2021 Quality Improvement Work Plan

Initiatives

Quality of Care

Resp Party/ Business Lead	Project Manager	Topic	Goal	Due Date/ Timeframe for Completion	Q1, 2021	Q2, 2021	Q3, 2021	Q4, 2021	Summary	Subcommittee	Projected Due Date	Plan Update	Date Completed	Name/Title
QI Director / QI Medical Director	QI Manager	**HEDIS Rates MY 2020 - Continuation**	Increase the HEDIS AQFS rate by 1% 2019-2020 season	Dec., 2021	No updates at this time.	Final rates were submitted to DHCS and NCQA on 6/15/21.	QI Projects ongoing; ongoing reporting and care gap sharing.	The 2021 QI projects are coming to an end. Many of the projects are aimed at various measures that will have an impact on the AQFS rate. The predominant focus has been on preventative care and screening as well as primary care visits. The team is consider which projects to continue, adapt, and abandon.	Every year, multiple QI projects, AAH undertakes multiple QI projects. Many of the projects align with the P4P program and also the DHCS MCAS list. The projects aim to positively aim member care and outcome. Finally, the projects aim to positive influence the AQFS Rate.	Internal Quality Improvement Committee	6/15/2021		6/15/21	S. Wakefield, RN, Sr. Dir. Quality Dr. S. Bhatt, QI Medical Director J. Pedden, QI Manager
QI Director / QI Medical Director	QI Manager	**HEDIS Retrieval and Overreads MY 2020 - Continuation**	Alongside the analytics team, provide HEDIS support related to medical record retrieval, abstraction, and overreads. The goal is to overread 20% of the abstracted charts for the hybrid measures.	May 2021	All retrievals were completed. We retrieved or closed out 3,597 out of the 3,960 records requested. Only 2,509 of the requested records were found.	For all of the hybrid measures, the Plan overread more than 20% of the abstracted charts.	No updates at this time.	The HEDIS MY2021 Timeline is being compiled with meetings starting in Q1, 2022.	In conjunction with the analytics team, the QI team provides HEDIS support related to medical record retrieval, abstraction, and overreads. Project and timeline are co-owned.	Internal Quality Improvement Committee	5/2021		5/1/20	S. Wakefield, RN, Sr. Dir. Quality Dr. S. Bhatt, QI Medical Director J. Pedden, QI Manager
QI Director / QI Medical Director	QI Manager	**HEDIS Retrieval and Overreads MY 2021**	Alongside the analytics team, provide HEDIS support related to medical record retrieval, abstraction, and overreads. The goal is to overread 20% of the abstracted charts for the hybrid measures.	Q2, 2021	2 Audits scheduled and completed.	Ongoing abstraction and overreads by the QI and QA teams.	Final Audit Reports submitted.		In conjunction with the analytics team, the QI team provides HEDIS support related to medical record retrieval, abstraction, and overreads. Project and timeline are co-owned.	Internal Quality Improvement Committee	5/2021		5/1/21	S. Wakefield, RN, Sr. Dir. Quality Dr. S. Bhatt, QI Medical Director J. Pedden, QI Manager
QI Director / QI Medical Director	QI Medical Director	**Pay For Performance (P4P) 2021 Continuation**	Incentives providers to improve care through P4P measures	December 2021	The P4P documents were given to participating delegates and providers.	No updates at this time.	The final measures were identified on 10/21/21 and were sent to review and approve by SLT.	Formal meetings conducted with each delegate/provider stakeholder to rollout final P4P handbook materials. Provider P4P rollout to be complete Jan. 2022. To be presented to BOG Q1, 2022.	The P4P program aims to promote quality initiatives and care, promote primary and preventative care, prioritize cost containment strategies all under a standardized payment methodology.	Health Care Quality Committee			1/1/22	Dr. S. Bhatt, QI Medical Director
QI Director / QI Medical Director	QI Manager	**QIP #1: Improve Well-Child Visits (WCV)**	Adapt the strategy that was utilized in the 2017 PIP to improve adolescent access to preventive healthcare services by improving AWC rates.	December 2021	In Q1, the QI team began to evaluate the MY2020 rates for WCV for all delegates after the first data refresh	No updates at this time.	Starting in September 2021, QI partnered with 19 pediatric sites to provide a $25 member incentive at the completion of a well-child visit for members 3-21 years old.	Using State approved Color-Coded Post Card Care Gap preventive care member reminders. Also, ongoing member incentive. Finally, final discussion with delegate regarding sponsoring of texting platform.	Due to COVID-19, the Plan is committed to improve preventive care utilization in our pediatric member population.	Internal Quality Improvement Committee	12/2021			J.Pedden, QI Manager S. Wakefield, RN Sr. Director of Quality
