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Owner	monica Hampton: Clinical Specialist
Policy Area	Children Services
Applicability	Detroit Wayne Integrated Health Network

Intensive Care Coordination with Wraparound (ICCW)

POLICY

It is the policy of the Detroit Wayne Integrated Health Network (DWIHN) to provide Intensive Care Coordination with Wraparound (ICCW) services that promote and support youth, under the age of 21 to live in the community with their families and achieve improved functioning in their homes, schools and communities, using a strength-based model.

PURPOSE

The purpose of this policy is to ensure the DWIHN, contractors and subcontractors provide promising practices within the continuum of services in order to promote the best interest of the youth receiving services.

APPLICATION

1. The following groups are required to implement and adhere to this policy:
    a. DWIHN Board
    b. DWIHN PIHP Staff includes the following
        1. DWIHN PIHP Staff
    c. Contractual Staff
    d. Clinically Responsible Service Provider (CRSP) and their subcontractors
    e. Specialty Providers,
    f. Crisis Services Vendors,

g. Credentialing Verification Organization (CVO),
h. Designated Collaborating Organizations (DCO),

2. This policy serves the following populations: Children up to their 21st birthday,
    a. Individuals with Intellectual and/or Developmental Disabilities (I/DD)
    b. Serious Emotional Disturbance (SED)
    c. Substance Use Disorder (SUD)
    d. Severe Mental Illness (SMI)
    e. Autism
3. This policy impacts the following contracts/service lines:
    a. Medicaid
    b. SUD
    c. Autism
    d. Grants

KEYWORDS

1. Contractor
2. Case Record
3. Serious Emotional Disturbance Waiver (SEDW)
4. Certified Mental Health Professional (CMHP)
5. Ecosystem
6. Family Member
7. Family-Driven
8. Person-Centered Planning
9. Youth
10. Serious Emotional Disturbances (SED)
11. Intellectual and/or Developmental Disability (I/DD)
12. Qualified Intellectual Disabilities Professional (QIDP)
13. Service Provider
14. System of Care (SOC)
15. Intensive Care Coordination with Wraparound (ICCW) is an evidence-informed approach to ensuring comprehensive coordination and holistic planning for children, youth, young adults, and their families with the most intensive needs. ICCW is an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) State Plan service when delivered to children, youth, and young adults under 21 years of age.
16. Wraparound Plan

17. Youth Guided

STANDARDS

1. **Responsibility of DWIHN:**
    a. Coordinate local activities to ensure ongoing development and maintenance of an infrastructure that supports the fidelity, quality and workforce development of Intensive Care Coordination with Wraparound (ICCW) in Wayne County.
    b. Participate in all statewide ICCW activities related to model fidelity, development and implementation to ensure ICCW in Wayne County aligns with Michigan Department of Health and Human Services (MDHHS) standards.
    c. Ensure the model is developed and maintained with Wayne County's System of Care for children with Serious Emotional Disturbance (SED), Severe Mental Illness (SMI) & Intellectual and/or Developmental Disability (I/DD) in order to promote the values, practices and principles of SOC within DWIHN's continuum of services for children.
    d. Ensure availability and access to ICCW when clinically and developmentally appropriate.
    e. Provide oversight and technical assistance to all ICCW service providers under DWIHN in Wayne County.
2. **Responsibility of the ICCW Service Provider:**
    a. Shall ensure that adherence to this policy, including development, implementation and monitoring of any policies and procedures relevant to this policy, is carried out with regard for the cultural, ethnic, gender and community values of the minors and families.
    b. Shall collaborate with systems that are likely to affect the lives of youth and their families, with an effort toward influencing an outcome that supports youth living with their families. This includes, ensuring that the coordination of services and programs occurs within the community to better support improved functioning in the home, school and community of the youth.
    c. Shall demonstrate and document activities that engage families in collaborative partnerships and community support systems that are sufficiently comprehensive to support youth living with their families and support improved functioning in their home, school and community.
    d. Shall develop, administer, provide and coordinate services which are family focused within the context of the ICCW and Person and Family Driven Planning Models.
    e. Obtain certification in MichiCANS if responsible for the completion of the annual MichiCANS
    f. Shall participate in local meetings and adhere to DWIHN reporting protocols.
    g. Shall ensure that children/youth with I/DD who receive ICCW services, do not also receive Supports Coordination at the same time.
    h. Every ICCW provider must also provide the Serious Emotional Disturbance Waiver (SEDW) and hold capacity to serve youth in the SEDW.

i. Must request and receive MDHHS approval through a certification process defined by MDHHS prior to ICCW provision. Certification must occur every three years. ICCW programs are to be certified to ensure adherence to Medicaid policy requirements and fidelity to the ICCW model.

