Status **Pending** PolicyStat ID **18428711**

Origination	N/A	Owner	Shama Faheem: Chief Medical Officer
Last Approved	N/A	Policy Area	Medical
Effective	Upon Approval	Applicability	Detroit Wayne Integrated Health Network
Last Revised	N/A		
Next Review	1 year after approval		

Practice Guidelines for Persons Served Who Are Non-Engaging and Non-Adherent to Treatment

POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) to establish evidence-based guidelines for its provider network based on literature search and consensus.

PURPOSE

To provide evidence-based, recovery-oriented, trauma-informed, and person-centered approaches for engaging individuals who are non-engaging or non-compliant with behavioral health treatment. These guidelines support staff across mental health, substance use disorder (SUD), and co-occurring disorder (COD) services in reducing disengagement and improving outcomes.

APPLICATION

1. The following groups are required to implement and adhere to this policy:
    a. DWIHN Board,
    b. DWIHN Staff including the following
        1. DWIHN PIHP Staff
        2. DWIHN Community Care Clinic Staff (Direct Care Staff)
        3. DWIHN Community Care Clinic Staff (DWIHN staff operating as a CCBHC)
        4. DWIHN Crisis Care Center Staff
        5. DWIHN Mobile Crisis 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:
    a. Adults
    b. Children
    c. Individuals with Intellectual and/or Developmental Disabilities (I/DD)
    d. Serious Mental Illness (SMI),
    e. Serious Emotional Disturbance (SED),
    f. Substance Use Disorder (SUD)
    g. Autism
    h. Mild/Moderate levels of care
3. This policy impacts the following contracts/service lines:
    a. Autism
    b. Certified Behavioral Health Clinics
    c. General Fund
    d. Grants
    e. MI-HEALTH LINK
    f. Medicaid
    g. SUD

KEYWORDS

1. Non-engaging
2. Non-compliant
3. Non-adherenet
4. AOT
5. Guardianship
6. DPOA

STANDARDS

The following guidelines can be helpful in improving treatment engagement and adherence. The evidence is based on external literature or internal data. These guidelines are intended to be used as guidance and should not replace your own review (particularly for updates), clinical judgment and medical necessity standards.

General Principles Across Populations

1. **Person-Centered, Strength-Based Approach**
    a. Assess individual goals, values, and motivations to tailor care.
    b. Use Motivational Interviewing (MI) and harm reduction approaches.
2. **Trauma-Informed Care**
    a. Recognize that non-engagement may be rooted in trauma histories, mistrust, or systemic barriers.
    b. Ensure physical and psychological safety and choice in services.
3. **Cultural Humility**
    a. Understand and respect the cultural background and lived experience of persons served, including stigma in minority populations.
4. **Assertive Outreach**
    a. Use community-based outreach methods such as home visits, wellness checks, and peer-led engagement.
    b. Persons served who are not engaging in outpatient services but continue to need higher level of care (HLOC) services should be outreached by establishing contacts during their crisis (HLOC) episode.
        1. This should be used to develop rapport, improve transitions.
        2. Barrier analysis should be completed and addressed.
        3. Use of care co-coordinators/case managers and peers should be considered
        4. Follow-up reminders should be used to ensure care is not dropped.
5. **Collaboration and Coordination**
    a. Coordinate with legal, housing, social services, and primary care partners when appropriate.
    b. Ensure warm handoffs, especially after hospitalization or crisis events.
6. **Documentation**
    a. Clearly document efforts to engage, risk levels, and informed refusal while ensuring the person's rights are respected.

Mental Health: Best Practices for Engagement

1. **Use of Assertive Community Treatment (ACT) or Home-Based Services (for Youth)**
    a. Multidisciplinary team-based interventions with 24/7 access such as ACT should be considered for individuals who are meeting the criteria and are better served in the community with intensive in-person support.
    b. Intensive home-based services should be considered for youth meeting the criteria and are not able to engage in regular office visits.
2. **Peer Support Services**

a. Include Certified Peer Support Specialists (parent support partners and youth peer support for child and adolescent population) in engagement efforts, leveraging lived experience.

