Dennis R. Jones
Office of Dixon Court Monitor

1111 W. 10th Street
Psychiatry Building
PB, Room A208
Indianapolis, IN. 46202
(317) 278-9130

August 16, 2010

Stephen T. Baron, Director
Department of Mental Health
64 New York Avenue NE
Fourth Floor
Washington, DC 20002

Re: Evidence of Compliance with Exit Criteria #1 – Methods of Measuring Consumer Satisfaction

Dear Mr. Baron,

I have reviewed your letter of June 4, 2010 requesting inactive monitoring status on Exit Criterion #1. This Exit Criterion requires that DMH select specific consumer satisfaction method(s), which must be approved by the Court Monitor and that DMH shall then implement these method(s) so as "to provide timely, accurate and service-specific information". The key factor is that "consumer satisfaction data is being considered and utilized as appropriate to improve the availability and quality of care".

DMH selected three (3) different consumer satisfaction methods and has included these in DMH policy 115.2, (Consumer Satisfaction Methods). I approved these three (3) as of my July 2006 Report to the Court. These methods include: 1) the use of the nationally standardized Mental Health Statistics Improvement Program (MHSIP) Survey regarding consumer satisfaction; 2) random convenience sampling of consumers and; 3) the use of focus groups to obtain feedback from consumers on specific issues or services. The implementation of these consumer satisfaction methods has been via contracts; several different consumer groups have performed the annual MHSIP Survey and the Consumer Action Network (CAN) has conducted the convenience sampling and focus groups methods.

I have reviewed the three (3) specific quality improvement initiatives that have grown out of information received from consumers via the above-referenced methods. These include:

1. The Analysis and Utilization of MHSIP Survey Data – The DMH in the 2009 MHSIP Survey made improvements to the long-standing deficiencies in the MHSIP survey design and protocol, in response to recommendations made by the Internal Quality Committee (IQC). As a result, participation improved by 33% for adults and 27% for children & youth from the 2008 survey. DMH has performed a careful analysis of the 2009 MHSIP results which were presented to the

IQC in April 2010. The IQC has identified four (4) specific satisfaction areas that will require additional analysis before actions steps are taken.

2. Consumer Participation in Treatment – The DMH learned from the 2008 CAN Focus Group Report that many consumers had concerns about lack of participation in treatment planning. As a result, DMH has developed a Quality Review tool that measures markers of consumer involvement in treatment planning. This review tool was implemented as part of the overall pilot phase of the new Provider Scorecard in FY 2009. For FY 2010, the results of the quality reviews, as reported in the Scorecard, will be publicly available to providers and consumers. Consumers can then make informed choices about which provider can best meet their needs – with consumer participation as one of the measures.

3. Medical Co-Morbidity – DMH has targeted the whole issue of the high rate of medical morbidity for individuals with serious mental illness. This problem of premature death due to medical conditions has been widely discussed in national studies and is also evident in DMH's Mortality Review process. Starting in 2008, the IQC began a Quality Improvement Initiative intended to increase the number of consumers linked to primary care providers and to also reduce the number of medically-related adverse incidents. DMH has shown that, as a result of this Initiative, the percentage of consumers linked to primary care increased over the first year from 70.2% to 82% - an increase of 12%. This is an excellent example of DMH utilizing its Quality Wheel (Plan, Do Study, Act).

Based on the above analysis, it is clear that DMH now has an infrastructure in place to perform quality improvement. It is also clear that DMH is utilizing the consumer satisfaction methods to improve the availability and quality of care. Therefore, I recommend that Exit Criterion #1 (Consumer Satisfaction Methods) move to an inactive status.

Dennis R. Jones, MSW, MBA
Dixon Court Monitor

Cc : Anthony Herman, Plaintiffs Counsel
Iris Gonzales, Plaintiffs Counsel
Robert Duncan, Counsel for Court Monitor
Grace Graham, Counsel for District of Columbia

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

Office of the Director

June 4, 2010

Dennis R. Jones, Monitor
1111 10th Street, Suite 201
Indianapolis, Indiana 46202

Re: Dixon et al. v. Fenty, et al.
CA No. 74-285 (TJH)
Evidence of Compliance with Exit Criterion #1 – Methods of Measuring Consumer Satisfaction

Dear Mr. Jones:

I am pleased to report that the Department of Mental Health ("DMH") has met the performance requirements for Exit Criterion #1. Therefore, in accordance with the December 12, 2003 Consent Order Approving Agreed Exit Criteria With Measurement Methodology and Performance Levels (the "Exit Criteria Order"), DMH is formally submitting evidence that the District of Columbia has achieved compliance with Exit Criterion #1, Demonstrated Implementation and Use of Functional Consumer Satisfaction Data.