3. **Responsibility of the Community Team:**
    a. The purpose of the Community Team is to assist in barrier busting at a community organizing level as well as address issues/concerns that are affecting the community in which providers serve. The Community Team shall:
        1. Include children, youth, young adults and parents/caregivers with lived experience and local system and community partners.
        2. Work collaboratively to address barriers, provide support, and identify available community services and programs for children, youth, and families.
    b. The membership of the Community Team should be those individuals who can support the work of the Child and Family Teams and the ICCW process. The Community Team should reflect the uniqueness of the community. Team membership should include but not limited to:
        1. Administrators and mid-managers of public agencies providing services, Department of Health and Human Services (DHHS), Community Mental Health, ICCW Supervisors, Care Coordinators, Public Health, Schools, Probate and Family Court.
        2. Parents and youth who have experience with ICCW services.
        3. Community members which may include private non-profit administrators or mid-managers, local business people, faith-based, civic leaders, and other community leaders with an interest in children and families.

4. **Qualified Staff**:
    a. Possess a Bachelor's Degree in any field. Be designated as a Child Mental Health Professional (CMHP) (when overseeing provision to SED youth) and/or Qualified Intellectual Disabilities Professional (QIDP) (when overseeing provision to Intellectual/Developmental Disabilities [I/DD] youth).

5. **New Care Coordinator Provisional ICCW Request** :
    a. Inform MDHHS Statewide ICCW Coordinator that you have a new ICCW staff
    b. Complete Provisional request for ICCW (return form to MDHHS Statewide ICCW Coordinator)
    c. Register for the first day “orientation” session, staff will receive an email with a link from the MDHHS Capacity Building Center (CBC) to register. After the orientation session is completed, Care Coordinators will register for the three half-day ICCW Certification training, these will be available to register on the CBC website. (The full ICCW Certification is four half-days, the orientation and the certification training).
    d. If an ICCW Care Coordinator departs from an agency, please inform the MDHHS Statewide ICCW Coordinator. There is a requirement to keep an ongoing list of Care

Coordinators for training purposes.

6. **Care Coordinators must:**
    a. Receive certification in ICCW through MDHHS-provided training or have been granted provisional approval prior to provision.
    b. Maintain certification in ICCW:
        1. Complete one annual ICCW booster.
        2. Complete at least two MDHHS-provided trainings related to ICCW.
        3. Complete an additional 16 hours of training (annually) related to provision of support to children, youth, or young adults and their families when providing ICCW to those served under the SEDW.
    c. Participate in and complete MDHHS-required evaluation and fidelity measurements.
    d. Provide full scope of ICCW and facilitate the Wraparound Planning Process to model fidelity to develop a Wraparound Plan.
    e. Participate in Person-Centered Planning Process training, including Self Determination.
    f. Facilitate the Person-Centered Planning Process in alignment with family-driven and youth-guided guidelines in adherence to applicable policy to develop an Individual Plan of Service (IPOS).
    g. Obtain certification in MichiCANS if responsible for the completion of the annual MichiCANS.
    h. Demonstrate knowledge of State Plan and SEDW service array and community resources and programs.
    i. Attend Community Team meetings as needed to support their Wraparound Teams.
    j. Care Coordinators may not have more than one provider role with a family. If Care Coordinators are providing other mental health services, including crisis response, they may not provide ICCW to the same child, youth, or young adult and their family.
    k. If Coordinators are assigned to other programs as well as ICCW, the number of child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing Wraparound facilitation.

