DWIHN
Detroit Wayne Integrated Health Network
Your Link to Holistic Healthcare

Quality Operations Technical Assistance Workgroup Meeting Agenda
Wednesday, April 29, 2026
Via Zoom Link Platform
9:30 a.m. – 11:30 a.m.

I.	Announcements	A. Siebert
II.	Substance Use Disorder (SUD)(**Table**)	G. Lindsey
III.	Recipient Rights	S. Pride
IV.	**QAPIP Effectiveness**	
	Quality Improvement	
	- Verbal Consent (Follow-up)	D. Dobija
	- MDHHS Waivers & iSPA Updates	D. Dobija
	- Medicaid Claims Verification Reviews	D. Dobija
	- Reducing the Racial Disparity of AA Members (7-Day)	A. McGhee
	- HEDIS Updates/Analysis	L. Harmon/T. Greason
	- MMBPI	
	○ PI#2a Analysis	L. Harmon/T. Greason
	- BTAC Data/Analysis Report (Q1)(**Table**)	F. Nadeem
	- CE/SE/RCA Report (Q1)(**Table**)	C. Sight-Mackey
V.	Adjournment	

Quality Operations Technical Assistance Workgroup Meeting Agenda
Wednesday, April 29, 2026
Via Zoom Link Platform
9:30 a.m. – 11:30 a.m.
Note Taker: DeJa Jackson

1) Item: Announcements:

- Staffing Updates:
  - Sheree Jackson, Vice President of Compliance, is no longer with DWIHN.
  - Dawn Ison appointed as Interim Vice President of Compliance.
  - Providers are instructed to direct compliance communications to:
    - Compliance email box
    - Dawn Ison
- Annual Report Availability:
  - FY24–FY25 Annual Report available on DWIHN website
- HEDIS & Performance Indicator Updates:
  - Quality Team transitioning focus toward HEDIS measures following discontinuation of most MMBPI measures.
  - Exception:
    - Performance Indicator 2A remains state-required:
      - Completion of biopsychosocial assessment within 14 days of Initial Request.
  - Plans of Correction
    - Providers performing more than 5 percentage points below benchmark on HEDIS measures will receive Plans of Correction.
    - Notification letters forthcoming.
- Behavior Treatment Network Trainings:
  - Completed Trainings
    - March 30, 2026
    - Topic: MDHHS 101 staffing requirements
    - April 27, 2026
    - Topic: Compliance with ACBS requirements
  - Upcoming Training
    - May 18, 2026
    - Topic: Billing practices and coding for behavior treatment services

- Behavior Treatment Survey:
  - First member/guardian survey distributed regarding:
    - Behavior Treatment Committee process
    - Overall experience and satisfaction
  - Purpose:
    - Gathering member feedback
    - Improve committee operations and quality outcomes
  - Timeline:
    - Survey anticipated to close around May 18, 2026

- SUD Credentialing Milestone:
  - 100% of SUD providers are now fully credentialed

2) Item: Substance Use Disorder (SUD) – G.Lindsey/ Matthew Yascolt
Goal: Updates from SUD
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
No SUD Updates.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
SUD will provide updates at the next scheduled meeting.		

3) Item: Recipient Rights – Schakerra Pride
Goal: Updates from ORR

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

<table>
<tr><th>Discussion</th><th></th><th></th></tr>
<tr><td>Schakerra Pride, ORR Department Manager, provided the following ORR Updates:

Verbal Consent Policy:
• Policy Clarification:
  ○ Verbal consent is permissible if:
    ▪ Witnessed
    ▪ Documented by someone other than the treating provider.
• Policy Revision:
  ○ ORR leadership identified inaccurate policy language requiring follow-up signatures.
  ○ Discussion underway regarding policy revision.

Recipient Rights Training Compliance:
• New Training Rule:
  ○ Missed scheduled new-hire recipient rights training:
    ▪ One (1) missed class allowed
    ▪ ORR trainers will assist with re-registration within a 30-day compliance window
• Ongoing Issues:
  ○ Repeated missed trainings causing scheduling burdens
  ○ Rules for attending classes are implemented to preserve fairness and compliance.

Monitoring & Site Review Findings
• Main Areas of Noncompliance:
  1. New hire training exceeding 30-day requirement
  2. Missing training documentation/evidence
• Guidance:
  ○ Providers are required to:
    ○ Maintain copies of training certificates onsite
    ○ Prepare documentation prior to site reviews</td><td></td><td></td></tr>
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Provider Feedback	Assigned To	Deadline
Questions: 1. Can verbal consent stand alone with witness documentation? 2. Did the increase in new hires contribute to training issues? 3. Why must providers submit training evidence already accessible through MHWIN? **Answers:** 1. MDHHS expects follow-up signatures after verbal consent. 2. The main issue is failure to attend after registration. Adequate class availability remains if onboarding occurs promptly. 3. Providers are expected to maintain onsite documentation regardless of DWIHN system access.		
Action Items	**Assigned To**	**Deadline**
None required.		