QI Director / QI Medical Director	QI Manager	**QIP #2: Improve A1C Testing in AAM**	Adapt the strategy that was utilized in the 2017 PIP to improve HbA1c rates in the African American male diabetic population.	December 2022	No updates at this time.	No updates at this time.	Discussion with delegates regarding DM metric (CDC); finalization of CDC-9 metric to align with QIP.	Informed provider partners of upcoming P4P program and focus on DM metric.	This project targets African American men with DM to undergo HbA1c testing annually.	Internal Quality Improvement Committee	12/2022			J.Pedden, QI Manager S. Wakefield, RN Sr. Director of Quality
QI Director / QI Medical Director	QI Manager	**QIP #3: Tdap Completion Rates - Continuation**	Working with DPH, improve Tdap immunization rates among pregnant women to 90% by December 31, 2021	December 2021	Given COVID-19 AAH's partners at ACDPH are not available to continue the work on this QIP.	AAH QI Department will be begin reevaluating the current Tdap data to determine if there is a provider that should be targeted to help improve immunization rates.	No updates at this time and QI Manager recommends abandoning this initiative due to lack of support at this time from the County since focus is on COVID-19 Vaccinations.	This will be abandoned due to limited county resources with ongoing pandemic.	This projects targets pregnant women in their third trimester and aims to improve Tdap vaccination rates; low performing, high volume delivery sites will be identified and targeted for resources and education.	Internal Quality Improvement Committee	12/2021			J.Pedden Clinical Quality Manager S. Wakefield, RN Sr. Director of Quality
QI Director / QI Medical Director	Sr. Dir. Quality	**PDSA Cycle Continuation**	Ensure that all divisions within HCS utilize the PDSA performance improvement model to develop and evaluate activities	Ongoing	PDSA improvement model is incorporated in QI initiatives and activities that include cross functional team members from HCS - UM, Pharmacy, CM	Continuous PDSA	Continuous PDSA	Continuous PDSA	HCS utilizes the PDSA cycle of performance improvement to identify barriers, interventions, and next steps of initiatives and activities. QI works worked with cross-functional departments in using the model.	All Sub-Committees	12/2021			S. Wakefield, RN, Sr. Dir. Quality Dr. Bhatt, QI Medical Director
QI Director / QI Medical Director	QI Manager	**PIP #1: Improve Compliance Rate for the African American Women in Breast Cancer Screening**	To address the disparity that exists with BCS, by December 31, 2022, increase the percentage of breast cancer screenings among African American women between the ages of 52 and 74, from 46.76% to 53.76%.	December 2022	On March 25, 2021, Module 1 was submitted to HSAG for approval.	Module 1 was approved by HSAG and Module 2 was submitted on June 11, 2021 for review.	Module 2 and Module 3 have been approved by HSAG.	DHCS approval of two-tiered MI gift card for initiative starting 01/01/2022 - 01/01/23. Tier 1 - Screening $10 Completion $50	This was identified as the focus for the DHCS Equity PIP.	Internal Quality Improvement Committee	6/2022			J.Pedden, QI Manager S. Wakefield, RN Sr. Director of Quality
QI Director / QI Medical Director	QI Manager	**PIP #2: Improve Compliance Rate for Members Assigned to 5 Direct Providers for WCV Priority PIP**	By December 31, 2022, increase the overall WCV admin rate from 49.53% to 55% for the two identified providers: (1) Susana Nolasco MD an (2) Merlin Tungol Venzon MD.	December 2022	On March 2, 2021, Module 1 was submitted to HSAG for approval.	Module 1 was approved by HSAG and Module 2 was submitted on May 7, 2021 for review.	Module 2 and Module 3 have been approved by HSAG.	Awating state approval with new gift card options Using State approved Color-Coded Post Card GAP-IN-CARE preventive care member reminders	This was identified as the focus for the DHCS Access PIP.	Internal Quality Improvement Committee	03/2022			J.Pedden, QI Manager S. Wakefield, RN Sr. Director of Quality
