Sustaining Your Integration Efforts: The Role of Data and Measurement

Presented by:
Dr. Jeff Capobianco
# Levels of Integration

<table>
<thead>
<tr>
<th>Co-Located</th>
<th>Integrated</th>
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<tbody>
<tr>
<td><strong>Key Element:</strong> Communication</td>
<td><strong>Key Element:</strong> Physical Proximity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>Level 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration On-Site</td>
<td>Close Collaboration On-Site with Some System Integration</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/ Merged Integrated Practice</td>
</tr>
</tbody>
</table>

Behavioral health, primary care and other healthcare providers work:

- In separate facilities, where they:
- In separate facilities, where they:
- In same facility not necessarily same offices, where they:
- In same space within the same facility, where they:
- In same space within the same facility (some shared space), where they:
- In same space within the same facility, sharing all practice space, where they:
## Defining Integration

<table>
<thead>
<tr>
<th>Stage</th>
<th>Characteristics</th>
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<tbody>
<tr>
<td>1. <strong>Initial Integration</strong>&lt;br&gt;Have separate systems</td>
<td>Communicate about cases only rarely and under compelling circumstances&lt;br&gt;May never meet in person&lt;br&gt;Have limited understanding of each other’s roles</td>
</tr>
<tr>
<td>2. <strong>Intermediate Integration</strong>&lt;br&gt;Have separate systems</td>
<td>Communicate, driven by provider need&lt;br&gt;Communicate periodically about shared patients&lt;br&gt;May meet as part of larger community&lt;br&gt;Appreciate each other’s roles as resources&lt;br&gt;Feel part of a larger yet ill-defined team</td>
</tr>
<tr>
<td>3. <strong>Advanced Integration</strong>&lt;br&gt;Have separate systems</td>
<td>Communicate, driven by specific patient issues&lt;br&gt;Collaborate, driven by need for each other’s services and more reliable referral&lt;br&gt;Meet occasionally to discuss cases due to close proximity&lt;br&gt;Have a basic understanding of roles and culture</td>
</tr>
<tr>
<td>4. <strong>Advanced Integration</strong>&lt;br&gt;Have separate systems</td>
<td>Share some systems, like scheduling or medical records&lt;br&gt;Communicate in person as needed&lt;br&gt;Have regular face-to-face interactions about some patients&lt;br&gt;Have an in-depth understanding of roles and culture</td>
</tr>
<tr>
<td>5. <strong>Full Integration</strong>&lt;br&gt;Actively seek system solutions together or develop work-arounds</td>
<td>Communicate frequently in person&lt;br&gt;Collaborate, driven by need for consultation and coordinated plans for difficult patients&lt;br&gt;Have regular face-to-face interactions about some patients&lt;br&gt;Have roles and cultures that blur or blend</td>
</tr>
<tr>
<td>6. <strong>Fully Integrated</strong>&lt;br&gt;Have resolved most or all system issues, functioning as one integrated system</td>
<td>Communicate consistently at the system, team and individual levels&lt;br&gt;Collaborate, driven by shared concept of team care&lt;br&gt;Have formal and informal meetings to support integrated model of care&lt;br&gt;Have roles and cultures that blur or blend</td>
</tr>
</tbody>
</table>
• C. J. Peek suggests that in order to impact healthcare, three worlds must be addressed simultaneously
  ✓ Clinical
  ✓ Operational
  ✓ Financial
IHI Triple Aim Works

• Berwick (et al) Improvement in healthcare requires three aims:
  ✓ Improving the patient experience of care
  ✓ Improving health
  ✓ Attending to costs and financing
## Proposed Metrics for Collaborative Care (Miller et al., 2009)

<table>
<thead>
<tr>
<th>Percent Detected</th>
<th>Percent Treated</th>
<th>Percent Improvement</th>
<th>Cost to the PC practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood of detection</td>
<td>Likelihood of treatment</td>
<td>Overall Efficacy</td>
<td>Professional training/salary</td>
</tr>
<tr>
<td>All patients screened</td>
<td>Trust – PCP to MH/BHP</td>
<td>Protocol-based</td>
<td>PCP involvement required</td>
</tr>
<tr>
<td>Periodic screening (i.e. annual)</td>
<td>Process integration</td>
<td>Treatments used</td>
<td>PCP time saved</td>
</tr>
<tr>
<td>Actionable screening results</td>
<td>Trust transfer for patient</td>
<td>Tailored to patient</td>
<td>Use of Brief Interventions</td>
</tr>
<tr>
<td>Range of conditions detected</td>
<td>MH stigma – social</td>
<td>Continuity of care</td>
<td>Common Sched/Billing</td>
</tr>
<tr>
<td>PCP training side-effect</td>
<td>MH stigma – education</td>
<td></td>
<td>Common facilities</td>
</tr>
<tr>
<td></td>
<td>Overcoming denial</td>
<td></td>
<td>Common EMR/IT</td>
</tr>
<tr>
<td></td>
<td>Patient’s logistics</td>
<td></td>
<td>PCP Coverage</td>
</tr>
<tr>
<td></td>
<td>Patient’s ability to pay</td>
<td></td>
<td>The Triple Aim (Berwick, 2008)</td>
</tr>
<tr>
<td></td>
<td>Seamless with medical</td>
<td></td>
<td>Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Health</td>
</tr>
<tr>
<td>Three Worlds of Healthcare (Peek, 2008)</td>
<td></td>
<td></td>
<td>Cost</td>
</tr>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Financial</td>
<td></td>
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</tbody>
</table>