4) Item: QAPIP Effectiveness
Goal: Quality Improvement

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems X Quality ☐ Workforce
NCQA Standard(s)/Element #: QI 1 CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		

Danielle Dobija, Quality Administrator - Performance Monitoring, shared the following:
 	
MDHHS Waivers & iSPA Updates
• Review Status:
  ○ MDHHS review initiated March 2026
  ○ Review scheduled through May 22, 2026
• Preliminary Clinical Record Findings:
  ○ Recurring findings include:
    ▪ Goals written as service-driven instead of outcome-driven
    ▪ Objectives not measurable
    ▪ Missing amount/scope/duration/frequency
    ▪ Increased use of prohibited “range language”
    ▪ Services not delivered as written in plans
• Staff File Review Findings:
  ○ Findings Summary
    ▪ 749 staff files submitted
    ▪ 291 returned for additional follow-up
  ○ Major Issues
    ▪ Missing Qualified Intellectual Disabilities Professional (QIDP) documentation
    ▪ Missing supervision evidence
    ▪ Incomplete qualification records
• Corrective Action Plan (CAP) Process Updates
  ○ New State Process:
    ▪ CAP findings are now managed through the CRM software platform.
    ▪ Increased administrative burden anticipated.
  ○ Requirements
    ▪ Individual remediation is due within 90 days
    ▪ Systemic remediation reviewed at next annual review		

Medicaid Claims Verification Reviews
• Audit Scope
  ○ 1,075 claims sampled
  ○ 241 providers involved
• Guidance
  ○ Providers may reference previously submitted staff files to reduce duplicate submissions.
 	
HCBS-Compliant IPOS Project
• Update
  ○ DWIHN reviewing HCBS-compliant IPOS attestations against MHWIN audit tool scores.
• Provider Requests
  ○ Providers asked to verify:
    ▪ Plans are compliant
    ▪ Plans are amended if necessary
    ▪ Or remediation remains in progress		

Provider Feedback	**Assigned To**	**Deadline**
Questions/Concerns: 1. Unrealistic to retrieve employment documentation from 10+ years ago. **Answers:** 1. Danielle Dobija agreed that DWIHN would advocate with MDHHS for realistic expectations.		
Action Items	**Assigned To**	**Deadline**
The Quality Improvement team will share the final MDHHS audit report results with this workgroup.	QI (Danielle Dobija)	June 30, 2026

4) Item: QAPIP Effectiveness
Goal: Quality Improvement

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

Angel McGhee, Data Analyst, shared the following:
 	
Reducing the Racial Disparity of AA Members (7-Day)
• Project Overview
  ○ Goal: Reduce racial disparity in 7-day follow-up after psychiatric hospitalization.
• Barriers Identified
  ○ Poor coordination of care
  ○ Staff shortages
  ○ Member disengagement
  ○ Scheduling difficulties
  ○ Limited resources
  ○ Members lacking an assigned CRSP provider
• Interventions
  ○ Peer reminder calls
  ○ Transportation partnerships:
    ▪ Mariners Inn
    ▪ Gatsby
  ○ Automated racial disparity reporting
• Data Review
  ○ Racial Disparity Trends
    ▪ 2021 baseline: 4.51%
    ▪ 2022: 8.73%
    ▪ 2023: 7.57%
    ▪ 2024: 4.93%
    ▪ 2025: 5.58%		

○ Compliance Rates
▪ African American Members
  ✚ 2025: 37.11%
▪ White/Caucasian Members
  ✚ 2025: 42.69%
• Final Submission
○ Final PIP submission due to HSAG:
▪ May 15, 2026
Please refer to the handout "QOTAW Racial Disparity Power Point 04.28.2026.pptx" for additional information.		

Provider Feedback	**Assigned To**	**Deadline**
No provider feedback		
Action Items	**Assigned To**	**Deadline**
The Quality Improvement team will share the final PIP audit report results with this workgroup.	QI (Angel McGhee)	August 30, 2026

4) Item: QAPIP Effectiveness
Goal: Quality Improvement

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

Lauren Harmon, Clinical Specialist - Performance Improvement and Tania Greason, QI Administrators, shared the following:
 	
HEDIS Updates/Analysis:
The Quality Improvement Team finalized performance data for the January–December 2025 reporting period on March 31, 2026. Performance Improvement Plans (PIPs) will be initiated only for the following measures for which a provider's compliance is more than 5 percentage points below the benchmark
 	
