Strategy and External Affairs~~ • ~~QI Program Manager I~~	Annual Goal Met: Yes☐ No☐ Quarterly Updates: • Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
Objective 5: Ensure Organizational Oversight of Delegated Functions						
~~48.~~51. Delegation Oversight						
Ensure Organizational Oversight of Delegated Functions	Completion of Delegation Oversight Audits • Credentialing • Quality Improvement • Utilization Management • ~~Member's Rights~~ • Member Experience • Claims • Call Center • Cultural and Linguistics • Transportation (NEMT/NMT) • Population Health Management	100% of all audits completed at least annually with corrective action plans (CAPs) closed timely.	1. Complete audits per scheduled timeline 2. Issue CAPS as applicable. 3. Follow-up on CAPs as applicable 4. Report to Compliance Committee and Quality Improvement Committee	1. 01/01/254-12/31/2543 2. 01/01/254-12/31/254 3. 01/01/254-12/31/254 4. 02/0668/254, 05/0816/254, 08/0713/254, 11/0614/254	• Sr. Director, Compliance • Delegations Oversight Program Manager • Privacy Officer-Internal Audit Director • Delegation Oversight Audit Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Gold Coast Health Plan℠
A Public Entity

2025 Quality Improvement & Health Equity Transformation Work Plan

QIHEC Approved: January 21, 2025
Commission Approved: January 27, 2025

GOLD COAST HEALTH PLAN

Reference Guide

	Metric	Goal	Department
1	2025 Quality Improvement & Health Equity Transformation (QIHET) Program Description	Update the 2025 QIHET Program Description.	Quality Improvement
2	2025 Quality Improvement and Health Equity Transformation Work Plan	Update the 2025 QIHET Work Plan	Quality Improvement
3	2024 Quality Improvement and Health Equity Transformation Program and Work Plan Evaluation	Complete the 2024 QIHET Program and Work Plan Evaluation.	Quality Improvement
4	2025 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Description	Update the 2025 CLAS Program Description and Work Plan	Health Education & Cultural Linguistics
5	2024 CLAS Program and Work Plan Evaluation	Complete the 2024 CLAS Program and Work Plan Evaluation.	Health Education & Cultural Linguistics
6	2025 HEDIS® Compliance Audit™	Successfully complete and pass the annual HEDIS® Compliance Audit™ and receive "reportable" status for all measures.	Quality Improvement
7	Population Needs Assessment (PNA)	Maintain NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS.	Population Health
8	Wellth Program	Maintain and expand a QI focused programs with Wellth for full-scope Medi-Cal members who are 18+ years of age, are taking at least one medication and have multiple care gaps for which GCHP is held to the DHCS MPL (50th percentile).	Population Health
9	Health Risk Assessment	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	Population Health
10	Utilization Management: Clinical Practice Guidelines	Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including the Diabetes and Asthma Clinical Practice Guidelines (CPG).	Utilization Management
11	Complex Case Management	Maintain and monitor a standardized turn-around-time (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements.	Care Management
12	Care Gap Closure	Implement strategies to close care gaps for MCAS measures.	Care Management
13	Tobacco Cessation	Increase the rate of tobacco cessation counseling and utilization of tobacco cessation medication in members identified as tobacco users.	Health Education / Cultural Linguistics
14	Initial Health Appointment (IHA)	Increase rates of Initial Health Appointment (IHA) completion by providers.	Quality Improvement
15	Opioid Utilization Monitoring	Monitor member opioid utilization via pharmacy claims from Medi-Cal Rx and monitor for any trends where the utilization exceeds more than a 5% increase from the prior quarter.	Pharmacy
16	Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	Increase the FUM-30 rate to exceed the DHCS MPL (50th percentile).	Behavioral Health
17	Behavioral Health: Follow-Up After Emergency Department Visit for Substance Use – 30 Days	Increase the FUA-30 rate to exceed DHCS MPL (50th percentile).	Behavioral Health

	Metric	Goal	Department
18	2023-2026 PIP Non-Clinical Topic: Percentage of Provider Notifications for Members with SUD/SMH Diagnoses within 7 Days of an ED Visit	Improve the percentage of provider notifications for members with substance use disorder (SUD) and / or specialty mental health (SMH) diagnoses following or within 7 days of emergency department (ED) visit.	Quality Improvement
19	2024-2025 DHCS/IHI Behavioral Health Collaborative	DHCS / IHI / VCBH Collaborative focused on improving the existing navigator workflows at the county-run hospital (Ventura County Medical Center) to improve outcomes for individuals who visit the ED for an FUA and FUM condition.	Behavioral Health
20	Breast Cancer Screening (BCS)	Increase the percentage of members 50-74 years of age who had a mammogram to screen for breast cancer to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement Health Education/ Cultural Linguistics
21	Cervical Cancer Screening (CCS)	Increase percentage of members 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
22	Colorectal Cancer Screening (COL)	Increase the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer to meet the Medicare 50th percentile.	Quality Improvement
23	Asthma Medication Ratio (AMR)	Increase the AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a ≥ 0.50 ratio of controller medications to total asthma medications to exceed the DHCS MPL (50th percentile).	Quality Improvement Pharmacy
24	Asthma Medication Ratio (AMR)	Implement multi-disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio.	Quality Improvement
25	Health Equity Controlling Blood Pressure (CBP)	Increase the percentage of members with hypertension who are 21-44 years of age and have a blood pressure rate of <140/90 to exceed the DHCS MPL (50th percentile).	Quality Improvement Population Health
26	Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD-Poor Control	Decrease the percentage of members with diabetes who are 18-75 years of age and have GSD > 9.0% to meet the DHCS HPL (90th percentile).	Quality Improvement
27	Chlamydia Screening in Women (CHL)	Increase the rate of chlamydia screening in members 16 to 24 years of age to meet or exceed the 75th national Medicaid percentile established by NCQA.	Quality Improvement Health Education / Cultural Linguistics
28	Prenatal and Postpartum Care (PPC)	Increase the percentage of members with live birth deliveries who completed timely prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
29	Childhood Immunization Status – Combo 10 (CIS-10)	Increase the percentage of members who completed all Combo-10 immunizations by their 2nd birthday to exceed the 75th national Medicaid percentile established by NCQA.	Quality Improvement
30	Immunization Status for Adolescents – Combo 2 (IMA-2)	Increase the percentage of members who completed all IMA-2 immunizations by their 13th birthday to exceed the 75th national Medicaid percentile established by NCQA.	Quality Improvement
31	Developmental Screening in the First Three Years of Life (DEV)	Increase the percentage of members screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding, or on, their first, second or third birthday, by 3% compared to the prior measurement year.	Quality Improvement
32	Lead Screening in Children (LSC)	Increase the percentage of members who had one or more capillary or venous blood lead tests for lead poisoning by their 2nd birthday to meet the 75th national Medicaid percentile established by NCQA.	Quality Improvement
33	Topical Fluoride Varnish (TFL)	Increase the percentage of members, ages 1 through 20, who received at least two topical fluoride applications during the measurement year to exceed the DHCS MPL (50th).	Quality Improvement