Integrated Care Metrics Based on IHI/Peek/NCQA – Operational Metrics

- Shared Medical Records
- Common Waiting Area
- Shared Scheduling Procedures
- Single Treatment Plan
- Phone Follow Up
- Ability to Bill
- MH Provider in Medical Staff Activities
- Shared Office Space
- Use of EMR and IT
Access Metrics

- Open Access
- Procedure for Immediate Referral and intervention
- Shared Clinical Notes
- Shared Scheduling
Identification and Referral Metrics

- Systematic Screening Procedures
- % Screened
- % Detected
Treatment Metrics

- % Referred who initiated treatment
- % Referred who complete treatment
- Protocols for evidence based treatment
- Protocols for disease specific problems
- Treatment available irrespective of ability to pay
- Seamless medical care
- Immediate and regular contact between providers to discuss treatment
- Consultation
- Joint appointments
- Care management functions
Improvement Metrics

• % Referred who initiated treatment
• % Referred who complete treatment
• Protocols for evidence based treatment
• Protocols for disease specific problems
Financial and Financial Management Metrics

- Cost
- Professional training/salary
- PCP Involvement required
- PCP Time Saved
- Use of brief interventions
- Shared billing
- PCP Coverage
- Practice management
- Tracking outcomes
- Use of data for practice improvements
- Case mix tracking
- Use of data to assess cost outcomes/effectiveness
- Use of data in financial planning and resource decision making
Measure Simultaneously

Clinical

Financial

Operational

Contact: Communications@TheNationalCouncil.org
202.684.7457
What do you Measure?
BMI Indicators

• % of mental health consumers receiving atypical antipsychotic agents whose Weight/Height/Body Mass Index (BMI) [calculated value using weight and height] is > 25 on initial evaluation
• % of mental health consumers receiving atypical antipsychotic agents whose Weight/Height/Body Mass Index (BMI) [calculated value using weight and height] is > 25 at 4-6 weeks
• % of mental health consumers receiving atypical antipsychotic agents whose Weight/Height/Body Mass Index (BMI) [calculated value using weight and height] is > 25 at 12 weeks
• % of mental health consumers receiving atypical antipsychotic agents whose Weight/Height/Body Mass Index (BMI) [calculated value using weight and height] is > 25 at 6 months

• POLLING QUESTION: ARE YOU CURRENTLY COLLECTING BMI’S ON YOUR CONSUMERS?
Blood Pressure

- % of mental health consumers receiving atypical antipsychotic agents whose blood pressure systolic/diastolic reading is >125/90` on initial evaluation
- % of mental health consumers receiving atypical antipsychotic agents whose blood pressure systolic/diastolic reading is >125/90` at 4-6 weeks
- % of mental health consumers receiving atypical antipsychotic agents whose blood pressure systolic/diastolic reading is >125/90` at 12 weeks
- % of mental health consumers receiving atypical antipsychotic agents whose blood pressure systolic/diastolic reading is >125/90 at 6 months

• POLLING QUESTION: DO YOU ROUTINELY CHECK BP AT EACH MEDICATION REVIEW APPOINTMENT?
HgA1C - Sugar

- % of patients in PC with evidence of an assessment for hyperglycemia within 16 weeks after initiating treatment with an atypical antipsychotic agent

- POLLING QUESTION: ARE YOU CURRENTLY COLLECTING GLUCOSE MONITORING INFORMATION ON YOUR CONSUMERS ON A REGULAR BASIS?
Depression/Bipolar Screening

- % of primary care patients with diagnosis of depression at 12 weeks,
- % of primary care patients with diagnosis of depression at 6 months
- % of primary care patients with depression with PHQ-9 on initial evaluation
- % of primary care patients with depression with PHQ-9 at 4-6 weeks
- % of primary care patients with depression with PHQ-9 at 12 weeks
- % of primary care patients with depression with PHQ-9 at 6 months
- % of patients screened annually for depression in primary care
- % of patients treated for depression who were assessed, prior to treatment, for the presence of current and/or prior manic or hypomanic behaviors

- POLLING QUESTION: ARE YOU ROUTINELY USING THE PHQ 9 AS A SCREENING AND OUTCOME TOOL FOR DEPRESSION?
Suicide Assessment

• % of patients diagnosed with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide
• % of patients diagnosed with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for current or past alcohol or chemical substance use