We request that the Dixon Court Monitor: (1) find that DMH has met the performance requirements for Exit Criterion #1; (2) report on the performance levels to the U.S. District Court as required by the Exit Criteria Order; and (3) cease active monitoring of Exit Criterion #1.

Exit Criterion #1 Requirements.

The Exit Criteria Order includes the following requirements for demonstrating compliance with the performance levels established in Exit Criterion #1:

General Methodology for Measurement:

(a) DMH will select specific consumer satisfaction method(s) and submit them to the Court Monitor for review and approval.
(b) The Monitor will review the implementation of the approved method(s).

Required Performance Levels: Approval shall be based on the ability of the methods to provide timely, accurate and service-specific information. The Monitor will assess the degree to which consumer satisfaction data is being considered and utilized as appropriate to improve the availability and quality of care.

Evidence of Compliance with Measurement Methodology and Required Performance Level

1. **Selection and Approval of Consumer Satisfaction Methods**. DMH selected several methods for measuring consumer satisfaction. These methods include the annual Mental Health Statistics Improvement Program ("MHSIP") survey, random convenience sampling and focus groups.[1] In your July 2006 Report to the Court (the "July 2006 Report"), you approved the DMH selected methods for measuring consumer satisfaction.[2]

2. **Implementation of Approved Consumer Satisfaction Methods**.

(a) The MHSIP Survey. DMH conducts an annual consumer survey pursuant to the terms of the Data Infrastructure Grant from the U.S. Department of Health and Human Services, Substance Abuse Mental Health Services Administration ("SAMHSA") (the "DIG"). DMH uses the MHSIP survey for adults and the Youth Services Survey for Families ("YSS-F") to survey the parents and guardians of children. The DIG mandates the format and questions used for both the MHSIP and the YSS-F.[3] The MHSIP and the YSS-F are sometimes collectively referred to as the "MHSIP."

(b) Periodic Convenience Sampling and Focus Groups. In 2003, DMH contracted with the Consumer Action Network, a consumer-operated organization ("CAN") for a series of projects relating to consumer satisfaction.[4] This contract remains valid. CAN continues to conduct regular convenience surveys about consumer satisfaction and periodic focus groups to inform DMH of the needs and desires of consumers.

3. **On-going Consumer Satisfaction Data Reporting and Quality Improvement Activities**

You have discussed DMH's quality improvement program extensively in your July reports since 2007.[5] As you know, DMH has implemented a series of steps to ensure that consumer satisfaction data is fully integrated and utilized in existing and future quality improvement

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[1] *See* DMH Policy 115.2, Consumer Satisfaction Methods,
[2] *See* July 2006 Report to the Court, page 4.
[3] You have been provided with copies of the MHSIP and YSS-F reports and have commented about the MHSIP and YSS-F reports in your reports to the Court beginning in July 2006.
[4] You have been provided with copies of the CAN reports and have commented about the CAN reports in your reports to the Court beginning in July 2006.
[5] *See* July 2007 Report to the Court, page14; July 2008 Report to the Court, pages 16 - 17; and July 2009 Report to the Court, pages 15 - 16.

activities based on identified needs. The DMH Internal Quality Council ("IQC")[6] is responsible for the oversight of this process.

The IQC reviews and approves the reports developed as a result of the data collection activities (primarily the MHSIP, Focus Groups and Convenience Sample although other methods are also used). The members of the IQC[7] make recommendations regarding the reports during the review and approval process. Specific activities include:

- Identification of agency priority areas for quality improvement;
- Recommendations for improvements in data collection and survey methods, including access and participation;
- Additional information gathering and/or analyses to clarify identified issues;
- Identification of existing Quality Improvement ("QI") activities or initiatives or development of new QI activities or initiatives which address identified priority areas; and
- Recommendations to program managers, directors and other leadership for further action and monitoring.

The IQC has recommended several QI activities and several QI initiatives based upon the consumer satisfaction survey data. For the purpose of providing evidence about compliance with the requirements of Exit Criterion #1, DMH is submitting the following information about three such activities.