QI Director / QI Medical Director	QI Manager	**QIP #6: Improve Colon Cancer Screening Rates**	By December 31, 2022, increase the overall colon cancer screening rates in African American members assigned to West Oakland Health Center.	December 2022	On March 16, 2021, QI team had initial meeting with the CMO at West Oakland to learn about their current initiatives around colon cancer screening for their assigned patients.	Continue to have regular check-ins with West Oakland to develop quality improvement initiative.	In July 2021, QI provided WOHC gift cards to be given to members who come to their initial visit to be educated on the importance of receiving colon cancer screening and when their ColoGuard test is resulted.	74 members met incentive qualifications 36 members claimed incentive 6 positive cases identitfied and referred to care	Increase precentage of members 50-75 years screen for colorectal cancer					
QI Direct / QI Medical Director	Sr. Dir. Quality	**Pediatric Care Coordination Continuation**	Improve the Plan's pediatric population timely access to EPSDT care and screenings.	Ongoing	Continue ACF5 Pediatric Care Pilot HEDIS QIP #1 Improve Adolescent Access to Care PIP Launch CHCN Pediatric Care Pilot PIP #1 Improving Preventive Care Service (EPSDT) W15 PIP #2 Improving Preventive Care Service (EPSDT) W34 Focus of Pediatric Care Coordination	Ongoing	Ongoing	Developed enhanced plan for integration within Pop Health Strategy - for 2022 Ongoing work with First5 (see below) Demonstrate integration with all identified cross-functional departments via wowrk group activities - Strategy Document a workplan with timelines Develop and Document PDSA process Implement workplan activities Evaluate outcome - Share ongoing results with internal and external committees and stakeholders	In order to address the 2018 Auditor Report findings of underutilization of preventive healthcare services by the pediatric population	Internal Quality Improvement Committee Health Care Quality Committee	12/2021			S. Wakefield, RN, Sr. Dir. Quality J. Pedden, QI Manager

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QI Direct / QI Medical Director	Sr. Dir. Quality	**Pediatric Care Management Program**	Improve the Plan's pediatric population timely access to EPSDT care and screenings.	Ongoing	Pediatric Health Program Pilot with delegate CHCN	Ongoing	CHCN to report on HEDIS Measures Outcome ACF5 Care Management Program Launch - ACES/PEARLS Provider Training & Attestations DHCS Quality Conference Poster presentation "ABCs of EPSDT" -QI Project r/t WCV -Care Coordination	Program Report indicates exceeding target goals for % of members successfully contacted for scheduling and completion of PCP visit.	Targeted focus to increase EPSDT benefit utilization and mitigate non-utilization and underutilization of preventive healthcare services by the pediatric population	Internal Quality Improvement Committee	12/2021			S. Wakefield, RN, Sr. Dir. Quality
QI Direct / QI Medical Director	Sr. Dir. Quality	**Over and Under Utilization**	In conjunction with UM department ensure mechanisms to detect both under- and overutilization of health care services. Establish and maintain internal reporting mechanisms used to detect Member utilization patterns.	Ongoing	HEDIS Underutilization data presented Internal Quality Improvement Committee (IQIC) Health Care Quality Committee (HCQC) Delegate Joint Operations Meeting (JOM)	HEDIS Underutilization data presented -IQIC -HCQC -Delegate JOM	HEDIS Underutilization data presented -IQIC -HCQC -Delegate JOM	Ongoing Monitoring tracking, trending reporting of date at internal and external committee meetings with delegates. BOG discussing non-utilizers as a population of focus	Ensure robust monitoring procedures to detect both over- and under-utilization of health care services of HEDIS measures	Internal Quality Improvement Committee	12/2021			J.Pedden, QI Manager S. Wakefield, RN Sr. Director of Quality
QI Direct / QI Medical Director	Sr. Dir. Quality	**Delegation Oversight**	Conduct ongoing oversight via P&Ps & auditing to ensure that delegated providers are fulfilling all delegated QA responsibilities.	Ongoing	Reviewed reports and documents from BEACON and Kaiser as applicable	Reviewed reports and documents from BEACON and Kaiser as applicable. Provided PQI Training for CHCN.	Reviewed reports and documents from BEACON and Kaiser as applicable. Established Bi-Weekly PQI meetings with BEACON. Kaiser Annual Audit 9/2021. PQI Audit Findings noted.	CAP established. 45 days for correction.	BEACON Health Options Audit scheduled for Jan. 2022	Compliance Committee and QI Delegation Oversight	12/2021			J.Pedden, QI Manager S. Wakefield, RN Sr. Director of Quality