	Metric	Goal	Department
34	Well-Child Visits in the First 30 Months of Life (W30)	Increase the percentage of members who had well-child visits with a PCP to exceed the DHCS MPL (50th percentile)	Quality Improvement
35	Child and Adolescent Well-Care Visits (WCV)	Increase the percentage of members, 3-21 years of age, who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year to exceed the DHCS MPL (50th percentile).	Quality Improvement
36	2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members	Improve the performance rate for Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) among the Hispanic/Latinx population.	Quality Improvement
37	2024-2025 DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits.	Quality Improvement
38	Cultural and Linguistic Needs & Preferences	• By July 31, 2025, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules to include Diversity, Equity, and Inclusion (DEI) training program as per DHCS (APL 23-025) that encompasses sensitivity, diversity, cultural competence and cultural humility, and health equity trainings. • By July 31, 2025, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with Network Provider offices per quarter. • By December 31, 2025, GCHP's HECL Department shall report on the number of C&L fulfilment and benchmarks quarterly during the QIHEC meeting.	Health Education / Cultural Linguistics
39	Primary and Specialty Care Access	Ensure primary and specialty care access standards met for minimum of 80% of providers.	Provider Network Operation
40	Network Adequacy	Assess and improve network adequacy as demonstrated by availability of practitioners.	Provider Network Operations
41	After Hours Availability	Conducts surveys to ensure members are able to reach a provider after hours.	Provider Network Operations
42	Provider Satisfaction	Field provider survey and develop action plan(s) to improve areas of low performance.	Provider Network Operations
43	Facility Site Review Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements.	Quality Improvement
44	Physical Accessibility Review Surveys (PARS)	Complete Physical Accessibility Reviews (PARs) 100% on time.	Quality Improvement
45	Credentialing/Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners/ providers to provide care to members.	Provider Network Operations
46	Grievances and Appeals	Monitor all member grievances and appeals to identify trending issues. Communicate these trends to relevant departments to develop actionable plans aimed at addressing highly reported concerns and improving the overall member experience	Grievances and Appeals
47	Call Center Monitoring	Meet call center benchmarks to ensure members have timely access to call center staff and implement interventions on any deficient benchmarks. (1) ASA: 30 seconds or less; (2) Abandonment Rate: 5% or less; (3) Phone Quality Results: ≥ 95%.	Member Services

	Metric	Goal	Department
48	CAHPS: Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and complete analysis of survey results.	Quality Improvement
49	CAHPS: Access to Specialty Care	Improve access to specialty care for adults and children.	Operations Strategy/External Affairs Quality Improvement
50	CAHPS: Improve CAHPS Scores	Improve CAHPS scores based on MY 2024 CAHPS outcomes, including Getting Care Quickly and Getting Needed Care.	Operations Strategy/External Affairs Quality Improvement
51	Delegation Oversight	100% of all audits completed at least annually with corrective action plans (CAPs) closed timely.	Compliance