3. **Engagement Plans**
    a. Develop specific engagement strategies for individuals who miss multiple appointments or have repeated crises. Consider including such goals in their treatment plans.
    b. Every missed appointment should be followed with an attempt to reschedule them as soon as possible.
    c. Every organization should keep a track of their person-served who have not been seen, at least once per month (will be re-evaluated) for any service, and be proactive in outreaching and engaging them.
4. **Utilize Telehealth and Flexible Scheduling**
    a. Reduce barriers related to transportation or stigma. If other barriers such as childcare, etc. limit attendance, offer appropriate resources and/or telehealth.
    b. Routine appointments should have reminder calls that not only confirm the appointment but addresses any barrier to appointments such as transportation. Use transportation services including DWIHN contracted transportation help as medically necessary.
5. **Family Involvement (with consent)**
    a. Engage natural supports where appropriate to re-engage individuals. Capture the information about natural supports as well as the required release of information to be able to coordinate care where needed.
6. **Assisted Outpatient Treatment (AOT)**:
    a. Utilize AOT (MCL 330.1401) where necessary for individuals with prior history of psychiatric hospitalization, lack of insight, and potential for deterioration.
    b. Coordinate with local courts and legal representatives to implement court-ordered outpatient care as a structured support for treatment adherence.
7. **Housing and Social Support**:
    a. **Transition population and homelessness and can be a barrier to consistent engagement.** Connect with housing resources, SOAR programs, and social services.

Substance Use: Best Practices for Engagement

1. **Low-Threshold Services**
    a. Provide services without requiring abstinence or extensive intake processes to increase accessibility.
2. **Contingency Management**
    a. Use evidence-based incentive programs to encourage participation such as Contingency management.
3. **Peer Recovery Coaches**
    a. Employ peer-led support and real-time navigation through systems of care.

4. **Medication-Assisted Treatment (MAT) Access**
    a. Ensure prompt access to MAT for opioid use disorder, alcohol use disorders and wherever, the evidence exist.
5. **Harm Reduction Tools**
    a. Distribute naloxone, fentanyl test strips, and clean supplies in outreach.
6. **Outreach in Natural Settings**
    a. Meet individuals in shelters, syringe service programs (SSPs), hospitals, or jails.
7. **Motivational Interviewing (MI)**:
    a. Use MI to explore ambivalence and reinforce autonomy.
    b. Use MI regularly to get individuals to develop insight into need for treatment
8. **Non-Punitive Engagement**: Treat recurrence of use as part of the illness, not failure.
    a. Do not terminate treatment as a consequence of a behavior which could a manifestation of the illness itself.
    b. Use those behaviors to develop behavior plans using principles of operant conditioning and use them as an opportunity to develop and teach contingency management.
9. **Involuntary Treatment Criteria:**
    1. Under the Michigan legislature, particularly sections MCL 330.1281a and MCL 330.1281b, a court may order involuntary treatment for an adult with a substance use disorder if the following conditions are satisfied:
        1. Verified Substance Use Disorder: A health professional must confirm that the individual has a substance use disorder.
        2. Imminent Danger: The individual must present an imminent danger or threat of danger to themselves, their family, or others due to the substance use disorder, or there must be a substantial likelihood of such danger in the near future.
        3. Potential Benefit from Treatment: The individual must be likely to benefit from treatment.

Co-Occurring Disorders (COD): Integrated Best Practices

1. **Screening, Brief Intervention and Referral to Treatment (SBIRT)**
    a. Mental Health Provider should train their intake clinicians on SBIRT
    b. It will be important to assess the severity of substance use and identify the appropriate level of treatment during Intake, provide brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
    c. Based on that, need for more extensive screening using ASAM and referral to more specialized Substance Use treatment could be identified.
2. **Integrated Dual Disorder Treatment (IDDT)**
    a. Combine mental health and substance use treatment in a single team using evidence-based practices.