7. **The ICCW Supervisor must:**
    a. Oversee ICCW, including evaluation.
    b. Receive/process referrals and assign children, youth, or young adults and their families to Care Coordinators.
    c. Adhere to policies/procedures that align with ICCW.
    d. Organize and facilitate Community Team meetings quarterly, at minimum.
    e. Participate in Person-Centered Planning Process training, including Self Determination.
    f. Obtain certification in MichiCANS if providing supervision to a Care Coordinator who

is responsible for completion of the annual MichiCANS.

g. Receive certification in ICCW through MDHHS-provided training prior to supervision of Care Coordinators.

h. Maintain certification in ICCW:

1. Complete one annual ICCW booster.
2. Complete at least two MDHHS-provided trainings related to ICCW, one of which must be supervisor specific.
3. Complete an additional 16 hours of annual training related to provision of support to children, youth, or young adults and their families when supervising the provision of ICCW to those served under the SEDW.

i. Provide weekly, individualized supervision and coaching to Care Coordinators and maintain a supervision log.

j. Maintain partnership with child, youth, or young adult and family community programs, systems, and partners.

k. Ensure Care Coordinators have knowledge of State Plan and SEDW service array and community resources and programs.

l. Ensure families and staff have access to a directory of community resources, systems,

m. Participate in the monthly DWIHN ICCW Project Team meetings.

n. Complete the FRAMES Competency Tool on a quarterly basis with each Care Coordinator.

8. **ICCW Program Administrators must**:

a. Attend ICCW 101 Training.

b. Attend one annual ICCW booster.

c. Provide direct oversight of ICCW Supervisors.

d. Provide local oversight of ICCW.

e. Align internal policies and procedures, contracts and/or memorandums of understanding with Wraparound philosophy and ICCW policy.

f. Broker services as needed.

g. Secure local partnership with child, youth, or young adult and family community programs, systems and partners

9. **Organization Structure:**

a. The required organizational structure of Wraparound ICCW must include a Child and Family Team, ICCW Care Coordinator, ICCW supervisor, and Community Team.

b. ICCW Care Coordinator Caseload Ratio (dedicated caseload):

1. 1:12 Care Coordinator to Wraparound Teams.
2. The dedicated ratio may increase to a maximum of 1:15 when at least

three Wraparound Teams are in the Hope phase.

3. Care Coordinators may not have more than one provider role with a family. If Care Coordinators are providing other mental health services, including crisis response, they may not provide ICCW to the same child, youth, or young adult and their family.
4. If Coordinators are assigned to other programs as well as ICCW, the number of child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing Wraparound facilitation.

c. ICCW providers must request approval to provide ICCW from MDHHS through a certification process defined by MDHHS, and certification must occur every three years. Programs must be certified to ensure adherence to Medicaid policy requirements and fidelity to the ICCW model.

10. **Services Delivery Procedure:**

a. ICCW serves children and youth up to age 21, who reside in Wayne County and have been diagnosed with a SED, I/DD, or an SMI who are involved in multiple systems and are at the highest risk of removal from their home and community or have been removed from their home and community.

b. ICCW is an evidence-informed approach to ensuring comprehensive coordination and holistic planning for children, youth, young adults, and their families with the most intensive needs. ICCW is an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) State Plan service when delivered to children, youth, and young adults under 21 years of age

c. ICCW requires the development of a Wraparound Team. The Team must be coordinated prior to the development of and adjustments to the Wraparound Plan. Wraparound Teams include, but are not limited to, the youth, child, or young adult and their family, natural supports, professional supports, and community partners. In the limited circumstance in which a child, youth, young adult, or parent/caregiver is unable to attend a Wraparound Team meeting, Care Coordinators are responsible for ensuring voice and choice

d. A Plan of Care shall be maintained for each child based on the work of the Child and Family Team and shall address the strengths and needs of the youth and family. It should be provided in a style that emphasizes the Michigan Wraparound, Best Practice Values and Philosophy and incorporates all of the Person-Centered Practice requirements. The plan should reflect a family-driven/youth-guided approach.

e. The Wraparound Planning Process follows four stages: 1) Hello-Engagement and Team preparation, 2) Help-Initial plan development, 3) Heal-Implementation, and 4) Hope-Transition. The Wraparound Planning Process utilizes a collaborative Wraparound Team approach including a child, youth, or young adult and their family and their choice of professional and natural supports. Care Coordinators facilitate the Wraparound plan development, considering all life domains.

f. Individualized child/youth and family outcomes that are developed and measured by each child/youth and family team.

g. Evidence of regular updates as the needs of the child/youth and family change (annual updates alone are not sufficient).

h. Evidence that the child/youth and family team review and measure outcomes at least monthly.

i. The Child and Family Team's plan is built on strengths and driven by underlying needs. The plan provides realistic strategies to meet meaningful, measurable and attainable outcomes that the Child and Family Team develop. Ongoing evaluation of the Child and Family Team's plan occurs during each Child and Family Team meeting and adjustments are made as needed.

j. Case Management cannot be authorized when ICCW is authorized. Case management functions through home-based services may not be reimbursed when ICCW is authorized.