• HEDIS Finalized System Data 2025:
  ○ Measures Meeting Benchmark
    ▪ FUH 30 Adult: 68.16%
    ▪ FUH 30 Total: 68.42%
    ▪ FUM30 Adult: 68.67%
    ▪ ADD Initiation: 68.35%
    ▪ ADD Continuation: 76.73%
    ▪ APP Total: 78.36%
  ○ Measures Below Benchmark
    ▪ FUH 30 Children: 74.95% (goal 79%)
    ▪ FUH 7 Adult: 44.01%
    ▪ FUH 7 Children: 52.95%
    ▪ FUM30 Children: 80.02%
    ▪ FU130 Total: 70.53% (slightly below benchmark)
    ▪ SAA: 44.53%
    ▪ SSD: 69.72%
    ▪ APM Total: 24.49%		

• Additional SUD-related HEDIS measures to be implemented in 2026:
  ○ IET
  ○ OUD
• HEDIS Performance Improvement Plans (PIPs) issued for Calendar Year 2025:
  ○ Measures Receiving PIPs:
    ▪ FUH30 Adult
    ▪ FUH30 Children
    ▪ SAA
    ▪ SSD
Please refer to the handout "HEDIS System PIP PowerPoint 2025 4.28.26.pptx" for additional information.		

Provider Feedback	**Assigned To**	**Deadline**
Questions: 1. Difficulty monitoring ED discharges due to limitations in ADT notifications and PAR reports. Providers noted: ADT notifications are difficult to manage, Information from hospitals is inconsistent, larger providers face significant workload reviewing ADTs. 2. Behavioral health providers may not have diabetes diagnoses available in EMRs for SSD interventions. 3. Child benchmark of 79% appeared unusually high. **Answers:** 1. DWIHN IT improvements are currently under review, additional information updates will be provided. 2. DWIHN agreed to discuss options internally. 3. Benchmarks were established by MDHHS. Child benchmark increased from 70% to 79%		
Action Items	**Assigned To**	**Deadline**
The Quality Improvement team will continue to share HEDIS data and reporting with the workgroup.	QI (Lauren Harmon)	Ongoing

4) Item: QAPIP Effectiveness
Goal: Quality Improvement

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<tr><td>Lauren Harmon, Clinical Specialist - Performance Improvement, and Tania Greason, QI Administrator, shared the following:

MMBPI: PI#2a analysis: (The percentage of new persons during the Period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service)
• Indicator Overview:
    ○ Measures completion of biopsychosocial assessment within 14 days.
    ○ Benchmark: 57%
• Performance Summary:
    ○ Quarter 1 FY26:
        ▪ Overall score: 51.41%
        ▪ Decline from prior quarter: Q4 FY25: 53.71%
    ○ Preliminary Quarter 2 FY26
        ▪ Improved to approximately 60.04%
• Population Trends:
    ○ Q1 Declines
        ▪ MI Child
        ▪ MI Adult
        ▪ DD Adult
    ○ Improvements in Q2:
        ▪ Largest gains:
            - DD Children
            - DD Adults
• Key Drivers of Noncompliance
    ○ Appointments scheduled outside 14-day window
    ○ No-shows
    ○ Cancellations
    ○ Staffing shortages</td><td></td><td></td></tr>
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○ Limited intake availability • Current Interventions ○ Increased intake staffing ○ Expanded appointment availability ○ Scheduling oversight improvements ○ Staff training ○ 45-day provider meetings ○ Daily intake monitoring		
Provider Feedback	**Assigned To**	**Deadline**
Questions: 1. Do telehealth intake appointments impact PI2A performance? **Answers:** 1. Telehealth remains allowable under certain conditions. Scheduling dependent on provider availability and policy guidelines.		
Action Items	**Assigned To**	**Deadline**
None required.		