(a) The MHSIP Survey. As discussed in your reports to the Court, one of the initial QI activities relating to the use of consumer satisfaction data involved the review and analysis of the FY 2007 MHSIP data[8]. This QI activity began during the first quarter of FY 2009 (November 2008)[9]. As a result of the analysis conducted by the IQC, recommendations were made regarding enhancements to the protocol for conducting the MHSIP. Those recommendations were implemented in FY 2009 and included the following: (1) use of mail surveys to supplement the telephone survey; and (2) use of a $10.00 incentive gift card for participants. The use of these techniques increased the likelihood of improving both the number and representativeness of the survey sample. As expected, the number of participants increased by approximately 33% for adults and 27% for children and youth from the year before, and it is

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[6] *See* Discussion about the role of the DMH Quality Council and the Internal Quality Council with respect to consumer satisfaction in the July 2006 Report to the Court, page 4; January 2007 Report to the Court, page 9; July 2007 Report to the Court, pages 4 – 5; January 2008 Report to the Court, page 8; July 2008 Report to the Court, pages 8 and 17; January 2009 Report to the Court, pages 5 – 6; July 2009 Report to the Court, pages 4 – 5 and 15 – 16; and January 2010 Report to the Court, pages 4 – 5.

[7] The IQC meets monthly and is comprised of the DMH Director of QI, Chief Clinical Officer, Director of Provider Relations, Director of Organizational Development, Manager of Applied Research and Evaluation, Risk Manager, the Director of OA, OA's Data Analyst, and staff from the Saint Elizabeths Hospital Division of Performance Improvement.

[8] The MHSIP workgroup began this analysis in November 2008. *See* July 2009 Report to the Court, pages 5 – 6.

[9] The FY 2008 MHSIP was conducted during August and September 2008. The final report was not available when the IQC began reviewing the MHSIP data in November 2008. However, the results were reviewed by the IQC and were considered when the IQC made recommendations about changes to the survey protocol.

suspected that the addition of these techniques is responsible for these increases. The results of the 2009 MHSIP have been analyzed and revealed:

- 83% of participating adults, and 76% of participating parents reported overall perceived satisfaction with care, self-reported functioning and outcomes;
- Adult and parent survey response patterns mirror results of other states that utilized a more robust random sample methodology;
- Adult participants rated access and quality and appropriateness of care amongst the most favorable aspects of service delivery;
- Parents of children and youth tended to rate cultural sensitivity and participation in treatment as the strongest aspects of service delivery;
- Perceptions of functioning and outcomes received the lowest ratings within the adult and parent samples; and
- Differences emerged in responses by gender, race/ethnicity, diagnosis and MHRS service utilization which will facilitate the development and implementation of targeted practice improvement and quality assurance activities.

A copy of a quality wheel illustrating the quality improvement process with respect to the 2007, 2008 and 2009 MHSIP is attached and marked as ***Exhibit A***.

The results of the FY 2009 MHSIP were presented to the IQC in April 2010. The IQC has made recommendations about focus areas for the remainder of FY 2010 and FY 2011 based upon the analysis of the FY 2009 MHSIP. DMH is currently implementing the next Plan, Do, Study, Act QI cycle with regard to the use of this consumer satisfaction data. There are four (4) areas identified: (1) perform cluster analyses regarding outcomes, functioning and social connectedness; (2) reduce dissatisfaction among ACT consumers; (3) analyze data from FY2009 and FY2010 community support QI initiatives and the MHSIP community support data; and (4) develop analysis regarding demographic data for both adults and children to address discrepancies in satisfaction with care.

(b) As consumer satisfaction data is received, stratified, and analyzed throughout FY2010, QI interventions are being developed for implementation in FY2011. OA, in collaboration with the IQC, utilizes this additional MHSIP analysis for the continuous development of QI Initiatives and service improvements. Additionally, the FY 2011 QI Initiatives build upon the ongoing analysis of the Community Support FY 2010 QI Initiative. The FY 2011 QI Initiatives will be rolled out to providers in the first quarter of FY 2011.Consumer Participation in Treatment Planning. In FY 2009, after review of CAN's 2008 Focus Group report and consumers' expressed concerns about lack of participation in the development of treatment plans, including the development discharge planning from the hospital, the Office of Accountability implemented a quality improvement activity to address concerns about consumer participation in treatment planning. First, OA developed a Quality Review tool designed to measure markers of consumer involvement in treatment planning. Next, OA conducted quality reviews of twenty (20) providers and reviewed over three hundred (300) patient charts. Data was collected and assessed regarding consumer participation in treatment

planning. At the same time, OA developed a pilot Provider Scorecard designed to test the quality review process in FY 2009.