11. **Amount and Scope of Services:**

a. **Amount of Service**

1. Wraparound Teams shall meet once per week, at minimum, during the Hello and Help phases.
2. Wraparound Teams shall meet twice monthly, at minimum, during the Heal phase. The Heal phase begins once the plan has been developed and the Team agrees stabilization has been achieved.
3. Wraparound Teams shall meet monthly, at minimum, during the Hope phase. The Hope phase begins when the Team agrees that the child, youth, or young adult and family are ready to graduate from the Wraparound Planning Process and no longer show a need for ICCW.
4. When a child, youth, or young adult is in placement and the Care Coordinator is facilitating transition planning back to the home and community, the meeting frequency may reflect the needs of the child, youth, or young adult. Only upon Wraparound Plan development or adjustment may the frequency of Team meetings decrease.
    i. Upon discharge, frequency of meetings should align with the phase that the Wraparound Team is in.
5. The Care Coordinator must review services at intervals defined in the Individual Plan of Service (IPOS). A formal review of the IPOS shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.
6. Frequency and scope (face-to-face and telephone) of other ICCW monitoring activities must reflect the intensity of the child, youth or young adult's health and welfare needs.

b. **Scope of Service:**

1. Ensure child, youth, or young adult and their family understand the ICCW and the Wraparound Planning Process. When SEDW is being utilized, orient child, youth, or young adult and their family to the SEDW process

and service array.

2. Ensure documentation from other service providers and systems partners (physicians, medication prescribers, mental health, education, child welfare, juvenile justice, community services, etc.) involved with the child, youth, or young adult and their family is available and utilized to support identified needs.
3. Coordinate communication among service providers and systems partners (physicians, medication prescribers, mental health, education, child welfare, juvenile justice, community services, etc.) who are involved with the child, youth, or young adult and their family.
4. Ensure child, youth, or young adult and their family are linked to relevant supports, community service providers and systems partners to expand support network and address identified needs.
5. Support and empower the Wraparound Team to advocate on behalf of the child, youth, or young adult and family.
6. Ensure child, youth, or young adult and their family and Wraparound Team have access to informational material that supports the ability to address identified needs (guidance on navigation of specific services or systems, psycho education materials, parent education materials, etc.).
7. Ensure Intake has been completed or is scheduled to be completed. • Ensure service provider is providing all medically necessary services that the child, youth, or young adult and their family choose and taking appropriate action when those services are unavailable.
8. Facilitate the brokerage of services and supports as identified through the Wraparound Planning Process. • Ensure Family-Driven, Youth-Guided Process is included to develop the IPOS.
9. Utilize the Wraparound Planning Process to ensure successful transition of the child, youth, or young adult back into their home and community.
10. Facilitate the Wraparound Planning Process with model fidelity to the MDHHS model to develop and update the Wraparound Plan as needed or required.
11. Facilitate the Family-Driven, Youth-Guided Process to develop and complete annual updates to the IPOS.
12. Ensure an annual MichiCANS is completed by the appropriate entity.

12. **Location:**
    a. **Telemedicine**
        1. All Child and Family Team meetings are to be provided in-person during the Hello and Help phases.
        2. Child and Family Team meetings may be provided either in-person or via simultaneous audio/visual telemedicine during the Heal and Hope phases, according to the preference of the child/youth and their parents/primary

caregivers, with the following exceptions:

i. Development of the transition plan (Hope phase) is to be completed in-person.

ii. Graduation activities (Hope phase) are to be completed in-person.

iii. Child and Family Team meetings are to be provided in-person for the first 60 days upon a child/youth transitioning back to their home and community from out-of home placement.

iv. In-person Child and Family Team meetings are to be provided once per month, at minimum, for children/youth served under the SEDW during both the Heal and Hope phases.