3. **Stage-Matched Interventions**
    a. Assess and address the individual's stage of change for both disorders.
4. **Modified Engagement Metrics**
    a. Allow for alternative definitions of engagement (e.g., brief contacts, telehealth check-ins).
5. **Cross-System Collaboration:**
    a. Ensure communication and coordination between mental health and substance use providers. Hold joint case conferences and use shared documentation where possible.
6. **Flexible Engagement Definitions:**
    a. Count phone calls, telehealth, peer contact, or brief check-ins as engagement.
7. **Cross-Training Staff**
    a. Ensure all staff are trained in co-occurring competencies, trauma, MI, and harm reduction.
8. **Flexible, Non-Punitive Service Delivery**
    a. Avoid discharging from treatment due to relapse or missed appointments; re-engagement is prioritized.
9. **Care Coordination**:
    a. If same provider is offering both treatments, it is important to consider holistic approach.
    b. If SUD and MH CRSP are different, coordinate care and share treatment plans with each other to improve care.
        1. This should ideally be approached by getting a release of information signed during intake and providing education to person on the why and how.
        2. Review the HIPAA coordination/continuity of care standards that permit coordination under limitations.
10. **Avoid Premature Discharge**:
    a. Recognize that intermittent engagement may be the best indicator of progress early on.
11. **Crisis and Re-Engagement Planning**:
    a. Use past disengagement patterns to inform future outreach.
    b. Use crisis episodes as opportunities to connect with persons who are otherwise not engaging and develop safe and effective transition plans.
    c. Use peers effectively.

Michigan-Specific Strategies

1. **Utilize MDHHS Guidelines**
    a. Align with Michigan Department of Health and Human Services (MDHHS) Behavioral Health Standards and updates.
2. **Coordination with PIHP Care Managers**

a. Use DWIHN supports for complex or high-utilizing individuals such as referral to complex case managers.

b. Use referral to Med Drop Program or Long acting Injectables for members non adherent to medications

c. Engage with Michigan's Medicaid Health Plans for physical and behavioral health coordination

3. **Leverage Michigan's Behavioral Health Home (BHH) and Substance Use Disorder Health Home (SUDHH) Programs**
    a. Connect eligible individuals to care coordination through BHH and OHH services.
4. **AOT (Assisted Outpatient Treatment)** available under Kevin's Law (MCL 330.1401–1472a) and **Involuntary Substance Use Treatmen**t available under MCL 330.1281a and MCL 330.1281b
5. **Mental Health-SUD Coordination** requirements
    a. DWIHN contract standards, HIPAA standards and MDHHS guidance.
6. **Behavioral Health Quality Improvement Initiatives**
    a. Quality teams within CRSPs should pay special attention to metrics for monitoring disengagement.
    b. Some existing metrics include Performance Indicator 2, 3 and 4.
    c. Each organization to also consider developing additional metrics that help in tracking engagement. (See IX for Metrics chart, includes first 3 measures with DWIHN/State benchmarks and others as suggestions for CRSP).

Staff Safety and Retention Considerations

1. Provide ongoing de-escalation (such as CPI), safety & crisis planning, and burnout prevention training for outreach staff.
2. Use supervision and team huddles to manage staff risk and promote reflective practices.

Legal and Ethical Considerations

1. Ensure all outreach, engagement efforts, and clinical decisions are documented in compliance with MDHHS and Medicaid requirements.
2. Utilize person-centered planning processes (PCP) to update goals as engagement status changes.
3. Respect individuals' autonomy while balancing clinical judgment and safety. Use guardianship, AOT, involuntary SUD treatment criteria or protective interventions when risk criteria are met, and legal pathways allow.
4. If a person is not following and/or refusing recommended treatment:
    a. Evaluate need for petition and certificate per mental health Code.
    b. If the person already has a guardian, discuss and involve them in treatment planning and decisions.
    c. If a person does not have a guardian, evaluate capacity for decision making.
        1. If a person is found to not have capacity, follow the State required protocols to establish surrogate decision maker. Review and follow the lined/attached

"Lack of Capacity Protocol" for guidance.

See Section X: Figure 1 for "Court involved Pathways and Steps for a person-served who is not following and/or refusing treatment decisions In behavioral health settings"

Other References

Federal and National Guidelines

1. Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *Treatment Improvement Protocol (TIP) 42: Substance Use Disorder Treatment for People With Co-Occurring Disorders*.
2. SAMHSA. (2014). *Trauma-Informed Care in Behavioral Health Services (TIP 57)*.
3. Centers for Medicare & Medicaid Services (CMS). (2021). *Behavioral Health Integration Services*.
4. National Council for Mental Wellbeing. (2022). *Engaging People in Care: A Toolkit for Behavioral Health*.

