**Quality Improvement Steering Committee (QISC)**
**September 26, 2023**
**10:30am – 12:00pm**
**Via Zoom Link Platform**
**Agenda**

| | | |
|---|---|---|
| **I.** | **Welcome** | **T. Greason** |
| **II.** | **Appointment/Reappointment Letters** | **T. Greason** |
| **III.** | **Authority Updates** | **Dr. S. Faheem** |
| **IV.** | **Approval of Agenda** | **Dr. S. Faheem/Committee** |
| **V.** | **Approval of Minutes**<br>- August 29, 2023 (Tabled) | **Dr. S. Faheem/Committee** |
| **VI.** | **Follow-up Items**<br>**QAPIP Effectiveness**<br>- Performance Improvement Plan Rates of Results<br>○ **Integrated Care**<br>▪ AMM Antidepressant Medication Management<br>▪ FUH-Follow up After Hospitalization<br>▪ SSD-Diabetes Screening for People with Schizophrenia of Bipolar Disorder<br>▪ HCV RNA test | **A. Oliver** |
| | ○ **Quality Improvement**<br>▪ Reducing the Racial Disparity of AA seen for Follow-Up Care within 7-Days of Discharge from a Psychiatric Inpatient Unit<br>- **Customer Service** | **J. Zeller** |
| | ○ SFY 2023 ECHO Children Survey Preliminary Results | **M. Keyes-Howard** |
| **VII.** | **Adjournment** | |

**Quality Improvement Steering Committee (QISC)**
**September 26, 2023**
**10:30am – 12:00pm**
**Via Zoom Link Platform**
**Meeting Minutes**
**Note Taker: DeJa Jackson**

**Committee Chairs:** Dr. Shama Faheem, DWIHN Chief Medical Officer and Tania Greason, DWIHN Provider Network QI Administrator

**1) Item: Welcome:** Tania Greason asked the committee to type their names, email addresses, and organization into the chat for attendance.

**2) Item: Appointment/Reappointment Letters:** Tania Greason informed the committee that for FY2024, appointment and reappointment letters will be forwarded to the providers and stakeholders. The length of service for the committee is for one year.

**3) Item: Authority Updates: Dr. Faheem shared the following updates:** DWIHN has applied for a "Zero Suicide" grant earlier this year, which DWIHN has been granted. Moving forward DWIHN will be working on a plan for Zero-Suicide which include things that we have been doing directly, for example, building of our crisis center, making sure that all of those Zero-Suicide practices are incorporated with the required services. Also, reaching out to our providers, making sure that we have a plan that aligns with the Zero-Suicide initiative. There is a slight delay with the opening of the crisis center and has been moved somewhere around December or January. DWIHN is also working on launching the mobile crisis team.