b. **Child Caring Institutions (CCI) and State Hospitals:**

1. ICCW is covered by Medicaid for up to 180 days while in placement for the purpose of transition back to the community; Wraparound must be suspended once the child/youth has been placed for more than 180 days. When Wraparound-enrolled children/youth are placed at a CCI, including a Qualified Residential Treatment Program (QRTP), or State Hospitals, transition planning should begin immediately in conjunction with the Wraparound Child and Family Team and facility staff.
2. A child, youth, or young adult who meets eligibility criteria for ICCW should be referred to the service planning provider in the community in which they reside.
3. The Care Coordinator will work with the child/youth and their caregiver(s) to develop a Child and Family Team. The Child and Family Team will work collaboratively with facility staff and other child-serving systems to facilitate a comprehensive and holistic plan of services and supports that will enable the child/youth to return to their community.
4. The child/youth must have an identified community to transition. (revised per bulletin MMP 24-41)
5. Medicaid does not cover services provided to persons/children involuntarily residing in non-medical public facilities (such as jails, prisons or juvenile detention facilities).

13. **Child and Family Team Plan and Wraparound Planning Process:**

a. The Wraparound Planning Process must be provided with fidelity in accordance with the MDHHS ICCW model. The Person-Centered Planning Process must be provided according to MDHHS policy, including Family Driven and Youth Guided policy.

b. The Safety/Crisis Plan, Wraparound Plan and the Individual Plan of Service (IPOS) are the resulting plans from the utilization of the Wraparound Planning Process and the Person-Centered Planning Process. The Wraparound plan should drive development and/or adjustment of the IPOS. The following planning process activities and supporting documentation shall be completed for each child/youth and family:

c. **Safety/Crisis Plan**

1. Safety/Crisis Plans must be developed upon the initial meeting with the child, youth, or young adult and their family.
    i. Existing Safety/Crisis Plans are to be reviewed with the child, youth, or young adult and their family following initial utilization and as needed to determine if modifications are necessary.
    ii. Safety/Crisis plans must be developed with fidelity to the MDHHS Wraparound model.

d. **Needs Assessment**

1. The initial Needs Assessment must be completed prior to the development of the initial Wraparound Plan. The Needs Assessment should be updated during Child and Family Team Meetings via meeting minutes as well as annually with the Wraparound Plan and IPOS.
2. The assessment's goal is to ensure the Wraparound Plan is tailored to the family's specific circumstances and leads to better functioning and success, often for youth involved in multiple service systems.

e. **Wraparound Plan**

1. The Wraparound Plan must be developed within 30 days of initial service provision and then quarterly thereafter.
    i. The Wraparound Plan's strategies are to be reviewed at each Team meeting, and Team adjustments to strategies are to be completed by the Care Coordinator.
    ii. The Wraparound Plan's outcomes are to be reviewed at least monthly, and Team adjustments to the Plan are to be completed by the Care Coordinator.
    iii. Wraparound Plan elements must be developed with fidelity to the MDHHS Wraparound model to ensure fidelity.

f. **Individual Plan of Services (IPOS**)

1. The IPOS Pre-Plan must be developed in the Wraparound Team meeting during the Hello phase.
    i. The annual IPOS Pre-Plan must be developed within the Wraparound Team meeting.
    ii. The IPOS must be developed in the Help phase following development of the Wraparound Plan. If there is an existing IPOS, it must be updated to reflect the newly developed Wraparound Plan. Each service provider is responsible for providing the narrative for their clinical intervention.
    iii. The annual IPOS must be developed within the Wraparound Team meeting, driven by the existing Wraparound Plan. Each service provider is responsible for providing the narrative for their clinical intervention.

iv. IPOS elements must comply with Michigan Administrative Code R330.7199 requirements.

g. **Wraparound Team Meeting Minutes**

1. Meeting minutes must be developed following each Wraparound Team meeting and distributed to all Wraparound Team members.
2. Meeting minutes elements must comply with documentation requirements for DHHS Wraparound model fidelity monitoring.

h. **Transition Plan**

1. The Transition Plan should be developed when the youth and family are in the Hope-Transition phase. The Transition Plan helps the family proactively think about support for future events and concerns that may arise after ICCW and who can support them if/when these things occur.

i. **Graduation Summary**

1. The Graduation summary must be completed within the last month of the Hope phase and distributed to the child, youth, or young adult, and their family.
2. The Graduation summary elements must be developed with fidelity to the MDHHS Wraparound model.