4) Item: QAPIP Effectiveness

Goal: Quality Improvement

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

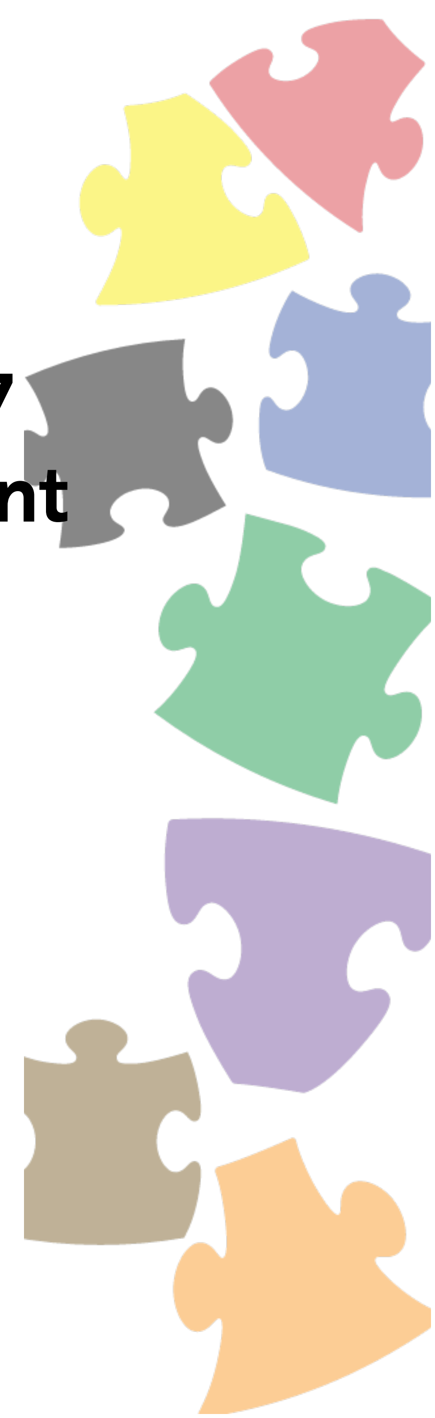
Discussion		
Fareeha Nadeem, Senior Psychologist, shared the following: *BTAC Data/Analysis Report (Q1)(Tabled for the next QOTAW)* • Noted Acknowledgments: ○ Fareeha recognized the DWIHN Customer Service and QI team for support with BTAC survey efforts: ▪ DeJa Jackson ▪ Elaine Thomas ▪ Amanda Levitt ▪ Dorian Johnson ▪ Demetrius Perry Information from the survey will be shared with the workgroup once compiled and analyzed.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback		
Action Items	**Assigned To**	**Deadline**
Data analysis will be shared with the workgroup once compiled.	QI (Fareeha Nadeem)	August 30, 2026

New Business Next Meeting: 5/27/26
Adjournment: 04/29/2026

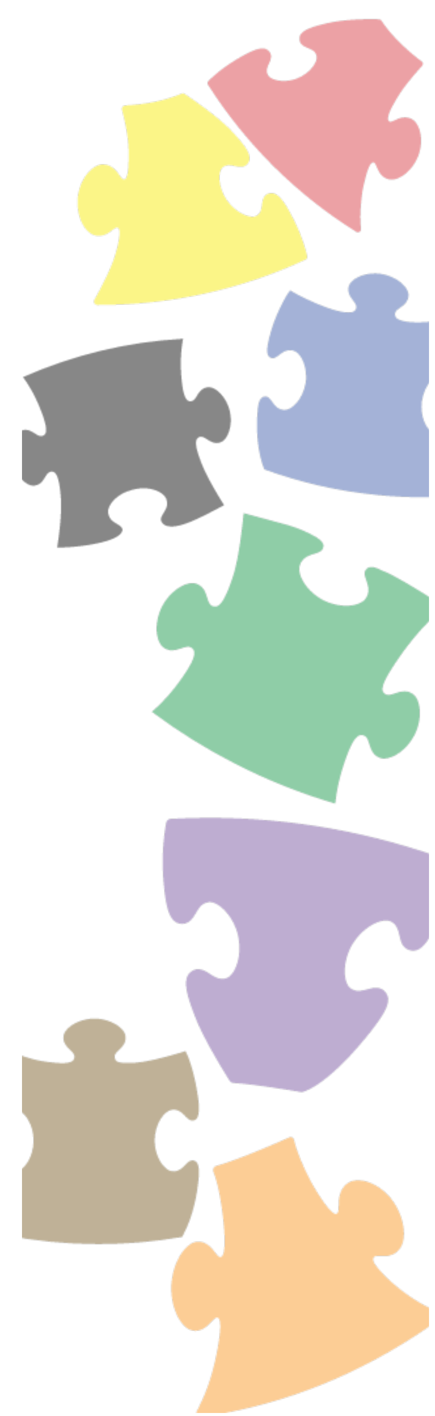
Reducing the Racial Disparity of African Americans Seen for Follow-Up Care Within 7 Days of Discharge From a Psychiatric Inpatient Unit

Quality Operations Technical Advisory Workgroup

April 29th, 2026



RACIAL DISPARITY BACKGROUND



- DWIHN has been closely monitoring its hospitalizations as well as working to reduce the number of members needing hospitalization services.
- DWIHN recognizes that providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care.
- Studies have also proven that poor integration of follow-up treatment in the continuum of psychiatric care leaves many individuals, particularly African Americans, with poor-quality of ongoing treatment. Based on a Michigan Health Endowment study, disparities in quality of care exist in all counties and PIHP regions, for most measures. There were differences in the extent of the disparity depending on the measure, county, and year. County-level rates for the White population are consistently higher than the statewide average.