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update

Objective 1: Improve Quality and Safety of Clinical Care Services

1. Quality: 2025 Quality Improvement and Health Equity Transformation (QIHET) Program Description						
Quality	2025 QIHET Program Description	Update the 2025 QIHET Program Description.	1. Collaborate with business units to review and update the 2025 QIHET Program Description. 2. Prepare and submit for approval to the Quality Improvement & Health Equity Committee (QIHEC). 3. Prepare and submit for approval to the Commission.	1. 11/18/24-01/15/25 2. 01/21/25 3. 01/27/25	• Sr. Director, Quality Improvement • QI Manager • QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
2. Quality: 2025 Quality Improvement and Health Equity Transformation Work Plan						
Quality	2025QIHET Work Plan	Update the 2025 QIHET Work Plan.	1. Collaborate with business units to review and update the 2025 QIHET Work Plan. 2. Prepare and submit for approval to the QIHEC. 3. Prepare and submit for approval to the Commission.	1. 11/18/24-01/15/25 2. 01/21/25 3. 01/27/25	• Sr. Director, Quality Improvement • QI Manager • QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
3. Quality: 2024 Quality Improvement and Health Equity Transformation Work Plan Evaluation						
Quality	2024 QIHET Program and Work Plan Evaluation	Complete the 2024 QIHET Program and Work Plan Evaluation.	1. Collaborate with business units to complete 2024 QIHET Program and Work Plan Evaluation. 2. Evaluate effectiveness of the quality improvement structure and resources. 3. Evaluate the QIHEC subcommittees are occurring according to each subcommittee's charter and cadence. 4. Conduct assessment of Committee Members. 5. Conduct assessment of systems and activities. 6. Conduct assessment of resources dedicated to addressing disparities. 7. Prepare and submit for approval to the QIHEC. 8. Prepare and submit for approval to the Commission.	1. 03/01/25-06/30/25 2. 03/01/25-07/31/25 3. 03/01/25-07/31/25 4. 07/31/25 5. 07/31/25 6. 07/31/25 7. 09/16/25 8. 09/23/25	• Sr. Director, Quality Improvement • QI Manager • QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
4. Health Equity: 2025 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Description						
Health Equity	2025 CLAS Program Description and Work Plan	Update the 2025 CLAS Program Description and Work Plan.	1. Update the 2025 CLAS Program Description and Work Plan.	1. 01/31/25	• Sr. Director, Health Education and Cultural Linguistics • Sr. Cultural and Linguistics Specialist • Sr. Health Navigator /Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☒ New objective added in 2025. Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
5. Health Equity: 2024 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Evaluation						
Health Equity	2024 CLAS Program and Work Plan Evaluation	Complete the 2024 CLAS Program and Work Plan Evaluation.	1. Complete evaluation of the 2024 CLAS Program and Work Plan Evaluation. 2. Evaluate effectiveness of the quality improvement structure and resources. 3. Conduct assessment of Committee Members 4. Conduct assessment of systems and activities 5. Conduct assessment of resources dedicated to addressing disparities. 6. Prepare and submit for approval to the QIHEC. 7. Prepare and submit for approval to the Commission.	1. 03/01/25-06/30/25 2. 03/01/25-07/31/25 3. 07/31/25 4. 07/31/25 5. 07/31/25 6. 09/16/25 7. 09/23/25	• Sr. Director, Health Education and Cultural Linguistics • Sr. Cultural and Linguistics Specialist • Sr. Health Navigator /Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☒ New objective added in 2025. Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
6. Quality: 2025 HEDIS® Compliance Audit™						
Quality	2025 HEDIS® Compliance Audit™	Successfully complete and pass the annual HEDIS® Compliance Audit™ and receive "reportable" status for all measures.	1. ROADMAP Submission 2. Non-Standard Supplemental Data Primary Source Validation 3. Preliminary rate review 4. Medical Record Review (MRR) Validation 5. Final rate review 6. Interactive Data Set Submission 7. Submit ROADMAP Management Representation Letter	1. 01/31/25 2. 03/28/25 3. 04/25/25 4. 05/23/25 5. 06/13/25 6. 06/13/25 7. 06/13/25	• Sr. Director, Quality Improvement • QI Manager • QI Program Manager II	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
7. Population Health: Population Needs Assessment (PNA)						
Population Health	Population Needs Assessment	Maintain NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS.	1. Develop and implement Population Health Management Strategic Objectives.	1. 12/31/25	• Sr. Manager of Population Health Management • Program Analyst of Population Health Management • Senior Healthcare Data Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
8. Population Health: Wellth Program						
Population Health	Wellth Quality Improvement Program	Maintain and expand QI focused programs with Wellth for full-scope Medi-Cal members who are 18+ years of age, are taking at least one medication and have multiple care gaps for which GCHP is held to the DHCS MPL (50th percentile).	1. The PHM team will continue to evaluate the outcomes associated with the Wellth QI program. 2. Implement a provider referral process. 3. Enroll additional members into the Wellth QI program to a total of 10,500.	1. 01/06/25 - 12/31/25 2. 2/28/25 3. 3/31/25	• Sr. Manager of Population Health • Wellness and Prevention Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
9. Population: Health Risk Assessment						
Population Health	Health Risk Assessment (HRA)	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	1. The PHM team will continue working with Carenet to conduct HRAs at a volume to match capacity for referrals. 2. Implement member HRA outreach via SMS/test through Carenet. 3. Transition HRA outreach from Carenet to the GCHP Call Center. 4. Enable HRA completion online via Customer Relation Management (CRM) software.	1. 06/30/25 2. 03/31/25 3. 07/01/25 4. 03/31/25	• Sr. Manager of Population Health • Wellness and Prevention Manager	Annual Goal Met: Yes☒ No☐ Quarterly Updates: Continue Objective: Yes☐ No☒ New objective added in 2025. Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
10. Utilization Management: Clinical Practice Guidelines						
Utilization Management	Preventive Health, Clinical Practice, and Utilization Management Guidelines	Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including the Diabetes and Asthma Clinical Practice Guidelines (CPG), and UM Guidelines.	1. Review and approval by the Credentialing /Peer Review Committee (C/PRC) 2. Post guidelines on the GCHP website and distribute guidelines to appropriate practitioners, upon request. 3. Ensure alignment of PHG with Provider Manual and applicable policies.	1. 03/06/25, 06/05/25, 09/04/25, 11/20/25 2. 01/01/25-12/31/25 3. 01/01/25-12/31/25	• Chief Medical Officer • Sr. Director Utilization Management • Sr. Director Quality Improvement	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
11. Care Management: Complex Case Management						
Care Management (CM)	Complex Case Management (CCM)	Maintain and monitor a standardized turn-around-time (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements.	1. Continue staff training as identified. 2. Review and revise staff auditing tools to align with NCQA and policy HS-058 Care Management including Complex Case Management guidelines associated with TAT for CCM. 3. Strategize with CM, QI, HS analyst on the development of metrics and benchmarks to capture CCM TAT. 4. Monitor CCM TAT dashboard and implement interventions for benchmarks not met.	1. 01/01/25-12/31/25 2. 01/01/25 – 12/31/25 3. 01/01/25-12/31/25 4. 03/01/25-12/31/25	• Director of CM • Sr. Manager, CM & Special Projects • CM Managers	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
12. Care Management: Care Gap Closure						
Care Management (CM)	Care Gap Closure	Implement strategies to close care gaps for MCAS measures.	1. Continue to include utilization of the MCAS care gaps dashboard as part of the CM process. 2. Review and revise JAM's/resource tools/to align with care gap report utilization. 3. Review and revise staff auditing tools as identified. 4. Provide staff with learning opportunities related to MCAS care gap report, programs and activities. 5. Strategize with QI and other departments as identified on the development of programs and activities to address identified care gaps.	1. 01/01/25-12/31/25 2. 04/01/25-12/31/25 3. 01/01/25-12/31/25 4. 01/01/25-12/31/25 5. 01/01/25-12/31/25	• Director of CM • Sr. Manager, CM & Special Projects • CM Managers • QI Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
13. Advance Prevention: Tobacco Cessation						
Advance Prevention	Tobacco Cessation	Increase rate of tobacco cessation counseling and utilization of tobacco cessation medication in members identified as tobacco users. **IHA benchmarks** • 100% of identified tobacco users receive counseling. • 32% of tobacco users receive cessation medication. **Admin benchmarks:** • 45% of identified tobacco users receive counseling. • 10% of tobacco users receive cessation medication.	1. Utilize DHCS methodology to identify tobacco users via data pulls for quarterly analysis and reporting. 2. Create and/or update provider and member education campaigns. 3. Measure tobacco cessation medication dispensing and cessation counseling quarterly via IHA medical record review and administrative data. 4. Report tobacco cessation medication dispensing and cessation counseling semi-annually.	1. 03/31/25, 06/30/25, 09/30/25, 12/31/25 2. 12/31/25 3. 03/31/25, 06/30/25, 09/30/25, 12/31/25 4. 03/31/25, 09/30/25	• QI RN Manager • Sr. Director of Health Education and Cultural Linguistics • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
14. Advance Prevention: Initial Health Appointment (IHA)						
Advance Prevention	Initial Health Appointment	Increase rates of Initial Health Appointment (IHA) completion by providers.	1. Distribute new member lists to clinic/health system for member outreach to schedule the IHA visit. 2. Monitor claims data for timely IHA completion within 120 days by clinic system. 3. Conduct medical record audits by provider site and provide feedback on opportunities for improvement. 4. Provide ongoing trainings on the IHA and IHA Outreach Log.	1. 11th day of each month 2. 03/31/25, 06/30/25, 09/30/25, 12/31/25 3. 01/01/25-12/3125 4. 01/01/25-12/31/25	• QI RN Manager • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
15. Pharmacy: Reduction in Potential Unsafe Opioid Prescriptions						
Pharmacy	Opioid Utilization Monitoring	Monitor member opioid utilization via pharmacy claims from Medi-Cal Rx and monitor for any trends where the utilization exceeds more than a 5% increase from the prior quarter.	1. Monitor the following statistics related to opioid utilization via pharmacy claims from Medi-Cal Rx in GCHP members: • Total number of unique users • Concurrent users of opioids and benzodiazepines • Concurrent users of opioids and antipsychotics • Number of high dose utilizers • Number of members who fill opioids at 3 or more pharmacies • Number of members who have opioids prescribed by 3 or more prescribers 2. Perform retrospective Drug Utilization Review (DUR) and implement Provider Interventions Related to Opioid Utilization as needed.	1. 03/31/25, 06/30/25, 09/30/25, 12/31/25 2. 01/01/25-12/31/25	• Director of Pharmacy Services • Clinical Programs Pharmacist	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
16. Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days						
Behavioral Health	Follow-Up After Emergency Department (ED)Visit for Mental Illness – 30 days. (FUM-30)	Increase the FUM-30 rate to exceed the DHCS MPL (50th percentile).	1. Continuously improve and develop new innovative interventions that promote members' access to behavioral health care services. 2. Monitor Carelon Behavioral Health performance towards the established incentive measure targets within the fully executed contract to ensure adequate follow-up care after ED visit. 3. Improve data exchange to ensure more complete, accurate, and timely data to improve robust capture of follow-up visits. 4. Include FUM in the Quality Incentive Provider Pool (QIPP) Program. 5. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 6. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 7. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 8. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions.	1. 12/31/25 2. 12/31/25 3. 12/31/25 4. 12/31/25 5. 12/31/25 6. 08/15/25 7. 01/31/25-12/31/25 8. 07/31/25	• Director, Behavioral Health and Social Programs • Manager, Behavioral Health • QI Program Manager III • Executive Director, IT • Director of Medical Informatics • Sr. Program Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
17. Behavioral Health: Follow-Up After Emergency Department Visit for Substance Use – 30 Days						
Behavioral Health	Follow-Up After Emergency Department (ED)Visit for Substance Use – 30 days. (FUA-30)	Increase the FUA-30 rate to exceed DHCS MPL (50th percentile).	1. Continuously improve and develop new innovative interventions that promote members' access to behavioral health care services. 2. Monitor Carelon Behavioral Health performance towards the established incentive measure targets within the fully executed contract to ensure adequate follow-up care after ED visit. 3. Improve data exchange to ensure more complete, accurate, and timely data to improve robust capture of follow-up visits. 4. Include FUA in the Quality Incentive Provider Pool (QIPP) Program. 5. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 6. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 7. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 8. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions.	1. 12/31/25 2. 12/31/25 3. 12/31/25 4. 12/31/25 5. 12/31/25 6. 08/15/25 7. 01/31/25-12/31/25 8. 07/31/25	• Director, Behavioral Health and Social Programs • Manager, Behavioral Health • QI Program Manager III • Executive Director, IT • Director of Medical Informatics • Sr. Program Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
18. Behavioral Health: 2023-2026 PIP Non-Clinical Topic: Percentage of Provider Notifications for Members with SUD/SMH Diagnoses within 7 Days of an ED Visit						
Evaluation & Barrier Analysis	2023-2026 Non-Clinical PIP	Improve the percentage of provider notifications for members with substance use disorder (SUD) and / or specialty mental health (SMH) diagnoses following or within 7 days of emergency department (ED) visit.	1. Submit PIP Modules as directed by DHCS and HSAG for review and approval. 2. Perform ongoing evaluation of the interventions and identify opportunities to improve. 3. Report updates and results to the QIHEC.	1. 09/01/25 2. 09/16/25, 11/18/25 3. 03/31/25, 06/30/25, 09/30/25, 12/31/25	• QI Program Manger III • Sr. Manager, CM & Special • Director of Behavioral Health and Social Program • Clinical Care Manager III, LCSW • Sr. QI Data Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
19. Behavioral Health: 2024-2025 DHCS/IHI Behavioral Health Collaborative with VCBH						
Quality / DHCS	DHCS / IHI / VCBH Collaborative focused on improving the existing navigator workflows at the county-run hospital (Ventura County Medical Center) to improve outcomes for individuals who visit the emergency department (ED) for an FUA and FUM condition.	By June 30 2025, improved care coordination processes and data exchange to increase the rate of follow-up behavioral health services by 5% for Ventura County Medi-Cal beneficiaries with behavioral health-related ED visits.	1. Implementation of data sharing mechanism & development of data use framework. 2. Enhance care coordination in the ED and between collaborating providers. 3. Improvement of delivery system processes.	1. 01/01/25-06/30/25 2. 01/01/25-06/30/25 3. 01/01/25-06/30/25	• GCHP staff ○ Director, Behavioral Health & Social Programs ○ Manager, Behavioral Health ○ Behavioral Health Specialist ○ Director, Medical Informatics ○ Senior Program Analyst ○ QI Manager ○ QI Program Manager III • VCBH Staff ○ Quality Improvement Manager ○ Sr. Program Administrator ○ Care Coordination Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
20. Cancer Prevention: Breast Cancer Screening (BCS)						
MCAS	Breast Cancer Screening	Increase the percentage of members 50-74 years of age who had a mammogram to screen for breast cancer to meet or exceed the DHCS HPL (90th percentile).	1. Provide clinics/providers with the annual MY 2024. MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Evaluate effectiveness of the breast cancer screening member incentive program and identify program changes and enhancements, as applicable. 5. Expand and evaluate the effectiveness of the point-of-care (POC) member incentive program and identify program changes and enhancements as applicable. 6. Distribute provider member incentive awards annually. 7. Promote and support access to mobile mammography services. 8. Conduct member outreach campaigns to increase preventive screenings and close care gap. 9. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 12/31/25 5. 12/31/25 6. 12/31/25 7. 09/30/25 8. 06/01/25-12/31/25 9. 01/01/25-12/31/25	• QI Manager • QI Program Manager 1 • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			implement interventions, promote best practices and increase awareness. 10. Include BCS in the Quality Incentive Provider Pool (QIPP) Program. 11. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	10. 12/31/25 11. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
21. Cancer Prevention: Cervical Cancer Screening (CCS)						
MCAS	Cervical Cancer Screening (CCS)	Increase percentage of members 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90th percentile).	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Evaluate effectiveness of the cervical cancer screening member incentive program and identify program changes and enhancements, as applicable. 5. Expand and evaluate the effectiveness of the point-of-care (POC) member incentive program and identify program changes and enhancements as applicable. 6. Distribute provider member incentive awards annually. 7. Conduct member outreach campaigns to increase preventive screenings and close care gap. 8. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best practices and increase awareness.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/31/26 5. 12/31/25 6. 12/31/25 7. 04/01/25-11/30/25 8. 01/01/25-12/31/25	• QI Manager • QI Program Manager I • QI RN • Sr. Health Navigator & Health Education	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			9. Include CCS in the Quality Incentive Provider Pool (QIPP) Program core measures. 10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	9. 12/31/25 10. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
22. Cancer Prevention: Colorectal Cancer Screening (COL)						
Advance Prevention	Colorectal Cancer Screening (COL-E)	Increase the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer to meet the Medicare 50th percentile.	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best practices and increase awareness. 7. Partner with lab vendors to pilot home test kits. 8. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 07/31/25 5. 01/01/25-12/31/25 6. 01/01/25-12/31/25 7. 06/30/25 8. 01/01/25-12/31/25	• QI Manager • QI RN • Sr. Director of Health Education, Cultural and Linguistic Services • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
23. Chronic Disease Management: Asthma Medication Ratio (AMR)						
MCAS	Asthma Medication Ratio	Increase the AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a ≥ 0.50 ratio of controller medications to total asthma medications to exceed the DHCS MPL (50th percentile).	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Retrospective Drug Utilization Review and Provider Interventions Related to Asthma Medication Use. 5. Explore development of community health workers (CHW) home visiting program in collaboration with Health Education. 6. Include AMR in the Quality Incentive Provider Pool (QIPP) Program. 7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 8. Conduct member outreach campaigns to members identify with <50% asthma medication ration. 9. Implement the asthma spacer member incentive program. 10. Engage in partnerships with internal departments, clinic	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 09/30/25 5. 09/30/25 6. 12/31/25 7. 12/31/25 8. 09/30/25 9. 06/30/25 10. 01/01/25-12/31/25	• Director of Pharmacy Services • Clinical Programs Pharmacist • QI Manager • QI Program Manager III • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best practices and increase awareness. 11. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee).	11. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
24. Chronic Disease Management: 2025 DHCS Lean Quality Improvement and Health Equity Improvement Project						
MCAS	Asthma Medication Ratio	Implement multi-disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio.	1. Submit the lean quality improvement and health equity process form. 2. Submit the initial progress form with SMART goals, run charts, and interventions. 3. Submit the final progress form.	1. 02/10/25 2. 06/10/25 3. 10/10/25	• QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☒ New objective added in 2025. Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
25. Chronic Disease Management: Health Equity Controlling Blood Pressure (CBP)						
MCAS	Controlling Blood Pressure	Increase the percentage of members with hypertension who are 21-44 years of age and have a blood pressure rate of <140/90 to exceed the DHCS MPL (50th percentile).	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Notify members and providers of the Medi-Cal Rx blood pressure cuff benefits. 7. Monitor and promote member utilization of the blood pressure devices to improve self-monitoring and reporting of blood pressure. 8. Collaborate with Care Management to promote the blood pressure cuff benefit. 9. Utilize the Wellth Program to collect blood pressure data. 10. Conduct community health fairs to collect blood pressure data and refer members with hypertension to care management.	1. 08/15/25 2. 01/01/25-12/31/25 3. 07/31/25 4. 07/31/25 5. 01/01/25-12/31/25 6. 03/31/25 7. 03/01/25-12/31/25 8. 09/01/25 9. 01/01/25-12/31/25 10. 12/31/25	• QI Manager • QI Program Manager II • QI RN • Manager, Care Management and Special Programs • Sr. Manager of Population Health • Wellness and Prevention Manager • HEDIS Data Master	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps: .