QI Direct / QI Medical Director	QI Medical Director	**Population Health Management**	Maintain and update an cohesive plan of action that addresses the Alliance member/population needs across the continuum of care	Ongoing	No updates at this time.	QI Department and Analytics run current data through the CareAnalyizer tool. Future meeting schedule created to ensure all populations are looked with the appropriate access to data	On 8/26/20, QI Department became the facilitators/owners of the Pop Health Work Group and continued to have meetings twice a month. Different departments within HCS started completing the strategy documents to identify the work that is being done for different disease states. The work group continued to discuss and evaluate the SODH findings based on the CareAnalyizer tool.	Ongoing workgroup meetings and plan updates as applicable. All populations and areas of focus reviewed (keeping members health, emerging risk, etc).	In accordance with NCQA 2020 Standards and Guidelines, Alameda Alliance for Health has developed a basic framework to support a cohesive plan for addressing member needs across the continuum of care. This continuum includes the community setting, through participation, engagements, and targeted interventions for a defined population. The Population Health Program aims to influence the health outcomes of the Alameda Alliance membership. The program oversees the health management system by ensuing that the system caters to the health needs of the enrolled member population. A key priority is to ensure that the new and ongoing programs target and close the gaps between identified disparities and the social	Internal Quality Improvement Committee Health Care Quality Committee	12/2021			Dr. S. Bhatt, QI Medical Director J.Pedden, QI Manager S. Wakefield, RN Sr. Director of Quality

Quality of Service

Business Lead	Project Manager	Topic	Goal	Timeframe for Completion	Q1, 2021	Q2, 2021	Q3, 2021	Q4, 2021	Summary	Subcommittee	Projected Due Date	Plan Update	Date Completed	Name/Title
QI Director / QI Medical Director	QI Manager	**QIP #4: IHA - Continuation**	To properly capture IHA completion rates, validate IHA completion, and promote IHA education	Ongoing	No updates at this time.	On May 5, 2021, the IHA results based on administrative data were shared at HCQC for 2019. An updated analysis comparing 2018 and 2019 rates was shared and there was only a 3.3% increase in IHA completion within 120 of member enrollment. The updated analysis took into account the coding validation and update to P&P QI-124 (11/19/20), which expanded the codes that count for an IHA visit.	On 8/09/21, QI began the process of randomly select medical records to begin the audit process.	IHA Care Gaps sent to providers Letter sent to providers informing them of the DHCS changes P4P will include reference to the IHA (though with no specific IHA metric)	IHAs (consisting of a history, PE, and SHA) are to be completed within 120 days of new membership. Of recent, IHA Codes have been validated, a P&P has been approved, Gap Lists are being shared, and IHA completion is now a P4P measure. In addition IHA monitoring, CAP, and education has been created and is ongoing.	Internal Quality Improvement Committee	Ongoing			J.Pedden, QI Manager S. Wakefield, RN Sr. Director of Quality

Safety

Business Lead	Project Manager	Topic	Goal	Timeframe for Completion	Q1, 2021	Q2, 2021	Q3, 2021	Q4, 2021	Summary	Subcommittee	Projected Due Date	Plan Update	Date Completed	Name/Title
QI Director / QI Medical Director	QI Manager	**QIP #5: Opioid / SUD - Continuation**	Develop an opioid / SUD continuum of care that supports: 1. Prevention 2. Intervention and Treatment 3. Recovery Support	Ongoing	Project developed to ensure focus on: Pharmacy UM Targets, Member Education, Provider Education, Network Maps, Best Practices, Academic Detailing, and Data Sharing and Reporting	Ongoing; regular pharmacy QI meetings to walk through each of the items; calls to highest risk members	High risk (highest MME) member packets mailed; additional items (as listed in Q1) completed	Preperation for Pharmacy Rx Ongoing monitoring of DUR	Develop an opioid / SUD continuum of care that supports: 1. Prevention 2. Intervention and Treatment 3. Recovery Support	Internal Quality Improvement Committee	Ongoing			Jessica Pedden, QI Manager Dr. Bhatt, QI Medical Director