RACIAL DISPARITY BARRIERS

- Poor coordination of care
- Hospitalized members unassigned to CRSPs
- Reduction of telehealth services
- Lack of technology
- Difficulty getting an appointment within required timeframes
- Lack of resources
- Staff biases

- Historical mistrust of providers
- Mental health stigma
- Staff shortages
- Failure to engage members resulting in no shows, cancelations, rescheduling of appointments or refusal of services

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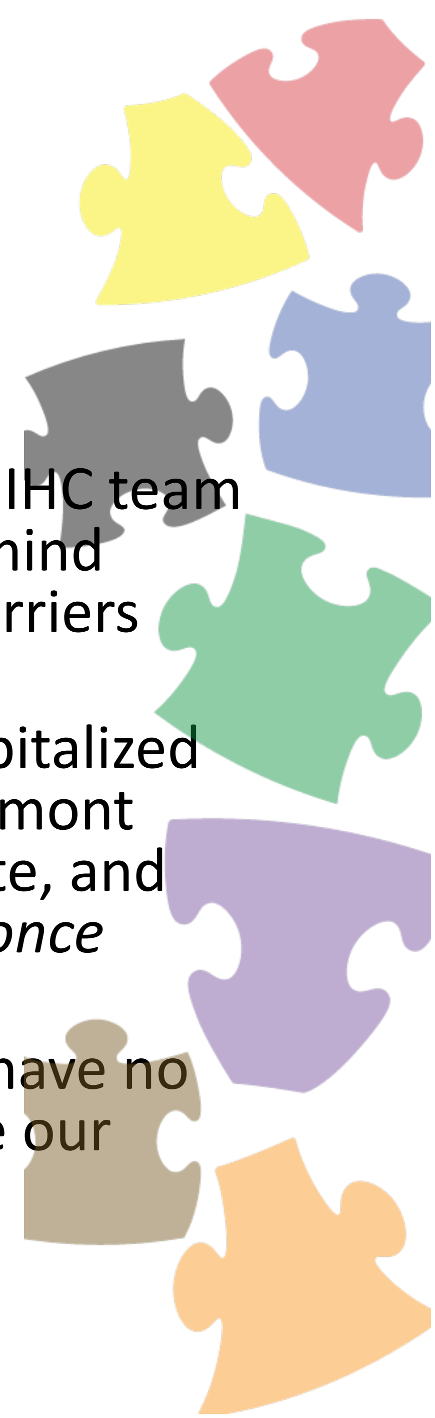
TOP WORK PLACES 2023
Detroit Free Press

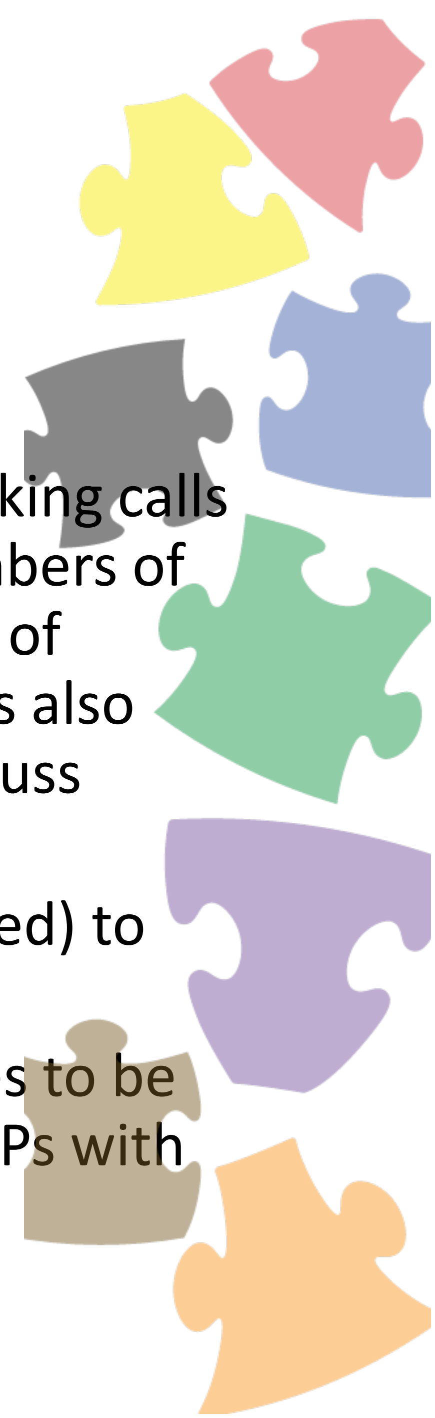
RACIAL DISPARITY INTERVENTIONS



- Peer Agents from DWIHN's Customer Service department work with IHC team to call members on the Transition of Care (TOC) list each week to remind them of their follow-up appointments and attempt to resolve any barriers that would prevent them from attending.
- DWIHN's Crisis Department Clinical Specialists are meeting with hospitalized members who are admitted without a CRSP at BCA Stonecrest, Beaumont Behavioral, and the new Henry Ford Behavioral to engage, collaborate, and improve participation in follow-up services. (*This stopped 4/1/2026 once PAR's were brought in-house to DWIHN*)
- A Clinical Specialist also visits kids at other hospitals at times if they have no CRSP, and DWIHN is partnering with Team, CCIH, and LBS so they use our process to see their members.