After the quality reviews were completed for FY 2009, the data collected was compiled, analyzed, and fed into the Provider Scorecard. The FY 2009 Provider Scorecard data, including data about consumer involvement in treatment planning was made available to providers for remedial purposes.[10] The results of the FY 2010 quality reviews will be compiled, analyzed and reported in a Provider Scorecard, which will be published and available for consumers to review and consider as part of the provider selection process. A copy of a quality wheel illustrating the quality improvement cycle with respect to the quality reviews and examination of consumer involvement in treatment planning is attached and marked as ***Exhibit B***.

(c) Medical Co-Morbidity QI Initiative. In 2008, the IQC identified continuity of care between physical health and mental health as an important issue that could be addressed through a QI initiative.

In addition to the national literature on the high rate of medical morbidity of individuals with serious mental illness, the Office of Accountability identified a similar trend through the Mortality Review process. Perhaps, most importantly, this was known to be an issue of general concern for DMH consumers. The DMH Medical Co-Morbidity QI initiative was designed to increase the number of consumers linked to primary care providers and to reduce the number of medically related adverse incidents.

DMH through its Office of Accountability embarked on a major effort to determine the system's performance in the area of coordination of mental health and primary health care. On August 7, 2008, providers were directed to review thirty (30) clinical records each quarter to ascertain whether there was appropriate coordination of behavioral health and primary care. Satisfactory evidence of linkage to primary care included: the name of the primary care provider, a copy of a physical examination performed within the year, date of last physical examination as reported by consumer, laboratory results within the year, a referral for primary care, medications documented for medical conditions listed in the clinical record and communications between the MHRS provider and the primary care provider. Providers were also directed to link consumers with an Axis III diagnosis to primary care during the following quarter, if there was no evidence of a primary care linkage in the clinical.

As a result of this QI initiative, 1943 consumers were sampled, of which 1365 (or 70.2%) were linked to a primary care physician when their charts were first examined. By the end of the fiscal year, an additional 12% had been linked to primary care, for a total of 1586 consumers linked to a primary care physician. The rate of consumer linkage to primary care physician for the entire sample over the year was 82%.

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[10] Since the FY 2009 Provider Scorecard data was collected for purposes of piloting the quality review instrument and the scorecard, DMH made a commitment to providers that the data would not be published.

The results of the FY 2009 Medical Co-Morbidity QI initiative were presented to providers at a Quality Council meeting on December 10, 2009. A copy of the slide from the presentation used during the Quality Council meeting is attached and marked as ***Exhibit C***.

The CAN Consumer Focus Group report was issued in August 2009 (the "CAN 2009 Focus Group Report"). The report included results that reinforced DMH's recognition of the concern about coordination with primary care. Specifically, the report stated: "Consumers have a tough time finding a primary care doctor and or CSA." This report further stated that "continuity of care between physical health treatment and mental health treatment was another major issue that was a shared concern among focus group participants." In addition, "[consumers] felt like they did not have ready access to physical health treatment when they needed it." Consumers also "stressed their desire to have their treatment team collaborate closely with their physical health provider to know exactly what their outstanding health issues are."

As a result of the data collected from the FY 2009 Medical Co-Morbidity QI and the information provided by the CAN 2009 Focus Group Report, the IQC recommended continuing and refining the Medical Co-Morbidity QI Initiative during FY 2010. The FY 2010 Medical Co-Morbidity QI requires that provider's self report data about two groups of consumers. The first group is a random sample of 15 consumers who will be tracked throughout the entire fiscal year. The second group is a random sample (the sample size is proportionally based upon the size of the provider agency and determined by OA) that will change each quarter. Providers will be asked to report on: (1) there is documentation in the clinical record about the consumer's general medical condition from the primary care provider; and (2) whether the IRP includes a plan for addressing medical conditions identified on Axis III. Data is reported quarterly to OA. A copy of the letter notifying providers about the FY 2010 quality initiatives is attached and marked as ***Exhibit D***. A quality wheel showing the process for integrating consumer satisfaction data into the Medical Co-Morbidity QI Initiative is attached and marked as ***Exhibit E***.