**4) Item: Approval of Agenda:** Agenda for September 26th, 2023, Meeting Approved.

**5) Item: Approval of Minutes:** QISC Meeting Minutes for August 29th,2023 Tabled.

**6) Item: Follow-up Items**
**Goal: QAPIP Effectiveness: Integrated Care**

**Strategic Plan Pillar(s):** ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce

**NCQA Standard(s)/Element #: QI #10 CC# 1, 2** ☐ UM #____ ☐CR # ___ ☐ RR # ___

| Discussion | | |
|---|---|---|
| Alicia Oliver, Clinical Specialist OBRA/PASRR shared and discussed the following with the committee for the Performance Improvement Plan (PIP's) rate of results from FY2021 through FY2022.<br><br>• AMM Antidepressant Medication Management (Measurement period, rate of results, and Comparison Goal) Effective Acute Phase Treatment: Adults who remained on antidepressant medication for at least 84 days (12 weeks).<br>  ○ The rate of results has declined from FY2021 (41.28%) to FY2022 (35.55%) by 5.73 percentage points. The goal/benchmark is set at 77.32%<br>• AMM Antidepressant Medication Management (Measurement period, rate of results, & Comparison Goal) Effective Continuation Phase Treatment: Adults who remained on antidepressant medication for at least 180 days (6 months).<br>  ○ The rate of results has declined slightly from FY2021(13.36%) to FY2022 (12.51%) by 0.85 percentage points. The goal/benchmark is set at 63.41%.<br>• FUH-Follow up after Hospitalization 30 days ages 6-17 (Measurement period, rate of results, comparison benchmark)<br>  ○ The rate of results has increased from FY2021 (66.32%) to FY2022 (67.99%) by 1.67 percentage points. The goal/benchmark is set at 70%.<br>• FUH-Follow up after Hospitalization 30 days ages 18-64 (Measurement period, rate of results, comparison benchmark)<br>  ○ The rate of results has increased from FY2021 (44.67%) to FY2022 (50.81%) by 4.14 percentage points. The goal/benchmark is set at 58.0%<br>• FUH-Follow up after Hospitalization 30 days ages 65+ (Measurement period, rate of results, comparison benchmark)<br>  ○ The rate of results has increased from FY2021 (22.58%) to FY2022 (36.36%) by 13.78 percentage points. The goal/benchmark is set at 58.0%<br>• FUH-Follow up after Hospitalization 7 days ages 6-17 (Measurement period, rate of results, comparison benchmark)<br>  ○ The rate of results has increased from FY2021 (44.14%) to FY2022 (45.70%) by 1.56 percentage points. The goal/benchmark is set at 70%<br>• FUH-Follow up after Hospitalization 7 days ages 18-64 (Measurement period, rate of results, comparison benchmark) | | |

| | | |
|---|---|---|
| ○ The rate of results has increased from FY2021 (28.33%) to FY2022 (30.74%) by 2.41 percentage points. The goal/benchmark is set at 58.0%<br>• FUH-Follow up after Hospitalization 7 days ages 65+ (Measurement period, rate of results, comparison benchmark)<br>○ The rate of results has increased from FY2021 (14.19%) to FY2022 (28.49%) by 14.3 percentage points. The goal/benchmark is set at 58.0%<br>• SAA – Adherence to Antipsychotic Medications for individuals with Schizophrenia (Measurement period, rate of results, comparison benchmarks)<br>○ The rate of results has increased from FY2021 (46.42%) to FY2022 (47.05%) by 0.63 percentage points. The goal/benchmark is set at 85.09%<br>• SSD – Diabetes Screening for people with Schizophrenia or Bipolar Disorder (Measurement period, rate of results, comparison benchmarks)<br>○ Rate of results has increased from FY2021 (64.8%) to FY2022 (70.69%) by 5.83 percentage points. The goal/benchmark is set at 86.36%<br>• HCV RNA test results: 2020 rate of results, 2021 rate of results, and 2022 rate of results.<br>○ The 2021 rate of result average is 2.22% in comparison to the 2022 rate of result average of 0.60%. This is a decrease of 1.62%. DWIHN's goal of 5% was not achieved. | | |
| **Provider Feedback** | **Assigned To** | **Deadline** |
| **Questions/Concerns:**<br>**1.** How do you measure an intervention that the provider is providing the education, and they're answering their questions? How is this intervention measured ?<br>**2.** Is the education material on our website specifically for our providers just to review? Or should our providers be assisting the members by showing them how to review that information on DWIHN's website?<br>**Answers:**<br>**1.** The interventions regarding the educational materials are measured through DWIHN's website. The measurement is calculated by reviewing the number of times providers, members or stakeholders visit the website "hit."<br>**2.** The educational material is under the provider site. Alicia has had conversations with our peers on how to pull the information and the importance of educating our members. | | |
| **Action Items** | **Assigned To** | **Deadline** |
| Dr. Faheem and the committee agreed to continue the PIPs as presented. DWIHN will continue to meet internally as well as with the provider network to review barriers and update interventions as required. Updated data for FY2023 will be brought to the committee by March 2024. | Alicia Oliver - IHC | March 30, 2024 |