Michigan Guidelines and Sources

1. Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration (BHDDA) Policy Bulletins.
2. MDHHS (2023). *Michigan Behavioral Health Standard Contract*.
3. MDHHS (2022). *OHH and BHH Provider Manual*.
4. Michigan Association of CMH Boards (MACMHB). (2021). *Best Practices for Engagement in Community-Based Services*.
5. https://www.legislature.mi.gov/Laws/MCL?objectName=mcl-330-1281a

Evidence-Based Practices

1. Drake, R. E., et al. (2004). *Implementing Dual Diagnosis Services for Clients With Severe Mental Illness*.
2. Prochaska, J. O., & DiClemente, C. C. (1986). *Transtheoretical Model of Behavior Change*.
3. Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping People Change* (3rd ed.).

Metrics to Evaluate Disengagement

Metric Name	Population	Definition	Target/ Benchmark	Purpose
Initial Appointment Follow-Up Rate	**All**	**% attending first intake appointment within 14 days of referral**	**≥57-60%**	**Detects drop-off before treatment starts**
30-Day Engagement in Services	**All**	**% receiving ≥1 services within 14 days of intake**	**≥85%**	**Captures early retention post-intake**
Hospitalization or Detox Follow-Up Rate	**MH or SUD**	**% seen in follow-up within 7 days of withdrawal management/ hospitalization discharge**	**≥95%**	**Ensures post-detox care linkage**

30-Day No-Show Rate	All	% of missed appointments in the first 30 days	Can consider ≤15%	Indicates risk of disengagement
Care Coordination Contact Rate	All	% receiving follow-up contact within 14 days of intake	Can consider ≥90%	Ensures active outreach
Outpatient MH Engagement Rate	MH	% with ≥2 MH visits within 60 days of intake	Can consider ≥75%	Shows retention in outpatient MH services
Crisis Utilization After Intake	MH	% using crisis/inpatient services within 90 days post-intake	Can consider ≤10%	May indicate failure to engage in routine care
Early Treatment Plan Completion	MH	% with treatment plan completed within 30 days of intake	≥90%	Early planning supports ongoing engagement
SUD Engagement Rate (HEDIS IET)	SUD	% initiating and engaging in SUD care within 34 days	≥42% (HEDIS benchmark)	National quality standard for SUD treatment engagement
MAT Linkage Rate	SUD	% of OUD clients receiving MAT within 14 days	Can consider ≥70%	Promotes evidence-based early intervention
Integrated Treatment Initiation Rate	COD	% receiving integrated services within 30 days of intake	Can consider ≥60%	Reduces fragmentation of dual care
Concurrent MH and SUD Visit Rate	COD	% receiving both MH and SUD services in same 30-day period	Can consider ≥65%	Tracks continuity of dual treatment

Figures and Attachments

Figure 1: Court involved Pathways and Steps for a person-served who is not following and/or refusing treatment decisions in behavioral health settings.