14. **Evaluation and Outcome Measurement:**

a. The enrolled provider will comply with the State of Michigan ICCW evaluation requirements. Current evaluation requirements are:

1. The enrolled ICCW provider will comply with MDHHS ICCW evaluation requirements as determined by the department.
2. Additional evaluation tools will be completed as identified and requested by MDHHS.
3. Adherence to ICCW model fidelity may be reviewed at enrollment, re-enrollment, and at technical assistance visits through file review, family interviews, and evaluation and fidelity tools.

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

All the attached exhibits within this policy are what DWIHN utilizes to monitor the fidelity of ICCW for CRSP's.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, contractors, and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. Michigan Mental Health Code, P.A. 258 of 1974, as amended.
2. 2009 Application for Renewal and Re-commitment (ARR) to Quality and Community in the Michigan Public Mental Health System (ARR) Section 2: Improving the Culture of Systems of Care.
3. MDHHS Family Driven-Youth Guide Policy (12/14/2010).

EXHIBITS

1. ICCW Quarterly Report
2. FRAMES Competency Tool
3. Strength Narrative
4. Michigan Wraparound Fidelity Tool
5. Wraparound Plan
6. Transition Plan
7. Crisis/Safety Plan
8. Needs Assessment
9. Graduation Summary
10. Meeting Minutes
11. CMHSP Checklist for Provisional Wraparound Coordinator Approval
12. FY2025 Case Record Review
13. Final Bulletin MMP 24-38 MichiCANS
14. Final Bulletin MMP 24-41 BCCHPS

RELATED POLICIES

1. Individual Plan of Service/Person-Centered Planning
2. Children's Diagnostic Treatment Services Program
3. Coordination of Care Policy
4. Serious Emotional Disturbance Waiver (SEDW) Policy

CLINICAL POLICY

YES

INTERNAL/EXTERNAL

EXTERNAL

Attachments

CMHSP CHECKLIST FOR PROVISIONAL WRAPAROUND COORDINATOR APPROVAL -10.8.24 (002).docx

Final Bulletin MMP 24-38-MichiCANS-final.pdf

Final Bulletin MMP 24-41-BCCHPS.pdf

FRAMES.pdf

FY2025 Case Record Review.docx

ICCW Crisis.Safety Plan.docx

ICCW Graduation Summary.doc

ICCW Meeting Minutes.docx

ICCW Needs Assessment.doc

ICCW Plan of Care.doc

ICCW Strengths Narrative.doc

ICCW Transition Plan.docx

Michigan Wraparound Fidelity Tool 2024.pdf

Revised ICCW Quarterly Report 4.8.25.docx

Approval Signatures

Step Description	Approver	Date
Clinical Review Committee	Shama Faheem: Chief Medical Officer	Pending

Clinical Review Committee	Marlena Hampton: Director of Utilization Management	Pending
Clinical Review Committee	Melissa Moody: Vice President Of Clinical Operations	Pending
Clinical Review Committee	Matthew Yascolt: Director of Substance Use Disorder Initiatives	11/2025
Clinical Review Committee	April Siebert: Director of Quality Improvement	11/2025
Clinical Review Committee	Daniel West: Director of Crisis Services	11/2025
Clinical Review Committee	Stacey Sharp: Associate Vice President of Clinical Operatio	11/2025
Clinical Review Committee	Jacquelyn Davis: Associate Vice President - Access and Strateg	11/2025
Clinical Review Committee	Polly McCalister: Director of Recipient Rights	11/2025
Clinical Review Committee	Ryan Morgan: Director of Residential Services	11/2025
Clinical Review Committee	Vicky Politowski: Director of Integrated Care	11/2025
NCQA Committee	Tania Greason: Quality Administrator	11/2025
NCQA Committee	Allison Smith: Director of Strategic Operations	11/2025
NCQA Committee	Justin Zeller: Project Manager	11/2025
NCQA Committee	Margaret Keyes-Howard: Strategic Planning Administrator	11/2025
Director Review	Cassandra Phipps: Director of Childrens Initiatives	11/2025
Unit Review and Approval	monica Hampton: Clinical Specialist	10/2025

Applicability

Detroit Wayne Integrated Health Network

Standards

Standard Body: 2.1206.2

Chapter: COUNTY COMMUNITY MENTAL HEALTH PROGRAMS

Standard Body: 2.1206.1

Chapter: COUNTY COMMUNITY MENTAL HEALTH PROGRAMS