**6) Item: Follow-up Items**
**Goal: QAPIP Effectiveness: Quality Improvement**
**Strategic Plan Pillar(s):** ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
**NCQA Standard(s)/Element #: QI 10** CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

| Discussion | | |
|---|---|---|
| Justin Zeller, Clinical Specialist Performance Improvement shared the following with the committee an update for Reducing the Racial Disparity of AA seen for Follow-Up Care within 7Days of Discharge from a Psychiatric Inpatient Unit Performance Improvement Project:<br>**Purpose and Background:**<br>HSAG, the MDHHS contracted External Auditor, directed PIHPs to create a 3-year PIP focusing on racial disparities in the network. The data reveals a disparity gap between the percentage of African American (AA) members compared to white members who received follow-up care within 7 days of discharge from a psychiatric inpatient unit. The purpose of this report is to provide an update on the targeted interventions to increase the follow-up care within 7 days of discharge from a psychiatric inpatient unit for t African American (AA) members, without demonstrating a decrease in the overall compliance scores for the White population.<br>**Data Analysis:**<br>The initial baseline data was pulled for FY2021 (4.51%) disparity gap was identified. The preliminary data from January – July 2023 demonstrated a disparity gap of 9.01% which is an increase of 4.5 percentage points.<br>**Initial Interventions:**<br>Following the analysis of the baseline data, DWIHN initiated general Interventions to improve compliance with 7-day discharge appointments after psychiatric admissions:<br>○ Monthly meetings with CRSP to educate them on the importance of hospital discharge appointments. Data on their compliance was reviewed and barriers were discussed.<br>○ Access was provided to CRSPs for the Performance Indicator module in MHWIN and job aides were created so the providers can self-monitor their data.<br>○ Medical Directors of CRSPs were notified of the data and gaps at their agencies and were provided education to access their own data.<br>○ Value-based performance incentives were provided to compliant providers on a quarterly basis.<br>**Next Steps:**<br>○ DWIHN's Integrated Health Care (IHC) has reached out to hospitalized members by calling the members 2 to 3 days after inpatient discharge to assist with care coordination focusing specifically on the Black/ African American population. These efforts will encourage members to attend their 7-day follow-up appointment and enroll in the voluntary Complex Case Management (CCM) programs. Data collection and outcomes will be tracked and reported to PCC quarterly.<br>○ DWIHN is working to reduce transportation barriers for members to attend their scheduled 7-day follow-up appointments. We have contracted with two vendors, God Speed Transportation, and Mariners Inn to provide transportation. Services begin September 2023.* | | |

| | | |
|---|---|---|
| ○ DWIHN's Member Experience and Quality Improvement teams are working in collaboration to administer a survey tool that will assess racial disparity among the African American population in our system. The survey is aimed to obtain additional information from members who are non-compliant with their required 7-day follow-up appointments, lack services between hospitalizations, and have high recidivism inpatient encounters.<br>○ The survey will also contrast data from white members/participants within the same non-compliant categories. This will aim to determine if there are any baseline similarities related to social determinants of health or to determine if there are more relevant causes for the racial disparity. Data collection and outcomes will be tracked and reported to PCC quarterly.<br>○ Continue to conduct targeted meetings with providers that have the highest disparities and a high number of AA population hospitalized.<br>○ DWIHN's Quality Monitoring team, through the annual monitoring process, has been focusing on reviewing a sampling of cases for members who did not make their appointments. These efforts are aimed at ensuring providers are practicing re-engagement and engagement attempts, per DWIHN's policy (i.e., phone, letter, in-person, etc.)<br>○ No less than monthly, DWIHN's Quality Improvement team will continue to remeasure the data for the effectiveness of the interventions and report outcomes to PCC quarterly. | | |
| **Provider Feedback** | **Assigned To** | **Deadline** |
| No provider feedback. | | |
| **Action Items** | **Assigned To** | **Deadline** |
| Dr. Faheem and the committee agreed to continue the PIP as presented. Ongoing updates will include data analysis, barriers, and updated progress on noted interventions. The next update will be presented by January 2024. | Justin Zeller - QI | January 31, 2024. |