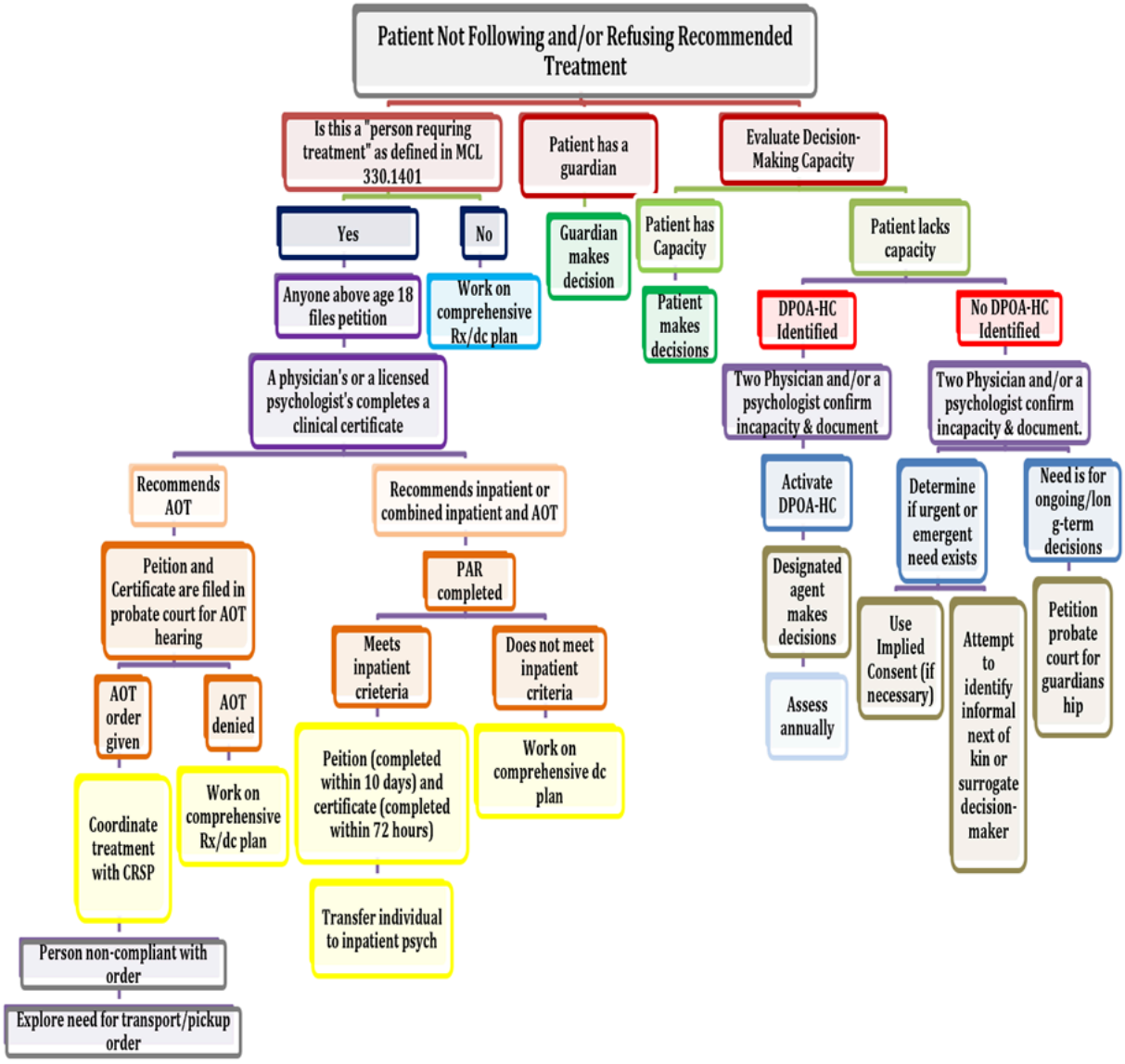

Figure 2 Summary of Interventions

General Best Practices

Person-Centered, Strength-Based Approach
- Assess individual goals, values, and motivations.
- Use Motivational Interviewing (MI) and harm reduction.

Trauma-Informed Care
- Non-engagement may be rooted in trauma histories, mistrust, or systemic barriers.
- Ensure physical and psychological safety and choice in services.

Cultural Humility
- Understand and respect the cultural background and lived experience of persons served, including stigma in minority populations.

Assertive Outreach
- Use community-based outreach methods such as home visits, wellness checks, and peer-led engagement.
- Not engaging in outpatient services but continue to need higher level of care (HLOC): should outreach by establishing contacts during their crisis (HLOC) episode.
  - ✓This should be used to develop rapport, improve transitions.
  - ✓Barrier analysis should be completed and addressed.
  - ✓Use of care co-coordinators/case managers and peers should be considered
  - ✓Follow-up reminders should be used to ensure care is not dropped.

Collaboration and Coordination
- Coordinate with legal, housing, social services, and primary care partners when appropriate.
- Ensure warm handoffs, especially after hospitalization or crisis events.

Documentation
- Clearly document efforts to engage, risk levels, and informed refusal while ensuring the person's rights are respected.