QI Director / QI Medical Director	QI Manager	**Blood Lead Level Screening**	Ensure that all of their network providers who perform Periodic Health Assessments (PHAs) on child members between the ages of six months to six years (i.e. 72 months) comply with current federal and state laws, and industry guidelines for health care providers issued by the Childhood Lead Poisoning Prevention Branch (CLPPB),	Ongoing		APL 20-016 requirements with next steps presented to HCQC. Complete DHCS Data integration with the Plan's current Blood Lead Report □ Meet with internal stakeholders to discuss findings □ Send delegates and clinics noncompliant member lists □ Allow feedback and possible data sharing to fill-in data gaps and determine where lack of data is originating from □ Educate providers on APL standards	Member Count and Compliant data presented to HCQC. Next Steps Provider letter – will be sent out beginning of September 2021 □ Pending workgroup with provider offices to understand barriers to screening reporting □ Pending workgroup to understand EHR documentation and possible data extraction opportunities □ Met with ACPHD to understand their strategies for mitigation, reporting, and tracking	Continue work with delegate CFMG. Working with DHCS on allowable codes for screening compliance						
QI Director / QI Medical Director	Sr. Dir. Quality	**Potential Quality Issues (PQIs) Continuation**	Monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on behalf of the Alliance in any setting along with internal data validation.	Ongoing	#1 Begin quarterly data collection and reporting of volume of Grievance Referrals received by Quality PQIs. #2 Quarterly reporting of PQI QOA and QOS trends		Ongoing Data Analyses Underway- Results TBD	Ongoing Data Analyses Underway- Results TBD	Potential Quality Issues are suspected deviation from expected provider performance, clinical care or outcome of care which requires further investigation; further investigation can determine whether an actual quality issue exists.	Internal Quality Improvement Committee	Ongoing			S. Wakefield, RN Sr. Dir. of Quality Dr. Bhatt, QI Medical Director
QI Director / QI Medical Director	Sr. Dir. Quality	**Exempt Grievances Auditing**	Ensure clinical monitoring of Exempt Grievences for Quality of Care issues per P&P QI-104	Ongoing	Findings presented in IQIC Meeting Feb. 24th Goal met >90% compliance. Increase case file review from 30 per quarter to 50	Ongoing	Findings presented in IQIC Meeting Aug. 25th Goal met >90% compliance	Findings presented in IQIC Meeting Oct. 27th. Goal met >90% compliance	Compliance goal of met throughout 2021. Increase of randomly selected case files to 100 up from 50 cases/quarter. Meeting minutes forwarded to HCQC for review.					S. Wakefield, RN, Sr. Dir. Quality Dr. Bhatt / Medical Director
QI Director / QI Medical Director	Sr. Dir. Quality	**Potential Quality Issues (PQIs) Internal Training**	Plan provides documented evidence of ongoing clinical training by clinical staff for both new and seasoned customer service staff who serve as the front-line entry for the intake of all potential quality of care grievances	Annual (PRN)	Plan Recently trained; ongoing discussion at meetings as needed	Planning for Q3 and Q4 education; ongoing presentation of PQIs at all JOMs	Training for Delegate CHCN	QI, Member Services, G&A Managers and Diretors meeting to review and revise Member Services Cheat Sheet PQI Training for MS, G&A, QI Review Nurses Meetings with Kaiser for provision of PQI Training materials	Training for CFMG Jan. 2022 Kaiser PQI Traing follow-up Jan. 2022					S. Wakefield, RN, Sr. Dir. Quality Dr. Bhatt / Medical Director
QI Director / QI Medical Director	Access to Care Manager	**Facility Site Review (FSR) Continuation**	Develop a strategy to ensure back up staff to complete FSR/MRR provider office audits for member safety.	Ongoing	DHCS issued APL 20-006 & IHA FSR/MRR tools & QI activities focused on incorporating updates in relevant internal/external docs. Modified DHCS tool for use in urgent care site reviews. Specialist tool revised/finalized & utilized for audits of OB/GYN sites. Discussions began re: need for facility cleanliness PQI referral workflow. On-site FSR/MRR audits placed on hold due to shelter-in-place order for Alameda County, supported by DHCS. 2019 FSR/MRR/IHA Audit reporting shared at 3/10/20 A&A Committee mtg. Continued purchase & arrange delivery of vaccine/drug storage units compliant with CDC for select group of PCPs. QI-105 revised to reflect removal of FSR requirement for OB/GYN specialists. Collaborated with Quality for better alignment of IHA audit reporting/tool &	Solicited provider feedback on prov-facing docs re: revised tools. DHCS issued APL 20-011 temporarily suspending contractual requirements for in-person site reviews & other monitoring activities. AAH agreed to remove FSR requirement for OB/GYN specialists given not a regulatory requirement. Sr. QINS began participating in statewide HP provider training workgroup. QI met w/Prov Services re: FSR updates most relevant for providers. DHCS confirmed implementation of new tools temporarily suspended until 6 mo. after end of pandemic. FSR updates shared at 5/12/20 A&A Committee mtg.	