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			11. Utilize the Chronic Disease Self-Management Program to educate members with hypertension care gaps on self-management skills. 12. Include CBP in the Quality Incentive Provider Pool (QIPP) Program. 13. Evaluate improvements in data collection to capture BP through administrative data (e.g., EMR, HIE).	11. 12/31/25 12. 12/31/25 13. 12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
26. Chronic Disease Management: Glycemic Status Assessment for Patients with Diabetes (>9.0%) (GSD)						
MCAS	Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD-Poor Control	Decrease the percentage of members with diabetes who are 18-75 years of age and have GSD > 9.0% to meet the DHCS HPL (90th percentile).	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Launch program to distribute at-home HbA1c screenings kits. 7. Include in the Quality Incentive Provider Pool (QIPP) Program 8. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 9. Continue community program to utilize test screenings: • Health Fairs • Pop-Clinics 10. Launch the new Arine Diabetes Management Program 11. Continue to promote Chronic Disease Self-Management Program to members with diabetes care gap and other co-morbidities.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 07/31/25 5. 01/01/25-12/31/25 6. 01/01/25-12/31/25 7. 12/31/25 8. 12/31/25 9. 01/01/25-12/31/25 10. 09/01/25 11. 01/01/25-12/31/25	• QI Manager • QI Program Manager III • QI RN • Sr. Director of Health Education, Cultural and Linguistic Services • Sr. Health Navigator & Health Education	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update