Mental Health Best Practices

Use of Assertive Community Treatment (ACT) or Home-Based Services (for Youth)

Multidisciplinary team-based interventions 24/7

Intensive home-based services should for youth not able to engage in regular office visits.

Peer Support Services

Include peers in engagement efforts, leveraging lived experience.

Engagement Plans

Develop specific engagement strategies for individuals who miss multiple appointments or have repeated crises. Consider including such goals in their treatment plans.

Every missed appointment should be followed with an attempt to reschedule

Keep a track of who have not been seen, at least once per month, be proactive in outreaching and engaging them.

Utilize Telehealth and Flexible Scheduling

Routine appointments should have reminder calls.

Use transportation services including DWIHN contracted transportation help.

Family Involvement (with consent)

Engage natural supports. Capture the information & release.

Assisted Outpatient Treatment (AOT)

Utilize AOT (MCL 330.1401) where necessary for individuals with prior history of psychiatric hospitalization, lack of insight, and potential for deterioration.

Coordinate with local courts and legal representatives to implement court-ordered outpatient care.

Housing and Social Support:

Connect with housing resources, SOAR programs, and social services.

Substance Use Disorder Best Practices

Low-Threshold Services
- Provide services without requiring abstinence or extensive intake processes to increase accessibility.

Contingency Management
- Use evidence-based incentive programs to encourage participation such as Contingency management.

Peer Recovery Coaches
- Employ peer-led support and real-time navigation through systems of care.

Medication-Assisted Treatment (MAT) Access
- Ensure prompt access to MAT for opioid use disorder, alcohol use disorders and wherever, the evidence exist.

Harm Reduction Tools
- Distribute naloxone, fentanyl test strips, and clean supplies in outreach.

Outreach in Natural Settings
- Meet individuals in shelters, syringe service programs (SSPs), hospitals, or jails.

Motivational Interviewing (MI):
- Use MI to explore ambivalence and reinforce autonomy.
- Use MI regularly to get individuals to develop insight into need for treatment

Non-Punitive Engagement:
- Treat recurrence of use as part of the illness, not failure.
- Do not terminate treatment as a consequence of a behavior which could a manifestation of the illness itself.
- Use those behaviors to develop behavior plans using principles of operant conditioning and use them as an opportunity to develop and teach contingency management.

Involuntary Treatment Criteria:
- Under the Michigan legislature, particularly sections MCL 330.1281a and MCL 330.1281b, a court may order involuntary treatment for an adult with a substance use disorder if the following conditions are satisfied

Co-Occurring Disorders (COD) Best Practices

Screening, Brief Intervention and Referral to Treatment (SBIRT)
- MH Provider should train intake clinicians on SBIRT
- Assess substance use and LOC during Intake, provide brief intervention on increasing insight and awareness regarding SUD and motivation toward change.
- Identify need for extensive screening using ASAM and referral to specialized treatment.

Integrated Dual Disorder Treatment (IDDT)
- Combine MH and substance use treatment in a single team using evidence-based practices.

Stage-Matched Interventions
- Assess and address the individual's stage of change for both disorders.

Modified Engagement Metrics
- Allow for alternative definitions of engagement (e.g., brief contacts, telehealth check-ins).

Cross-System Collaboration:
- Ensure coordination between MH and SUD providers. Hold joint case conferences & EMR integration.

Cross-Training Staff
- Ensure all staff are trained in co-occurring competencies, trauma, MI, and harm reduction.

Flexible, Non-Punitive Service Delivery
- Avoid discharging from treatment due to relapse or missed appointments; re-engagement is prioritized.

Care Coordination:
- If same provider: consider holistic approach.
- If SUD and MH CRSP are different, coordinate care and share treatment plans o improve care.
  - ✓Ideally be approached by getting a release & providing education on the why and how.
  - ✓Review the HIPAA coordination/continuity of care standards that permit coordination under limitations.

Avoid Premature Discharge:
- Recognize that intermittent engagement may be the best indicator of progress early on.

Crisis and Re-Engagement Planning:
- Use past disengagement patterns to inform future outreach.
- Use crisis episodes as opportunities to connect with persons who are otherwise not engaging and develop safe and effective transition plans.
- Use peers effectively.