RACIAL DISPARITY INTERVENTIONS CONT'D.

- DWIHN's Integrated Care Department's Care Coordinators began making calls to members to remind members including all African American members of their follow-up appointment. Educated members on the importance of keeping their appointment and addressing any barriers. Coordinators also contact hospital social workers prior to a member's discharge to discuss discharge planning.
- DWIHN has contracted with two agencies (Mariners Inn and Godspeed) to provide transportation for non-emergent appointments.
- DWIHN's IT team created an automated drive for racial disparity rates to be available within 24 hours of report. This data assists in providing CRSPs with their most recent data at the 30-day meetings.



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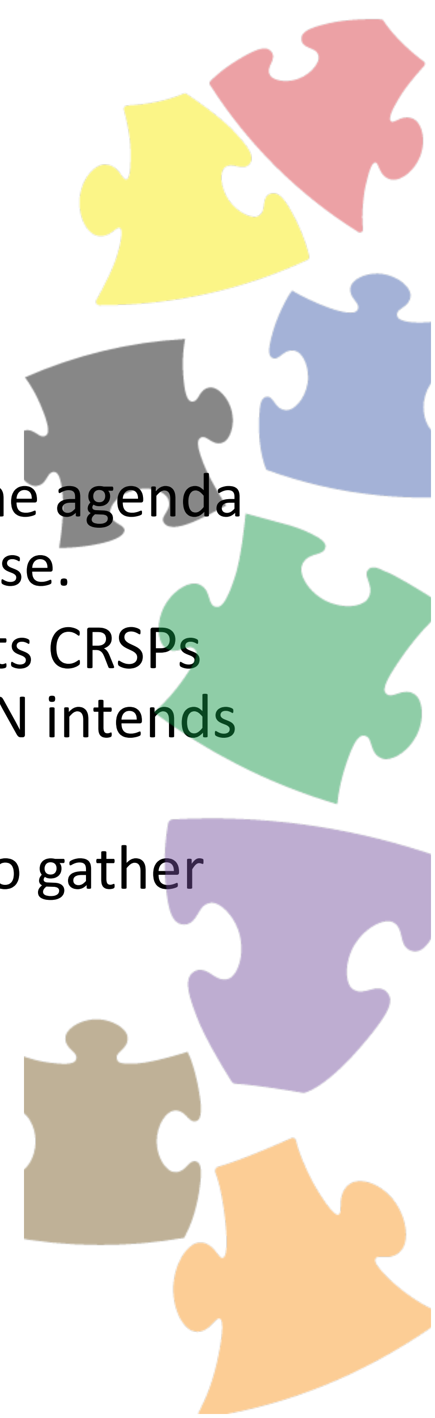
RACIAL DISPARITY INTERVENTIONS CONT'D.



- As of October 2023, DWIHN has added the racial disparity topic to the agenda of the Hospital Liaisons meeting to discuss ongoing issues as they arise.
- As of August 2023, DWIHN started meeting every 45 days with 6 of its CRSPs with the largest number of events and/or greatest disparities. DWIHN intends to continue these meetings until progress is shown.
- DWIHN's Customer Service department completed a phone survey to gather the top barriers for members missing follow-up appointments.