Evaluation & Barrier Analysis

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
27. Women's Health: Chlamydia Screening in Women (CHL)						
MCAS	Chlamydia Screening in Women	Increase the rate of chlamydia screening in members 16 to 24 years of age to meet or exceed the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with prospective MY 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 3. Identify low performing providers and conduct best practices presentations. 4. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 5. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Community Relations Department, Planned Parenthood, VCPH, VCOE) to implement interventions to increase access to care, promote best practices and increase awareness. 6. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities Trainings for low performing providers. 7. Include CHL in the Quality Incentive Provider Pool (QIPP) Program. 8. Evaluate programs to utilize chlamydia screenings test kits. • Health Fair • Home Test Kits	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 04/30/25 6. 06/30/25 7. 12/31/25 8. 01/01/25-12/31/25	• QI RN Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			9. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	9. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
28. Women's Health: Prenatal and Postpartum Care (PPC)						
MCAS	Prenatal and Postpartum Care	Increase the percentage of members with live birth deliveries who completed timely prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile). • Members who received a prenatal care visit during the first trimester, on or before the enrollment start date, or within 42 days of enrollment. • Members who completed a postpartum exam completed with 7 to 84 days after a live-birth delivery.	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Conduct member outreach campaigns to increase postpartum screenings and close gaps in care. 7. Include PPC in the Quality Incentive Provider Pool (QIPP) Program. 8. Continue monthly reports to improve early identification of members who are due for prenatal and postpartum visits. 9. Evaluate effectiveness of the Doula Pilot Program, 10. Provide Pregnancy and Postpartum packets with resources for providers to distribute to members.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 07/31/25 5. 01/01/25-12/31/25 6. 03/01/25-12/31/25 7. 12/31/25 8. 03/01/25 9. 06/30/25 10. 09/30/25	• QI RN Manager • QI RN • HECL/Sr. Health Navigator & Health Educator • Population Health Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps: .
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
29. Children's Health: Childhood Immunization Status – Combo 10 (CIS-10)						
MCAS	Childhood Immunization Status – Combo 10	Increase the percentage of members who completed all Combo-10 immunizations by their 2nd birthday to exceed the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Community Relations Department, VCPH, VCOE, VFC) to implement interventions to increase access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Conduct member outreach campaigns to increase immunizations and close care gaps. 7. Include CIS-10 in the Quality Incentive Provider Pool (QIPP) Program. 8. Continue the flu vaccine workgroup to improve the CIS-10 rate. 9. Evaluate effectiveness of the flu vaccine member incentive program.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 01/01/25-12/31/25 6. 03/01/25–11/30/25 7. 12/31/25 8. 08/01/25–12/31/25 9. 01/31/26	• QI RN Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps: .

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	10. 12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
30. Children's Health: Immunizations for Adolescents – Combo 2 (IMA-2)						
MCAS	Immunizations for Adolescents – Combo 2 (IMA-2)	Increase the percentage of adolescents who completed all IMA-2 immunizations by their 13th birthday to exceed the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Community Relations Department, VCPH, VCOE, VFC) to implement interventions, improve access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Conduct member outreach campaigns to increase immunizations and close care gap. 7. Evaluate effectiveness of the HPV immunization member incentive program and identify program changes/enhancements, as applicable. 8. Expand and evaluate the effectiveness of the POC member incentive program and identify program changes/enhancements as applicable.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 01/01/25-12/31/25 6. 03/0125-12/31/25 7. 12/31/25 8. 12/31/25	• QI RN Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps: .

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			9. Include IMA-2 in the Quality Incentive Provider Pool (QIPP) Program. 10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	9. 12/31/25 10. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
31. Children's Health: Developmental Screening in the First Three Years of Life (DEV)						
MCAS	Developmental Screening in the First Three Years of Life	Increase the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding, or on, their first, second or third birthday, by 3% compared to the prior measurement year.	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Community Relations Department, Help Me Grow/First 5, VCPH, VCOE) to implement interventions to improve access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 7. Include in the Quality Incentive Provider Pool (QIPP) Program 8. Conduct member outreach campaigns to increase preventive screenings and close care gap.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 09/30/25 6. 12/31/25 7. 12/31/25 8. 03/15/25-11/30/25	• QI RN Manager • QI Program Manager II • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
32. Children's Health: Lead Screening in Children (LSC)						
MCAS	Lead Screening in Children (LSC)	Increase the percentage of children who had one or more capillary or venous blood lead tests for lead poisoning by their 2nd birthday to meet the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Community Relations Department, Help Me Grow/First 5, , CDR, CLPPP, VCPH, VCOE) to implement interventions, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Compile and distribute lead screening gaps in care reports quarterly to providers (per DHCS APL 20-016). 7. Monitor provider compliance with lead screening requirements through medical record audits and issue PIPs for performance below 80% threshold.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 01/01/25-12/31/25 6. 05/31/25, 12/31/25 7. 03/15/25-11/30/25	• QI RN Manager • QI Program Manger II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			8. Conduct member outreach campaigns to increase blood lead screenings and close care gap. 9. Evaluate effectiveness of the LSC member incentive program and identify program changes/enhancements, as applicable. 10. Increase adherence to the DHCS APL (20-016) in the areas of anticipatory guidance and lead screening refusal forms. 11. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	8. 03/01/25-12/31/25 9. 12/31/25 10. 12/31/25 11. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
33. Children's Health: Topical Fluoride Varnish (TFL)						
MCAS	Topical Fluoride Varnish (TFL)	Increase the percentage of members, ages 1 through 20, who received at least two topical fluoride applications during the measurement year to exceed the DHCS MPL (50th).	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Community Relations Department, Help Me Grow/First 5, VCPH, VCOE, United Way) to implement interventions to improve access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Include TFL in the Quality Incentive Provider Pool (QIPP) Program. 7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 8. Work with vendors to administer topical fluoride varnish at health fairs.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 12/31/25 6. 12/31/25 7. 01/01/25-12/31/25 8. 01/01/25-12/31/25	• QI RN Manager • QI Program Manager II • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
34. Children's Health: Well-Child Visits in the First 30 Months of Life (W30)						
MCAS	Well-Child Visits in the First 30 Months of Life	Increase the percentage of children who had well-child visits with a PCP to exceed the DHCS MPL (50th percentile) for the following sub-measures. • Well-child visits in the first 15 months of life: Increase the percentage of children with six or more well-care exams within the first 15 months of life. • Well-child visits between 15 and 30 months of age: Increase the percentage of 30-month-old children who had two or more well-child exams between 15 and 30 months of age.	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with monthly prospective MY 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Health Education, Population Health, Community Relations, Help Me Grow/First 5, CHDP, VCPH, VCOE, WIC) to implement interventions, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Conduct member outreach campaigns to increase well-child preventive care screenings and close gaps in care. 7. Include W30 in the Quality Incentive Provider Pool (QIPP) Program 8. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 01/01/25-12/31/25 6. 03/01/25-11/30/25 7. 12/31/25 8. 01/01/25-12/31/25	• QI Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update