Michigan Specific Practices

Utilize MDHHS Guidelines
- Align with Michigan Department of Health and Human Services (MDHHS) Behavioral Health Standards and updates.

Coordination with PIHP Care Managers
- Use DWIHN supports for complex or high-utilizing individuals such as referral to complex case managers.
- Use referral to Med Drop Program or Long acting Injectables for members non adherent to medications
- Engage with Michigan's Medicaid Health Plans for physical and behavioral health coordination

Leverage Michigan's Behavioral Health Home (BHH) and Substance Use Disorder Health Home (SUDHH) Programs
- Connect eligible individuals to care coordination through BHH and OHH services.

AOT (Assisted Outpatient Treatment) available under Kevin's Law (MCL 330.1401–1472a) and **Involuntary Substance Use Treatment** available under MCL 330.1281a and MCL 330.1281b

Mental Health-SUD Coordination requirements per DWIHN contract standards, HIPAA standards and MDHHS guidance.

Behavioral Health Quality Improvement Initiatives
- Quality teams within CRSPs should pay special attention to metrics for monitoring disengagement.
- Some existing metrics include Performance Indicator 2, 3 and 4.
- Each organization to consider developing additional metrics that help tracking engagement. (See IX for Metrics chart, includes first 3 measures with DWIHN/State benchmarks and others as suggestions for CRSP).

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, risk management program, and Quality Assessment/Performance Improvement Program (QAPIP) Work-plan.

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

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, Contracted Network Providers, and their 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 Department of Health and Human Services Medicaid Provider Manual (in effect, and as as amended)
2. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program (PIHP/CMHSP contracts in effect, and as amended)

RELATED POLICIES AND PROCEDURES

Lack of Capacity Protocol

CRSP Member Re-Engagement and Case Closure Policy

PIHP DISENROLLMENT POLICY

CLINICAL POLICY

YES

INTERNAL/EXTERNAL POLICY

EXTERNAL

Approval Signatures

Step Description	Approver	Date
Compliance/Administrative Review	Rai Williams: Director of Contract Management	Pending

Compliance/Administrative Review	Yolanda Turner: Vice President Of Legal Affairs	Pending
Compliance/Administrative Review	Sheree Jackson: Vice President Of Compliance	10/2025
Compliance/Administrative Review	Stacie Durant: Vice President Of Finance	10/2025
Compliance/Administrative Review	Manny Singla: Deputy Chief Executive Officer	10/2025
Compliance/Administrative Review	Brooke Blackwell: Vice President Of Governmental Affairs	10/2025
Clinical Review Committee	Marlena Hampton: Director of Utilization Management	10/2025
Clinical Review Committee	Stacey Sharp: Associate Vice President of Clinical Operatio	08/2025
Clinical Review Committee	Cassandra Phipps: Director of Childrens Initiatives	07/2025
Clinical Review Committee	Jacquelyn Davis: Associate Vice President - Access and Strateg	07/2025
Clinical Review Committee	Ryan Morgan: Director of Residential Services	07/2025
Clinical Review Committee	Matthew Yascolt: Interim Director of Substance Use Disorder	07/2025
Clinical Review Committee	Daniel West: Director of Crisis Services	07/2025
Clinical Review Committee	Shama Faheem: Chief Medical Officer	07/2025
Clinical Review Committee	Polly McCalister: Director of Recipient Rights	07/2025
Clinical Review Committee	Vicky Politowski: Director of Integrated Care	07/2025
Clinical Review Committee	Melissa Moody: Vice President Of Clinical Operations	07/2025
Clinical Review Committee	April Siebert: Director of Quality Improvement	07/2025
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NCQA Committee	Tania Greason: Quality Administrator	07/2025
NCQA Committee	Justin Zeller: Project Manager [AS]	07/2025

NCQA Committee	Allison Smith: Director of Strategic Operations	07/2025
Clinical Officer	Marianne Lyons: Director of Adult Initiatives	07/2025
Unit Approval	Shama Faheem: Chief Medical Officer	07/2025

Applicability

Detroit Wayne Integrated Health Network

Standards

No standards are associated with this document