**6) Item: Follow-up Items**
**Goal: QAPIP Effectiveness: Customer Service**
**Strategic Plan Pillar(s):** ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
**NCQA Standard(s)/Element #:** QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

| Discussion | | |
|---|---|---|
| Margret Keyes-Howard, Manager Member Engagement CS, reviewed the following with the committee for the SFY 2023 ECHO Children Survey Preliminary Results:<br>**Overview:**<br>• Margaret discussed the overall decreases that are demonstrated in some of the reporting areas in with comparison to last year's results with the Children ECHO Survey. There are no significant decreases, but small enough noted decreases in barriers and interventions will need to be reviewed. | | |
| **Provider Feedback** | **Assigned To** | **Deadline** |
| No provider feedback. | | |
| **Action Items** | **Assigned To** | **Deadline** |
| The presentation for the Children's ECHO Survey results will be brought back to the October 2023 Committee meeting. | Margaret Keyes-Howard | October 31, 2023 |

**New Business Next Meeting: October 31, 2023**
**Adjournment: September 26, 2023**


# DETROIT WAYNE INTEGRATED HEALTH NETWORK

## 800-241-4949

## www.dwihn.org

# Performance improvement Plan Rate of Results

## AMM Antidepressant Medication Management

| | | | |
|---|---|---|---|
| Effective **Acute Phase** Treatment | **Measurement Period** 2020 | **Rate of Results** 26.94% | **Comparison Goal** 77.32% |
| Effective **Acute Phase** Treatment | 2021 | 41.28% | 77.32% |
| Effective **Acute Phase** Treatment | 2022 | 35.55% | 77.32% |

- *Effective Acute Phase Treatment:* Adults who remained on an antidepressant medication for at least 84 days (12 weeks).

# Performance improvement Plan Rate of Results

**AMM Antidepressant Medication Management**

| Effective **Continuation Phase** Treatment | **Measurement Period** 2020 | **Rate of Results** 21.66% | **Comparison Goal** 63.41% |
|---|---|---|---|
| Effective **Continuation Phase** Treatment | 2021 | 13.36% | 63.41% |
| Effective **Continuation Phase** Treatment | 2022 | 12.5% | 63.41% |

- *Effective Continuation Phase Treatment:* Adults who remained on an antidepressant medication for at least 180 days (6 months).

# Performance Improvement Plan Rate of Results

**FUH-Follow up After Hospitalization 30 days ages 6-17**

| | | | |
|---|---|---|---|
| 30 day Follow up After Hospitalization for Mental Illness Age 6-17 | **Measurement Period** 2020 | **Rate of Results** 62.96% | **Comparison Benchmark** 70% |
| 30 day Follow up After Hospitalization for Mental Illness Age 6-17 | 2021 | 66.32% | 70% |
| 30 day Follow up After Hospitalization for Mental Illness Age 6-17 | 2022 | 67.99% | 70% |

# Performance Improvement Plan Rate of Results

**FUH-Follow up After Hospitalization 30 days ages 18-64**

| | | | |
|---|---|---|---|
| 30 day Follow up After Hospitalization for Mental Illness<br>Age 18-64 | **Measurement Period**<br><br>2020 | **Rate of Results**<br>48.74% | **Comparison Benchmark**<br>58% |
| 30 day Follow up After Hospitalization for Mental Illness<br>Age 18-64 | 2021 | 46.67% | 58% |
| 30 day Follow up After Hospitalization for Mental Illness<br>Age 18-64 | 2022 | 50.81% | 58% |

# Performance Improvement Plan Rate of Results

**FUH-Follow up After Hospitalization 30 days agers 65+**

| | | | |
|---|---|---|---|
| 30 day Follow up After Hospitalization for Mental Illness<br>Age 65+ | **Measurement Period**<br>2020 | **Rate of Results**<br>27.37% | **Comparison Benchmark**<br>58% |
| 30 day Follow up After Hospitalization for Mental Illness<br>Age 65+ | 2021 | 22.58% | 58% |
| 30 day Follow up After Hospitalization for Mental Illness<br>Age 65+ | 2022 | 36.36% | 58% |