During the Adult Community Service Review ("CSR") data debriefing on May 14, 2010, Dr. Ivor Groves, team leader for the CSR, noted that coordination and linkage with primary care was one of many strengths noted by reviewers. This suggests that the FY 2009 and FY 2010 Medical Co-Morbidity QI has been effective in generating system change and improving the coordination of care.

Conclusion.

As a result of the various QI activities described above, DMH has met the performance requirements for Exit Criterion #1. It is clear that, as required by Exit Criterion #1, "consumer satisfaction data is being considered and utilized as appropriate to improve the availability and quality of care." DMH has developed and implemented a system through the IQC to consider consumer satisfaction data and to develop quality improvement initiatives to address needed system change. DMH has implemented quality improvement initiatives designed to effectuate system change, beginning in FY 2009 and continuing in FY 2010. Accordingly, DMH hereby requests that the Dixon Court Monitor: (1) find that DMH has achieved the performance levels

required for Exit Criterion #1; (2) report on the performance levels to the U.S. District Court; and (3) cease active monitoring of Exit Criterion #1.

If you have any questions or wish to discuss this matter further, please feel free to call me.

Sincerely,

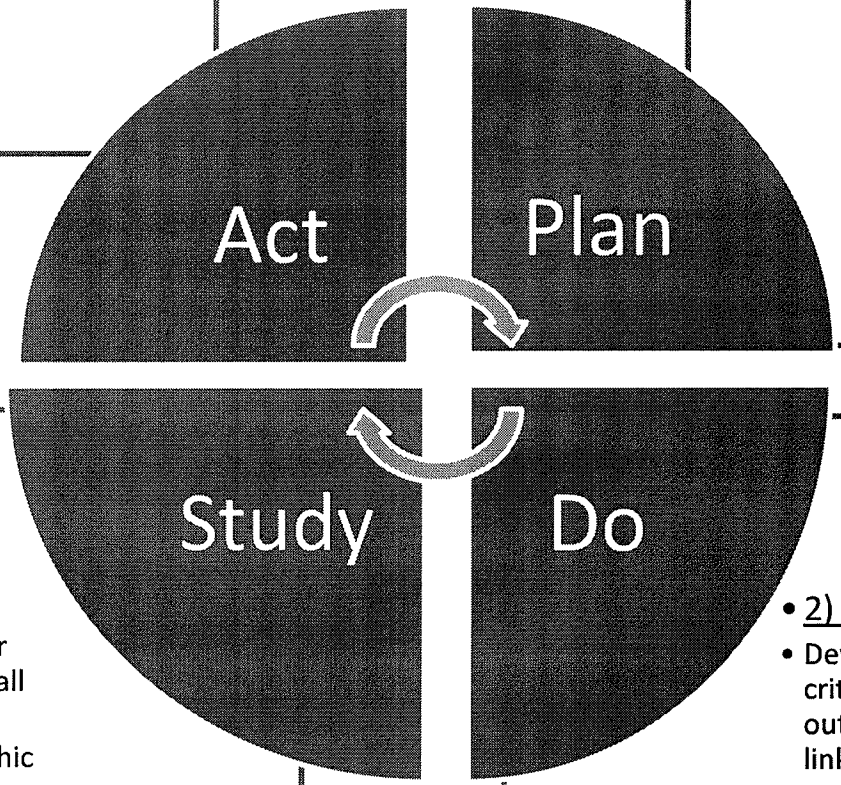
Stephen T. Baron
Director

Cc: Anthony Herman, Counsel to the Dixon Plaintiffs
Grace Graham, Counsel for the District of Columbia

EXHIBIT A

EXHIBIT A
MHSIP

- 4) Act
- IQC met to begin review & analysis of FY09 MHSIP cycle.
- MHSIP workgroup to continue CQI for MHSIP implementation.