QI-105 revised to reflect removal of FSR requirement for OB/GYN specialists. Collaborated with Quality for better alignment of IHA audit reporting/tool & provider ed consistency. FSR updates were shared at the 11/11/21 A&A Subcommittee mtg. Starting 10/1/21, MCPs to resume IHA activities. On 9/9/21 DHCS issued APL 20-004 Revised. MCPs must begin resumption of IHA activities by Oct 1, 2021	Resumption of IHA activities on Oct 1, 2021 Nayeema Wani, DHCS Chief of MMU, provided update via email on 12/21/21. MCPs can continue using 14-004 and 2019 version of FSR/MRR tool for on-site reviews by 3/1/22. On 12/29/21 Nayeema provided another update via email. During public health emergency (PHE), MCPs may continue to conduct onsite or virtual FSRs until 6/30/22 and to continue CAP verification virtually as needed.	Facility Site Review (FSR), Medical Record Review (MRR) and Physical Accessibility Review (PAR) is mandated for each Health plan by DHCS. Site reviews are another way the QI Department ensures safety within the provider office environment.	Access and Availability Subcommittee	Ongoing			S. Wakefield, RN, Sr. Dir. Quality Dr. Bhatt / Medical Director

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QI Director / QI Medical Director	QI Director / QI Medical Director	**Inter-rater Reliability (IRR) Continuation**	Ensure the monitor the consistency and accuracy of review criteria applied by all clinical reviewers - physicians and non-physicians - who are responsible for conducting clinical reviews and to act on improvement opportunities identified through this monitoring.	Annual and Ongoing PRN	PQI IRR Audit - RN Review Nurses & QI & UM Medical Directors. Target Goal of 90%. All participants passed with score of 100%.	No updates at this time.	No update at this time.	Next IRR Q1 2022		All Sub-Committees	Ongoing			S. Wakefield, RN, Sr. Dir. Quality Dr. Bhatt / Medical Director

Member Experience

Business Lead	Project Manager	Topic	Goal	Timeframe for Completion	Q1, 2021	Q2, 2021	Q3, 2021	Q4, 2021	Summary	Subcommittee	Projected Due Date	Plan Update	Date Completed	Name/Title
QI Director / QI Medical Director	Access to Care Manager	**CG-CAHPS Survey Continuation**	Ensure that survey questions align with DHCS timely access standards & meet member language needs	Quarterly -Ongoing	Q1 2021 survey fielded 2/22/2021 - 4/05/2021. Call Return Time and Call to Answer Time goal of 80% not met. Survey results shared at A&A Committee mtg.	Q2 survey fielded 4/29/2021 -6/29/2021. Call Return Time and Time to Answer Call goal of 80% not met. Q1 2021 results shared in A&A Committee	Q3 2021 survey fielded 7/26/2021 - 9/27/2021. Issued CAPs to providers non-compliant for 3 consecutive quarters, based on CG-CAHPS escalation process. Shared Q1 and Q2 2021 data with delegates. Due to continued COVID restrictions survey results may not be reliable.	Q4 survey fielded 10/26/2021 - 12/30/2021 pending results	Measurement tool to assess and evaluate member's experience with health plan and affiliated providers. Decision made to modify phone script to include reference to virtual visits starting with Q3 2020 surveys, given COVID. Starting June 2020, claims data for member databases were include telehealth visits in addition to face-to-face visits members had in previous 6 months.	Access and Availability Subcommittee		12/2021	Ongoing	Stephanie Wakefield, RN Sr. Dir. Quality
QI Director / QI Medical Director	Access to Care Manager	**Provider Satisfaction Survey Continuation**	Measures provider and staff satisfaction/experience with the health plan. To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities	Annual		Launched 2021 "Did You Know" Provider Satisfaction Campagin	Ongoing Did You Know Campagin Survey fielded 9/27/2021 - 12/01/2021	Results pending from vendor. Result and analysis Q1 2022	Measurement tool to assess and evaluate provider experience with health plan services	Access and Availability Subcommittee		12/31/2021		Stephanie Wakefield, RN Sr. Dir. Quality