# Performance Improvement Plan Rate of Results

**FUH-Follow up After Hospitalization 7 days ages 6-17**

| 7 day Follow up After Hospitalization Ages 6-17 | **Measurement Period**<br><br>2020 | **Rate of Results**<br><br>41.33% | **Comparison Benchmark**<br><br>70% |
|---|---|---|---|
| 7 day Follow up After Hospitalization Ages 6-17 | 2021 | 44.14% | 70% |
| 7 day Follow up After Hospitalization Ages 6-17 | 2022 | 45.70% | 70% |

# Performance Improvement Plan Rate of Results

**FUH-Follow up After Hospitalization 7 days ages 18-64**

| 7 day Follow up After Hospitalization Ages 18-64 | **Measurement Period**<br><br>2020 measurement period | **Rate of Results**<br><br>29.14% | **Comparison Benchmark**<br><br>58% |
|---|---|---|---|
| 7 day Follow up After Hospitalization Ages 18-64 | 2021 measurement period | 28.33% | 58% |
| 7 day Follow up After Hospitalization Ages 18-64 | 2022 measurement period | 30.74% | 58% |

# Performance Improvement Plan Rate of Results

**FUH-Follow up After Hospitalization 7 days ages 65+**

| 7 day Follow up After Hospitalization Ages 65+ | **Measurement Period** 2020 | **Rate of Results** 17.89% | **Comparison Benchmark** 58% |
|---|---|---|---|
| 7 day Follow up After Hospitalization Ages 65+ | 2021 | 14.19% | 58% |
| 7 day Follow up After Hospitalization Ages 65+ | 2022 | 28.49% | 58% |

# Performance Improvement Plan Rate of Results

**SAA -Adherence to Antipsychotic Medications for Individuals with Schizophrenia**

| SAA | **Measurement Period** | **Rate of Results** | **Comparison Benchmark** |
|---|---|---|---|
| SAA | 2021 | 46.42 | 85.09 |
| SAA | 2022 | 47.05 | 85.09 |

# Performance Improvement Plan Rate of Results

**SSD- Diabetes Screening for People with Schizophrenia or Bipolar Disorder**

| SSD | **Measurement Period**<br><br>2020 | **Rate of Results**<br><br>64.38% | **Comparison Benchmark**<br><br>86.36% |
|---|---|---|---|
| SSD | 2021 | 64.86% | 86.36% |
| SSD | 2022 | 70.69% | 86.36% |

# Performance Improvement Plan Rate of Results

**HCV RNA test results:**
2020 rate of results average is 0.70%
DWIHN Goal 5%

| Measurement Period | Measurement | Numerator | Denominator | Rate or Results |
|---|---|---|---|---|
| 2020 Q1 | ***Baseline*** | 25 | 3591 | 0.70% |
| 2020 Q2 | ***Baseline*** | 26 | 3744 | 0.70% |
| 2020 Q3 | ***Baseline*** | 13 | 3922 | 0.33% |
| 2020 Q4 | ***Baseline*** | 26 | 2670 | 0.98% |

Hepatitis C is a liver infection caused by the hepatitis C virus (HCV). Hepatitis C is spread through contact with blood from an infected person. Today, most people become infected with the hepatitis C virus by sharing needles or other equipment used to prepare and inject drugs.

# Performance Improvement Plan Rate of Results

**HCV RNA test results:**

2020 rate of result average is 0.70% in comparison to 2021 rate of result average 2.22%. This is an increase of 1.52%. DWIHN goal of 5% was not achieved.

| Measurement Period | Measurement | Numerator | Denominator | Rate or Results |
|---|---|---|---|---|
| 2021 Q1 | Remeasurement 1 | 65 | 2685 | 2.42% |
| 2021 Q2 | Remeasurement 2 | 66 | 2911 | 2.26% |
| 2021 Q3 | Remeasurement 3 | 64 | 3084 | 2.07% |
| 2021 Q4 | Remeasurement 4 | 69 | 3250 | 2.12% |