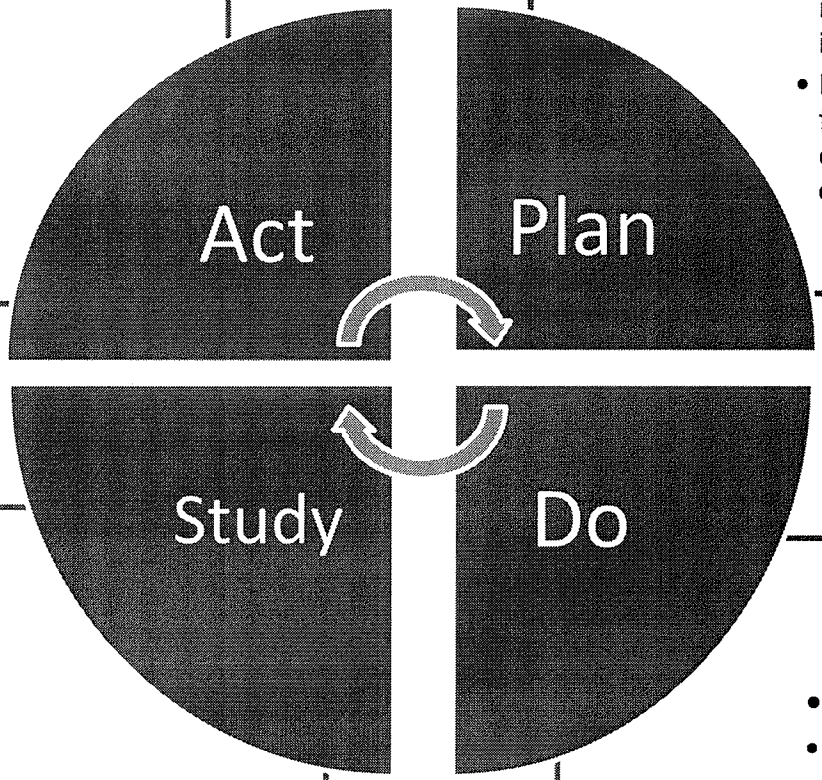
- 1) Plan
- Using consumer satisfaction data to plan and implement QIIs requires usable data.
- During FY09, DMH IQC determined MHSIP data for FY07 and FY08 was insufficient for analysis and planning.
- IQC identified changes to MHSIP protocol
- MHSIP workgroup was established.

- 3) Study
- New protocols returned better data & higher number of overall responses.
- Analyzed data with demographic and service information.
- Developed service improvements and special population recommendations.
- Results to IQC and major stakeholders for further study and interpretation.

- 2) Do
- Developed new implementation criteria including: new sampling & outreach procedures, incentives, linkage to other DMH data.
- Cleaned and updated contact information to increase response rate.
- Conducted FY09 survey Oct. 09- Feb. 10.

EXHIBIT B

EXHIBIT B
Treatment Plan Involvement



- 4) Act
- FY09 consumer participation data presented to providers for remedial purposes.
- FY10 Quality Reviews will assess changes in treatment planning participation data, and inform further CQI.
- FY10 publication of Scorecard designed for consumer use in selecting providers.

- 1) Plan
- IQC identified consumer participation in treatment planning for QI from 2008 CAN Focus Group Summary, .
- Designed Quality Review (QR) tool to measure markers of consumer involvement in treatment planning.
- Developed Pilot Provider Scorecard for FY09 to test QR process and enable future publication to promote consumer choice.

- 3) Study
- Compiled, analyzed, and fed consumer participation data into Provider Scorecard.
- Scorecards register consumer participation in treatment planning.

- 2) Do
- Conducted QRs throughout FY09.
- Visited twenty (20) providers; reviewed over 300 consumer charts.
- Collected and assessed data regarding consumer participation in treatment planning.