QI Director / QI Medical Director	Access to Care Manager	**CAHPS 5.1 (Member Satisfaction Survey)Continuation**	Measures member experience with health plan and affiliated providers. To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities	Annual	Survey fielded 2/2021 - 5/2021	Ongoing		MY 2020 Results Received 2021 shared with cross functional workgroup teams for analysis and PDSA Improvement Plans developed. Findings to be shared in Feb. 2022 A&A Committee Meeting Kick-off with SPH Analytics 12/29/2021 Mail Materials - completed Sample Frames uploaded- Jan 21, 2022	Measurement tool to assess and evaluate members' experiences with health plan and affiliated providers	Access and Availability Subcommittee		01/21/22		Stephanie Wakefield, RN Sr. Dir. Quality
QI Director / QI Medical Director	Access to Care Manager	**After Hours Care Continuation**	Audits after hours protocols and availability. To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities	Annual	No updates at this time.	No updates at this time.	Survey fielded 9/20/22021 - 11/09/2021	Analysis and report development. Present at QI 2022 A&A Sub-Committee	Measurement tool to assess and evaluate network provider after hours, emergency, availability and response times	Access and Availability Subcommittee		01/07/22		Stephanie Wakefield, RN Sr. Dir. Quality
QI Director / QI Medical Director	Access to Care Manager	**Initial Pre-Natal Visits Continuation**	To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities	Annual		DHCS Audit - Plan did not continuously review, evaluate and improve access to and availability of the frist prenatl visit	2021 Survey fielding	P&P QI 107 - Appointment Access & Availablity Standards and QI-108Access to BH Health Services revised Continue OB/GYN PQI monitoring ? Share survey results with Provider Services to assist with any provider discrepancies concerns ? Post 2021 PAAS survey cleanup that includes: ❑ Providers that have a different address or phone number than what we have listed for the PAAS survey ❑	Measurement tool to assess and evaluate network provider initial pre-natal appointment availability.	Access and Availability Subcommittee		01/07/22		Stephanie Wakefield, Sr. Dir. of Quality
QI Director / QI Medical Director	Access to Care Manager	**Oncology Survey Continuation**	To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities	Annual	No updates at this time.		2021 Survey fielding	P&P QI 107 - Appointment Access & Availablity Standards and QI-108Access to BH Health Services revised Continue OB/GYN PQI monitoring ? Share survey results with Provider Services to assist with any provider discrepancies concerns ? Post 2021 PAAS survey cleanup that includes: ❑ Providers that have a different address or phone number than what we have listed for the PAAS survey ❑ Provider that have an "ineligible" survey outcome. Will present survey findings by Q2 2022	Measurement tool to assess and evaluate network oncology provider appointment availability.	Access and Availability Subcommittee		01/07/22		Stephanie Wakefield, Sr. Dir. of Quality

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QI Director / QI Medical Director	Access to Care Manager	**PAAS (Provider Appt Availability Survey) Continuation**	To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities	Annual	In March, received 2020 survey results from Analytics.	4/24/20 Completed DMHC Timely Access Compliance Filing Submission, which contains numerous PAAS-related reports. Shared 2020 survey results highlights at 6/24/21 A&A Committee mtg. CAPs based on 2020 survey results issued to delegates and direct providers	PAAS began fielding in 8/2/2021 - 12/06/2021 Non-PAAS fielding 09/20/21 - 12/06/2021		Measurement tool to assess and evaluate network provider urgent and non-urgent appointment availability.	Access and Availability Subcommittee		2/17/2022	12/06/21	Stephanie Wakefield, RN Sr. Dir. Quality
QI Director / QI Medical Director	QI Director / QI Medical Director	**Annual QI Program Evaluation Continuation**	Conduct an annual written evaluation of the QI program that includes: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices	Q1 2022				To be conducted and presented to committees March 2022	Ongoing	All Sub-Committees and HCQC	5/2022			S. Wakefield, RN, Sr. Dir. Quality Dr. Bhatt / Medical Director