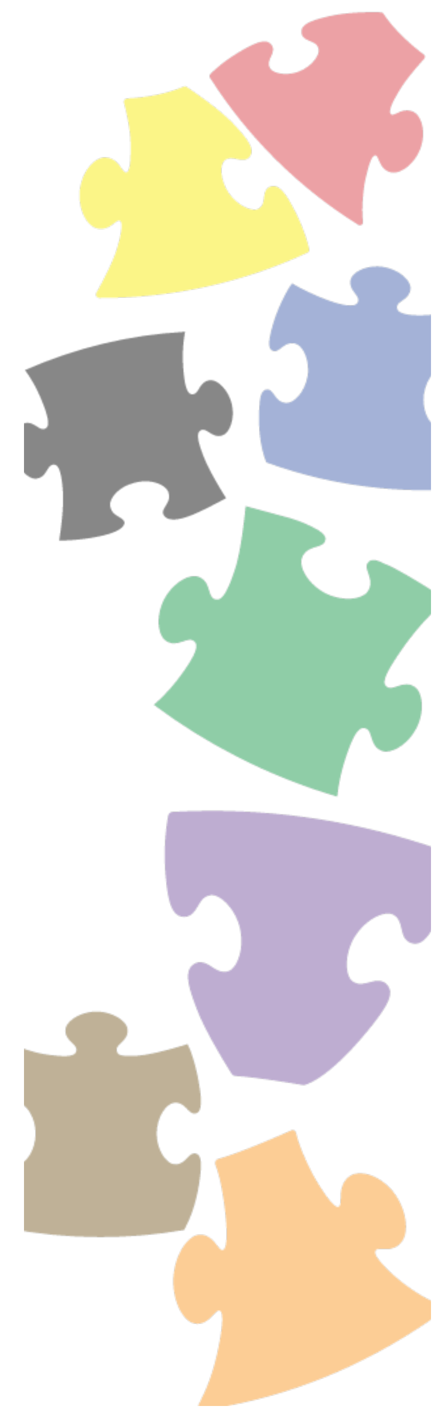
RACIAL DISPARITY DATA

DWIHN Racial Disparity Data

Racial Disparity (%)

Calendar Year	2021 (Baseline)	2022	2023	2024	2025	2026 (Preliminary)
Racial Disparity (%)	4.51%	8.73%	7.57%	4.93%	5.58%	-5.30%

Calendar Year



Goal 1: reduce racial disparity below 4.51%

RACIAL DISPARITY COMPLIANCE DATA

DWIHN 7-Day Follow-Up Compliance By Race

Calendar Year	Black	White
2021	35.65%	40.16%
2022	34.47%	43.21%
2023	33.65%	41.22%
2024	38.66%	43.48%
2025	37.11%	42.69%
2026 (Preliminary)	25.08%	19.78%

Compliance (%) axis: 0.00% – 50.00%; Calendar Year

■ Black ■ White

Goal 2: 40% compliance by race

Racial Disparity Project

- The final resubmission of the racial disparity performance improvement project (PIP) is due to HSAG on May 15th, 2026.
- Questions?

HEDIS Summary Report
System Data/Performance Improvement Plans
Detroit Wayne Integrated Health Network
Quality Improvement Department

HEDIS Finalized System Data 2025

The Quality Improvement Team finalized HEDIS performance data for the January-December 2025 calendar year on March 31, 2025.

Metric	Benchmark	Rate
FUH-30 AD	62.00%	68.16%
FUH-30 CH	79.00%	74.95%
FUH-30 Total	60.76%	68.42%
FUH-7 AD	62.00%	44.01%
FUH-7 CH	79.00%	52.95%
FUM-30 CH	84.33%	80.02%
FUM-30 AD	61.05%	68.67%
FUM-30 Total	70.87%	70.53%
SAA	66.28%	44.53%
SSD	80.99%	69.72%
ADD Initation	64.00%	68.35%
ADD Continuation	76.00%	76.73%
APM Total	27.60%	24.49%
APP Total	65.59%	78.36%

HEDIS Performance Improvement Plans 2025

- The Quality Improvement Team finalized performance data for the January–December 2025 reporting period on March 31, 2026. Performance Improvement Plans (PIPs) will be initiated only for the following measures for which a provider’s compliance is more than 5 percentage points below the benchmark.
- (FUH 30-Adult) Follow Up After Hospitalization for Mental Illness - Follow-up care with a mental health (therapist/Psychiatrist) provider within 30 days. **Benchmark 62.00%**
-
- (FUH 30-Children) Follow Up After Hospitalization for Mental Illness - Follow-up care with a mental health (therapist/Psychiatrist) provider within 30 days. **Benchmark 79.00%**
-
- (SAA) Adherence to Antipsychotics Medication for Individuals with Schizophrenia - Assesses adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period. **Benchmark 66.28%**
-
- (SSD) Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications - Assesses adults 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. **Benchmark 80.99%**

HEDIS PIP Summary Report – Calendar Year 2025
Department: Quality Improvement

PIP Distribution by Measure

Measure	Providers with PIP	Total Providers	% with PIP
FUH 30 – Adult	4	26	15.4%
FUH 30 – Children	12	22	54.5%
SAA	18	25	72.0%
SSD	22	29	75.9%

Thank you!

Quality Team

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PI #2a Narrative Analysis

Quarter 4 vs Quarter 1

Detroit Wayne Integrated Health Network

Quality Improvement Department

Purpose ("Why")

- PI #2a finalized at 51.41% in Q1, below benchmark of 57%
- Decline from 53.71% in Q4 → 51.41% in Q1
- –2.3 percentage point decrease
- Indicates:
- Interventions not sustained
- Gaps in system-level performance
- PI#2a preliminary data for Q2 has an impressive rate of 60.04% which highlights significant improvement from Q1 FY26 and Q4 FY25.