# Performance Improvement Plan Rate of Results

**HCV RNA test results:**
2021 rate of result average is 2.22% in comparison to 2022 rate of result average 0.60%.
This is a decrease of 1.62%.
DWIHN goal of 5% was not achieved.

| Measurement Period | Measurement | Numerator | Denominator | Rate or Results |
|---|---|---|---|---|
| 2022 Q1 | Remeasurement 5 | 15 | 3097 | 0.50% |
| 2022 Q2 | Remeasurement 6 | 19 | 3109 | 0.61% |
| 2022 Q3 | Remeasurement 7 | 22 | 3195 | 0.70% |
| 2022 Q4 | Remeasurement 8 | 20 | 3423 | 0.60% |

# Performance Improvement Plan Rate of Results

For all measures, quarterly scores are mailed to providers Chief Medical Officer or Chief Executive Officer.

They are asked to provide a plan of action to increase the scores.

Several providers have responded with a plan of action.

Resources

AskTheDoc@dwihn.org.

https://dwihn.org/brochures-and-handouts-DWIHN-Services.pdf

https://dwihn.org/access-mymobileapp

https://dwihn.org/health-wellness-support

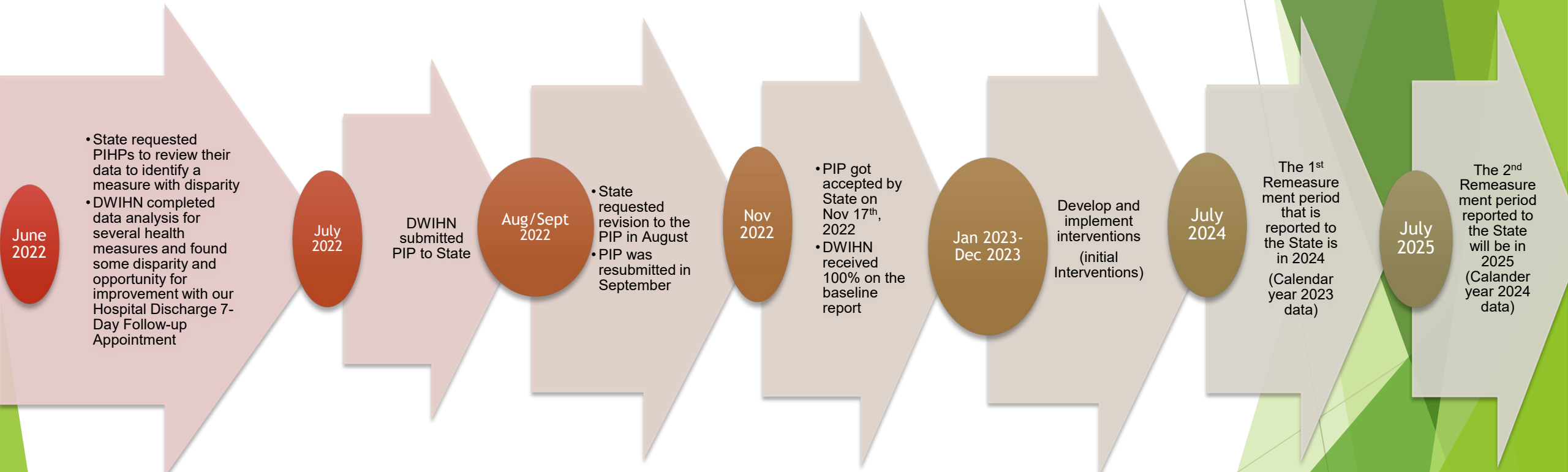
https://dwihn.org/providers-HEDIS

# HOSPITAL DISCHARGE FOLLOW-UP RACIAL DISPARITY PIP

# BACKGROUND & PURPOSE

- HSAG, the MDHHS contracted External Auditor, directed PIHPs to create a 3 year PIP focusing on racial disparities in the network.
- The data reveals a disparity gap between the percentage of African American (AA) members compared to white members who received follow-up care within 7 days of discharge from a psychiatric inpatient unit.
- The purpose of this report is to provide an update on the targeted interventions to increase the follow-up care within 7 days of discharge from a psychiatric inpatient unit for the African American (AA) members, without demonstrating a decrease in the overall compliance scores for the White population.