Evaluation & Barrier Analysis

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
35. Children's Health: Child and Adolescent Well-Care Visits (WCV)						
MCAS	Child and Adolescent Well-Care Visits	Increase the percentage of members, 3-21 years of age, who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year to exceed the DHCS MPL (50th percentile).	1. Provide clinics/providers with prospective MY 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 2. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 3. Evaluate MY 2025 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Health Education, Population Health, Community Relations Department, Help Me Grow/First 5, , VCPH, VCOE, WIC) to implement interventions to increase access to care, promote best practices and increase awareness. 7. Evaluate effectiveness of the well care member incentive program and identify program changes/enhancements, as applicable.	1. 07/31/25 2. 01/01/25-12/31/25 3. 07/31/25 4. 07/31/25 5. 01/01/25-12/31/25 6. 01/01/25-12/31/25 7. 01/31/25	• QI Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			8. Expand and evaluate the effectiveness of the point-of-care (POC) member incentive program and identify program changes/enhancements as applicable. 9. Distribute provider member incentive awards quarterly. 10. Conduct member outreach campaigns to increase preventive care screenings and close gaps in care. 11. Include WCV in the Quality Incentive Provider Pool (QIPP) Program	8. 01/01/25-12/31/25 9. 12/31/25 10. 03/01/25–10/31/25 11. 12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
36. Children's Health: 2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members						
Quality / DHCS	2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members	Improve the performance rate for Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) among the Hispanic/Latinx population.	1. Submit Modules as directed by DHCS/HSAG for approval. 2. Report updates/results to QIHEC.	1. 09/01/25 2. 09/16/25, 11/18/25	• QI Program Manager II	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
37. Children's Health: 2024-2025 DHCS/IHI Child Health Equity Collaborative						
Quality / DHCS	DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits.	1. Complete Interventions 4: Actor mapping & Community Partnership 2. Complete Intervention 5: Partnering for Effective Education and Communication	1. 01/16/2025 2. 01/16/2025-3/20/2025	• QI Program Manager I • QI RN • Senior Health Navigator • Manager, Community Relations	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
Objective 2: Improve Quality and Safety of Non-Clinical Care Services						
38. Cultural and Linguistic Needs & Preferences						
Improve Quality & Safety of Non-Clinical Care Services	Cultural and Linguistic Needs & Preferences	• By July 31, 2025, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules to include Diversity, Equity, and Inclusion (DEI) training program curriculum as per DHCS (APL 23-025) that encompasses sensitivity, diversity, cultural competence and cultural humility, and health equity trainings. • By July 31, 2025, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with three Network Provider offices per quarter. • By December 31, 2025, GCHP's HECL Department shall report on the number of C&L fulfilment and benchmarks quarterly during the QIHEC meeting.	1. Develop an action plan to evaluate existing C&L/DEI training modules on the GCHP website and develop a process to increase C&L/DEI trainings. 2. Engage various departments on the C&L/DEI training modules and solicit feedback. 3. Engage Community-Based Organizations on the C&L/DEI training modules and solicit feedback. 4. Engage Members on the C&L/DEI training modules for Providers and solicit their recommendations to ensure the Providers trainings are inclusive of GCHP membership. 5. Identify three Providers to conduct three C&L/DEI trainings. 6. Evaluate C&L/DEI trainings and prepare summary report of findings. 7. Prepare QIC dashboard summarizing the total number of C&L/DEI trainings and services at the quarterly QIHEC meetings.	1. 01/01/25-07/31/25 2. 08/01/25-12/31/25 3. 12/31/25 4. 12/31/225 5. 12/31/25 6. 12/31/25 7. 03/31/25, 06/30/25, 09/30/25 12/31/25	• Sr. Director of Health Education and Cultural Linguistics • Sr. C&L Specialist • Sr. Director, Network Operations • Manager, Provider Contracting & Regulatory	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
39. Primary and Specialty Care Access						
Improve Quality & Safety of Non-Clinical Care Services	Primary and Specialty Care Access	Ensure standards met for minimum of 80% of providers. **Primary Care Access** Members are offered: • Non-urgent primary care within 10 business days of request • Urgent care within 24 hours **Specialty Care Access** Members are offered: • Non-urgent specialty care appointment within 15 business days • Non-urgent ancillary services within 15 business days	1. Conduct survey and evaluate results. 2. Develop and implement corrective action plans when timely access standards are not met. 3. Report quarterly performance to QIHEC. 4. Monitor complaints and potential quality issues (PQIs), relating to the member access for appointments and/or referrals, and take action as appropriate.	1. 09/30/2025 2. 01/01/25-12/31/25 3. 03/31/25, 06/30/25, 09/30/25, 12/31/25 4. 01/01/25-12/31/25	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Manager, Provider Relations • QI RN Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
40. Network Adequacy						
Improve Quality & Safety of Non-Clinical Care Services	Assess and improve network adequacy as demonstrated by availability of practitioners.	• PCP and Provider Ratios: ○ 1 PCP 1:2000 ○ Total Physicians 1: 1200 • Physician Supervision to Non-Physician Practitioner Ratios: ○ Nurse Practitioners 1:4 ○ Physician Assistants 1:4 • Network maintained PCP located within 10 miles or 30 minutes from members residence. • Network maintained DHCS Core specialists located within 30 miles or 60 minutes from members residence. • Develop process for network certification (with ratios). • Hospitals 15 miles or 30 minutes from members residence	1. Conduct ratio analysis for primary care and high-volume specialties. 2. Monitor progress toward action plans to maintain or improve GeoAccess standards for Network maintained PCPs. 3. Monitor progress toward action plans to maintain or improve GeoAccess standards for Network maintained DHCS Core Specialists. 4. Develop process for network certification (with ratios). 5. Report biannual ratio analysis and annual GeoAccess findings to the QIHEC.	1. 03/31/25, 06/30/25, 09/30/25, 12/31/25 2. 01/01/25-12/31/25 3. 01/01/25-12/31/25 4. 12/31/25 5. 03/31/25, 06/30/25, 09/30/25, 12/31/25	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Executive Director, Delivery System Operations and Strategies	Annual Goal Met: Yes☐ No☒ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
41. After Hours Availability						
Improve Quality & Safety of Non-Clinical Care Services	After Hours Availability	Conducts surveys to ensure members are able to reach a provider after hours.	1. Conduct surveys and evaluate results. 2. Develop and implement action plans when timely access standards are not met. 3. Report quarterly performance to the QIHEC.	1. 09/30/25 2. 01/01/25-12/31/25 3. 03/31/25, 06/30/25, 09/30/25, 12/31/25	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Manager, Provider Relations • Executive Director, Delivery System Operations and Strategies	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
42. Provider Satisfaction						
Improve Quality & Safety of Non-Clinical Care Services	Provider Satisfaction Survey	Field provider survey and develop action plan(s) to improve areas of low performance.	1. Analyze results and identify opportunities for improvement. 2. Implement interventions as needed to improve satisfaction.	1. 10/31/25 2. 01/01/25-12/31/25	• Sr. Director, Network Operations • Manager, Provider Relations • Sr. Manager, Provider Network Operations – Program & Policy • Executive Director, Delivery System Operations and Strategies	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
43. Facility Site Review Requirements						
Improve Member Safety	Facility Site Review Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements.	1. Complete and document Initial, Interim, and Tri-annual Facility Site Reviews 100 % timely. 2. Issue and monitor corrective action plans (CAPs) as needed to facilitate clinic compliance and improvement on identified deficiencies. 3. Collaborate with PNO, Legal, and CMO on sites not meeting requirements. 4. Monitor member complaints / grievances and potential quality issues (PQIs) involving quality of care and safety concerns. 5. Submit biannual FSR data to DHCS: o January – June o July – December	1. 01/01/25-12/31/25 2. 01/01/25-12/31/25 3. 01/01/25-12/31/25 4. 01/01/25-12/31/25 5. 07/31/25, 12/31/25	• QI RN Manager • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
44. Physical Accessibility Review Surveys (PARS)						
Improve Member Safety	Physical Accessibility Review Surveys	Complete Physical Accessibility Reviews (PARs) 100% on time.	1. Compile reports for high volume / ancillary specialist visits for the Seniors and Persons with Disabilities (SPD) population and submit PAR reports to DHCS. 2. Complete and document PARs for identified high volume / ancillary specialist provider sites. 3. Complete and document PARs as indicated during the Initial and Periodic FSRs	1. 01/31/25 2. 12/31/5 3. 01/01/25-12/31/25	• QI RN Manager • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
45. Credentialing/Recredentialing						
Improve Member Safety	Credentialing / Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners/ providers to provide care to members.	1. Perform timely verification of all required credentialing elements to ensure current, accurate and complete files for credentialing decisions. 2. Perform timely recredentialing within 36 months of last approval date. 3. Perform ongoing monitoring of sanctions and adverse events timely. 4. Collaborate with Symplr on software configuration and automation to achieve efficiency in the credentialing process.	1. 01/01/25-12/31/25 2. 01/01/25-12/31/25 3. 01/01/25-12/31/25 4. 01/01/25-12/31/25	• Senior Director, Network Operations • Credentialing Specialist III • Credentialing Specialist II	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
Objective 3: Improve Quality of Service						
46. Grievances and Appeals						
Assess and improve member experience	Grievances and appeals	Monitor all member grievances and appeals to identify trending issues. Communicate these trends to relevant departments to develop actionable plans aimed at addressing highly reported concerns and improving the overall member experience.	1. Conduct quarterly assessment of grievances and appeals. 2. Identify opportunities for improvement. 3. Create and implement action plans for improvement.	1. 03/31/25, 06/30/25, 09/30/25, 12/31/25 2. 01/01/25-12/31/25 3. 01/01/25-12/31/25	• Director of Operations • Operations Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
47. Call Center Monitoring						
Assess and improve member experience	Call Center Monitoring	Meet call center benchmarks to ensure members have timely access to call center staff and implement interventions on any deficient benchmarks. • ASA: 30 seconds or less • Abandonment Rate: 5% or less • Phone Quality Results: ≥ 95%	1. Report Member Services Telephone Access Analysis • Monitor Average Speed of Answer (ASA) • Monitor Abandonment Rate • Phone Quality Results 2. Identify opportunities for improvement based on data analysis.	1. 03/31/25, 06/30/25, 09/30/25, 12/31/25 2. 01/01/25-12/31/25	• Director of Member Contact Center • Sr Operations Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update