EXHIBIT C

EXHIBIT C

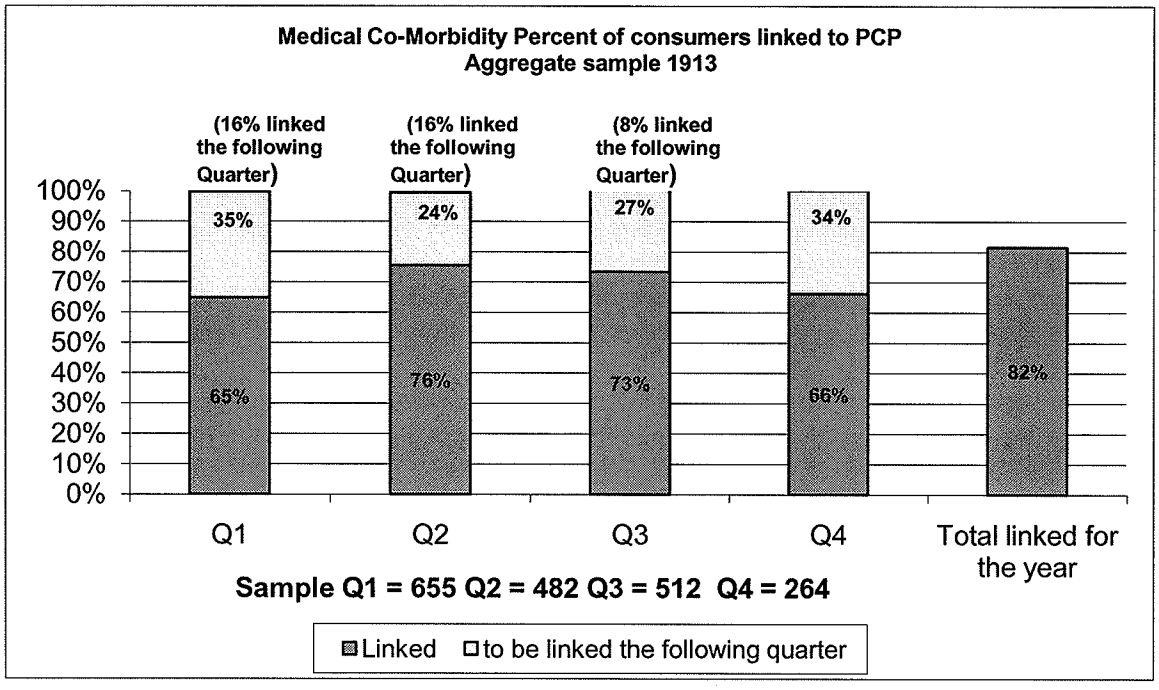

Medical Co-Morbidity Percent of consumers linked to PCP
Aggregate sample 1913
(16% linked the following Quarter)
(16% linked the following Quarter)
(8% linked the following Quarter)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
35%
65%
24%
76%
27%
73%
34%
66%
82%
Q1
Q2
Q3
Q4
Total linked for the year
Sample Q1 = 655 Q2 = 482 Q3 = 512 Q4 = 264
Linked
to be linked the following quarter

EXHIBIT D

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

December 10, 2009

Dear MHRS Quality Improvement Director:

As we discussed at the last quarterly DMH Quality Council meeting, the Department is launching new mandatory community based quality initiatives for FY 2010. The FY 2010 Quality Improvement Initiatives were derived from the Office of Accountability's analysis of trends in major reportable incidents, mortality review, major investigations, and the FY 09 QI initiative outcomes. The 2010 QI Initiatives also include recommendations from the DMH Internal Quality Committee. The FY 2010 Quality Improvement Initiatives are as follows:

(1) Medical Co-Morbidity:

You are required to track *two* groups for this initiative in FY 2010. The first group is a random sample of fifteen (15) consumers that you will monitor across all four quarters. The second group is a random sample of consumers proportional to the size of your agency. The consumers in the second group will change each quarter. The Office of Accountability will provide you with the sample size for the second group.

Each core service agency will internally review these records on a quarterly basis to ascertain whether:

a. The CSA has any current documentation on the consumer's general medical condition from the primary care provider *and*;
b. The CSA's IRP includes a plan for addressing medical problems identified on Axis III. This includes the utilization of SQIP brochures, posters, and handbooks for health teaching.

For the purposes of this QI Initiative, general medical conditions should be listed on Axis III. Examples of current documentation from the primary care provider include: a physical examination performed within the year, laboratory results from the primary care provider within the year, current list of medications from the primary care provider.

CSAs with consumers in the sample who have an Axis III diagnosis and do not meet criteria (a) or (b) should request the primary care treatment records and revise the IRP to include a plan for addressing medical problems by the following quarter.

(2) Clinical Supervision:

During the 1st Quarter of this QI Initiative, each CSA will be asked to submit its ***Supervision and Peer Review Policy.*** Then, thirty (30) clinical records will be reviewed quarterly by each CSA for (a) documentation of clinical supervision on the consumer's medical record, and (b) documentation of clinical supervision in the personnel file for the credentialed staff providing services to the consumer.