# SUMMARY OF TIMELINE



# BASELINE DATA (CALANDER YEAR 2021)

| Table 1: DWIHN 2021 Performance Indicator #4a | | | | |
|---|---|---|---|---|
| **Race** | Total Events | Compliant Events | Non-Compliant Events | Compliance Rates |
| **Black or African American** | 4,252 | 1,516 | 2,736 | 35.65% |
| **White** | 1,890 | 759 | 1,131 | 40.16% |
| **Disparity Gap** | - | - | - | 4.51% |

Data was collected and submitted to State in Summer 2022. Approved Nov 2022.

# INITIAL INTERVENTIONS

- Following the analysis of the baseline data, DWIHN initiated general Interventions to improve compliance with 7-day discharge appointments after psychiatric admissions:
  - Monthly meetings with CRSP to educate them on the importance of hospital discharge appointments. Data on their compliance was reviewed and barriers were discussed.
  - Access was provided to CRSPs for the Performance Indicator module in MHWIN and job aide was created so the providers can self-monitor their data.
  - Medical Directors of CRSPs were notified of the data and gaps at their agencies and were provided education to access their own data.
  - Value-based performance incentives were provided to compliant providers on quarterly basis.

# Preliminary Data
# African American/Black Members Follow-Up After Hospitalization (January-July 2023)

| Seen Within 7 Days | Member Rescheduled but seen Outside of 7 Days |
|---|---|
| 794 | 648 |
| 32.94% | 26.88% |

- The preliminary data reveals that there is an 9.01 percentage point disparity gap.
- There were a total of 2,410 AA members events during January – July 2023.
- While the 7 day compliance for AA members was 32.94%, the data demonstrates that the AA members that were not seen within the 7 days were eventually seen at an overall compliance rate of (59.82%).
- With additional reengagement efforts (appointment reminders, letters and calls) an additional 648 AA members followed up with providers after discharge but not within 7 days.

# PIP NEXT STEPS

- DWIHN's Integrated Health Care (IHC) has been reached out to hospitalized members by calling the members 2 to 3 days after inpatient discharge to assist with care coordination focusing specifically with Black/ African American population. These efforts will encourage members to attend their 7-day follow-up appointment and enroll in the voluntary Complex Case Management (CCM) programs. Data collection and outcomes will be tracked and reported to PCC quarterly.
- DWIHN is working to reduce transportation barriers for members to attend their scheduled 7-day follow up appointments. We have contracted with two vendors, God Speed Transportation and Mariners Inn to provide transportation. Services begin September, 2023.*
- DWIHN's Member Experience and Quality Improvement teams are working in collaboration to administer a survey tool that will assess racial disparity amongst our African American population in our system. The survey is aimed to obtain additional information from members who are non-compliant with their required 7-day follow-up appointments, lack services between hospitalizations, and have high recidivism inpatient encounters.
  - The survey will also contrast data from white member/participants within the same non-compliant categories. This will aim to determine if there is any baseline similarities related to social determinants of health or to determine if there are more relevant cause for the racial disparity. Data collection and outcomes will be tracked and reported to PCC quarterly.
- Continue to conduct targeted meetings with providers that have highest disparities and high number of AA population hospitalized.
  DWIHN's Quality Monitoring team, through the annual monitoring process, has been focusing on reviewing a sampling of cases for members that did not make their appointment. These efforts are aimed at ensuring providers is practicing re-engagement and engagement attempts, per DWIHN's policy (i.e., phone, letter, in-person, etc.)
- No less than monthly, DWIHN's Quality Improvement team will continue to remeasure the data for effectiveness of the interventions and report outcomes to PCC quarterly.