Objective 4: Assess and Improve Member Experience

48. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys						
Assess and improve member experience	CAHPS Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and complete analysis of survey results.	1. Submit Survey Sample Frame data to HSAG. 2. Assess CAHPS scores and complete analysis.	1. 01/06/25 2. 07/31/25	• Sr. Director, Quality Improvement • QI Manager • QI Program Managers II, III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
49. Consumer Assessment of Healthcare Providers and Systems (CAHPS): Access to Specialty Care						
Assess and improve member experience	CAHPS: Access to Specialty Care	Improve access to specialty care for adults and children.	1. Develop interventions to improve access to specialty care. 2. Participate in the ACAP CAHPS Collaborative.	1. 12/31/25 2. 02/01/25-12/31/25	• Chief Innovation Officer • Executive Director, Delivery Systems, Operations and Strategies • Chief Member Experience and External Affairs Officer	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
50. Consumer Assessment of Healthcare Providers and Systems (CAHPS): Improve CAHPS Scores						
Assess and improve member experience	CAHPS: Improve CAHPS Scores	Improve CAHPS scores based on MY 2024 CAHPS outcomes, including Getting Care Quickly and Getting Needed Care.	1. Utilize Voice of the Member to create interventions based on areas of low performance.	1. 12/31/25	• Chief Innovation Officer • Executive Director, Delivery Systems, Operations and Strategies • Chief Member Experience and External Affairs Officer	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update

Objective 5: Ensure Organizational Oversight of Delegated Functions

51. Delegation Oversight						
Ensure Organizational Oversight of Delegated Functions	Completion of Delegation Oversight Audits • Credentialing • Quality Improvement • Utilization Management • • Member Experience • Claims • Call Center • Cultural and Linguistics • Transportation (NEMT/NMT) • Population Health Management	100% of all audits completed at least annually with corrective action plans (CAPs) closed timely.	1. Complete audits per scheduled timeline 2. Issue CAPS as applicable. 3. Follow-up on CAPs as applicable 4. Report to Compliance Committee and Quality Improvement Committee	1. 01/01/25-12/31/25 2. 01/01/25-12/31/25 3. 01/01/25-12/31/25 4. 03/31/25, 06/30/25, 09/30/25, 12/31/25	• Sr. Director, Compliance • Delegations Oversight Program Manager • Privacy Officer-Internal Audit Director • Delegation Oversight Audit Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						