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HEALTHCARE INDUSTRY TOP WORK PLACES 2025

Population-Level Trends

- **Quarter 4 → Quarter 1 Comparison**
- MI Child: 55.59% → 51.29% ↓
- MI Adult: 58.75% → 56.75% ↓
- DD Child: 34.79% → 39.45% ↑
- DD Adult: 74.60% → 61.36% ↓ (largest decline)

Key Takeaway:

- Majority of populations declined
- DD Adult = biggest overall drop while still meeting the goal of 57%

- **Quarter 1 → Quarter 2 Comparison**
- MI Child: 51.29% → 56.37% ↑
- MI Adult: 56.75% → 63.48% ↑
- DD Child: 39.45% → 55.11% ↑
- DD Adult: 61.36% → 68.49% ↑

Key Takeaway:

- PI#2a performance improved across all populations from Q1 to Q2
- Largest gains seen in DD Child and DD Adult populations
- MI Adult exceeded the 57% benchmark
- Reflects strong system-wide improvement
- Continued focus needed to sustain progress

Key Drivers of Non-Compliance

- Appointments scheduled outside 14-day window
- Appointment status issues:
- No-shows
- Cancellations
- Rescheduling
- Limited intake availability
- Staffing and capacity challenges

Data Monitoring Approach

QI team is tracking:

- Requests outside / refused within 14 days
- Reasons for delayed scheduling
- Appointment status:
    - Completed
    - Cancelled
    - Rescheduled
    - No-show

Purpose:

- Identify root cause:
    - Capacity vs process vs client factors
- Drive targeted provider interventions

Current Interventions

- Providers are:
  - Increasing intake staffing
  - Strengthening scheduling practices
  - Improving calendar oversight
  - Expanding appointment availability
  - Implementing staff training on scheduling systems
  - Goal:
    - Improve % of assessments completed within 14 days
- Children's Initiative (DWIHN)
  - Developed Performance Improvement Project for PI# 2a I/DD Children.

Children’s Initiatives

Focus

- Benchmark: **57% (no exceptions)**
- FY26 Q1 IDD Children: 39.45%
- Historical range: ~21%–56%
- Persistent underperformance identified

Barriers

- Staffing shortages (Supports Coordination)
- High caseload sizes
- Limited intake slots
- Increased demand
- Families requesting providers outside 14 days
- Complex onboarding process

Preliminary Q2 data for IDD children has a rate of 55.11% which shows significant improvement from Q1 with a rate of 39.45%

Interventions

- **Current:**
- 45-day provider meetings
- Staffing + caseload tracking
- Core competency trainings
- Financial incentives
- Daily intake availability requirement
- **Proposed:**
- Expand provider network
- Streamline onboarding
- Training on engagement/re-engagement
- Analyze service utilization

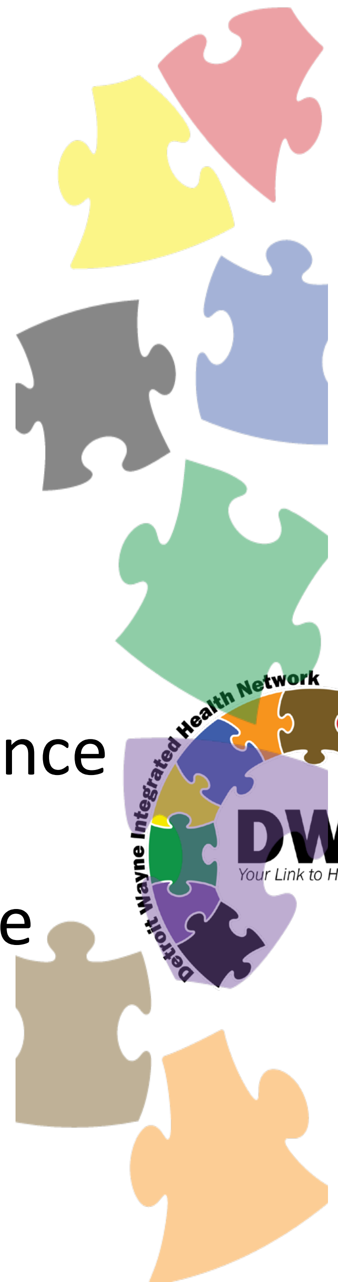
Key Takeaways/Next Steps

Key Takeaways

- Performance declined below benchmark
- System-wide issue, not isolated
- Core barriers remain unchanged:
  - Scheduling outside 14 days
  - Capacity limitations
  - Appointment instability

Next Steps

- Strengthen provider accountability measures
- Expand intake capacity
- Improve scheduling compliance monitoring
- Address no-show/reschedule patterns
- Continue event-level data analysis



Thank you!

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