(3) **Community Support Service Utilization:**
Each core service agency will internally review thirty (30) records on a quarterly basis for consumers who have high utilization of community support (more than 60 units per quarter, group and/or individual). The review will focus on assessments, treatment plans, monthly progress notes, and consumer's response to interventions; query the presence of clinical justification for the longevity, frequency, and duration of community support; determine if service levels of community support meet the criteria for medical necessity.

These initiatives will be monitored during the next twelve months. Report your quarterly data findings on these initiatives to the Office of Accountability (OA). The due dates for quarterly data submissions to OA are as follows:

FY 2010 Quarter Data Range	Date for Submission to OA
Q1: 10/1/09 – 12/31/09	February 1, 2010
Q2: 1/1/10 – 3/31/10	May 1, 2010
Q3: 4/1/10 – 6/30/10	August 1, 2010
Q4: 7/1/10 – 9/30/10	November 1, 2010

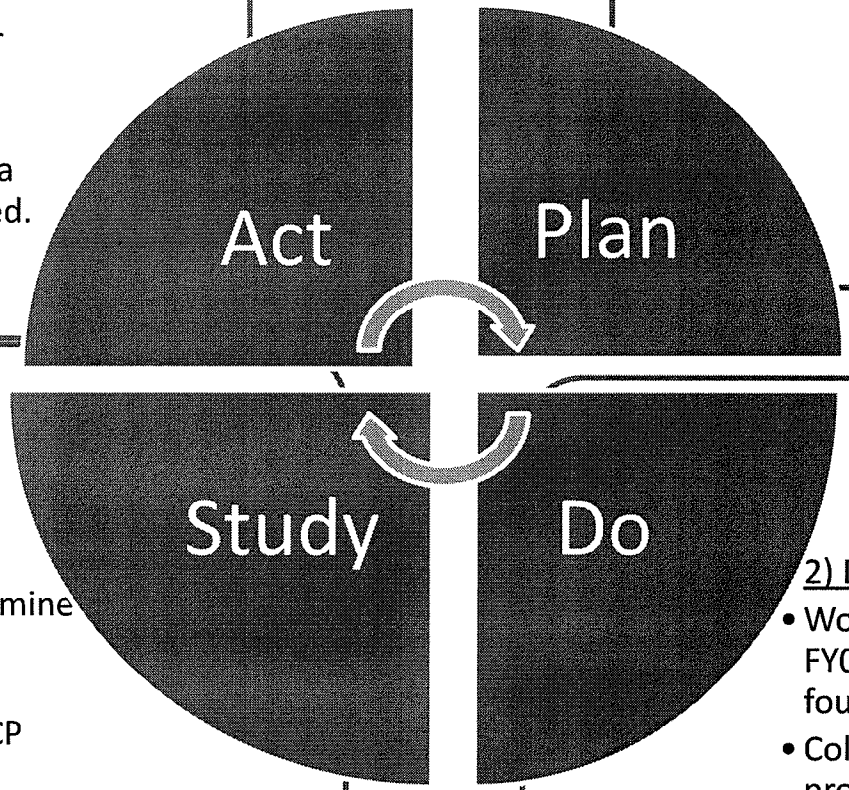
If you have any questions about these QI Initiatives, then please contact me at (202) 673-2255 or atiya.frame@dc.gov. The next meeting of the Quality Council will be held on March 18, 2010 at 9:30 a.m. I look forward to seeing you there to review the data submissions for the 1st quarter of FY 2010.

Sincerely,

Atiya Frame-Shamblee
Director of Quality Improvement
DMH Office of Accountability

EXHIBIT E

EXHIBIT E
Medical Co-Morbidity



- 4) Act
- Suggested expansion of Medical Co-morbidity QII based on CQI principles.
- Launched modified, more extensive QII for FY10.
- Expanded sample population, more data identified and collected.

- 1) Plan
- IQC identified consumer concerns re continuity of medical health care as CQI target.
- Developed quality improvement initiative (QII) for FY09 to measure & improve linkage of consumers with PCPs.
- Developed implementation guidance for providers with request to link consumers to PCP when no link found.

- 3) Study
- Analyzed final data to determine outcome & plan follow-up initiative.
- 70% of patients linked to PCP before QII.
- 40% of those not linked were linked during QII.
- Final result: 82% sampled consumers linked to a PCP at QII conclusion.

2) Do
- Worked with providers over FY09 to implement QII over four quarters.
- Collected data, met with providers, tracked results.
- Providers tasked to track consumers not linked to PCP & attempt to link to care.