POLLING QUESTION: ARE YOU ROUTINLEY USING AN EVIDENCE BASED TOOLS FOR SCREENING FOR SUICIDE?
Additional Key Measures

- % of mental health consumers receiving atypical antipsychotic agents assessed for family history of diabetes, hypertension, cardiovascular disease
- % of mental health consumers receiving atypical antipsychotic agents assessed for Tobacco Use/History
- % of mental health consumers receiving atypical antipsychotic agents assessed for Substance Use/History
- % of mental health consumers receiving atypical antipsychotic agents evaluated for social supports using the LOCUS/IV. Recovery Environment (Level of Stress, Level of Support) score
- % of mental health consumers receiving atypical antipsychotic agents with an identified primary care provider and a physical examination within the last year
- % of primary care patients with major depressive or bipolar disorder meeting severity/complexity criteria for specialty MH services (as established by state and local payers) referred for specialty MH care
- % of patients referred to MH specialty care who attend initial visit
- % of patients referred to Primary Care from MH who attend initial visit
SAMPLE Objectives and Measures Required in 2011

- Maintain an up-to-date problem list of current and active diagnosis based on ICD-9 or SNOMED
- % of diabetics with A1c under controls
- % hypertensive patients with BP under control
- % of smokers offered smoking cessation counseling
- Record vital signs; calculate and display BMI
- % of consumers with recorded BMI
- Prevention measures (flu vaccine, mammogram, colorectal cancer screenings

SAMPLE Objectives and Measures Required in 2013

- Manage chronic conditions using patient lists and decision support
- Preventable ER visits
- Access for all patients to PHR populated in real time with patient health
- % of patients with full access to PHR in real time
- Provide summary care data for visits
Common Outcome Measures Being Used

• Track and Trend
  • HGA1c
  • Metabolic Syndrome Measures
  • Blood Pressure
  • Asthma/Corticoid Steroid Inhaler
  • NOMS – National Outcome Measures
  • PHQ 9
  • GAD 7
  • CAGE – AID, AUDIT, MAST, DAST
What Are We Seeing?
PBHCI Grantees

Change in Section H Indicators from Baseline to Most Recent Recording - Oct 11, 2012

- Blood Pressure - Systolic
- Blood Pressure - Diastolic
- Blood Pressure - Combined
- BMI
- Waist Circumference
- Breath CO
- Plasma Glucose (Fasting)
- GluBAlc
- HDL Cholesterol
- LDL Cholesterol
- Triglycerides

Legend:
- At-risk at Baseline
- Outcome Improved
- No Longer At-risk
## Missouri State Data

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<table>
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<tbody>
<tr>
<td><strong>Base Period (CY2006)</strong></td>
<td></td>
<td>$1,556</td>
</tr>
<tr>
<td><strong>Expected Trend</strong></td>
<td></td>
<td>16.67%</td>
</tr>
<tr>
<td><strong>Expected Trend with no Intervention</strong></td>
<td></td>
<td>$1,815.81</td>
</tr>
<tr>
<td><strong>Actual PMPM in Performance Period (FY2007)</strong></td>
<td></td>
<td>$1,504.34</td>
</tr>
<tr>
<td><strong>Gross PMPM Cost Savings</strong></td>
<td></td>
<td>$311.47</td>
</tr>
<tr>
<td><strong>Lives</strong></td>
<td></td>
<td>6,757</td>
</tr>
<tr>
<td><strong>Gross Program Savings</strong></td>
<td></td>
<td>$25,254,928</td>
</tr>
<tr>
<td><strong>Vendor Fees</strong></td>
<td></td>
<td>$1,301,560</td>
</tr>
<tr>
<td><strong>Net Program Savings</strong></td>
<td></td>
<td>$23,953,368</td>
</tr>
<tr>
<td><strong>NET PMPM Program Savings</strong></td>
<td></td>
<td>$295.41</td>
</tr>
<tr>
<td><strong>Net Program Savings/(Cost) as percentage of Expected PMPM</strong></td>
<td></td>
<td>16.3%</td>
</tr>
</tbody>
</table>
Independent Living increased by 33%
Vocational Activity increased by 44%
Legal Involvement decreased by 68%
Psychiatric Hospitalization decreased by 52%
Illegal Substance use decreased by 52%
IN ADDITION- Study shows CMHCs services substantially decrease overall medical cost
Impact on Costs

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue PMPM</th>
<th>Expense PMPM</th>
<th>Margin PMPM</th>
<th>W/O Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2003</td>
<td>$20</td>
<td>$100</td>
<td>$-80</td>
<td>$-120</td>
</tr>
<tr>
<td>2005</td>
<td>$180</td>
<td>$140</td>
<td>$-40</td>
<td>$-100</td>
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Washtenaw County, Michigan
Sharing Data and Confidentiality
Overview of HIE Activity Informing Consent Management Issues
42 CFR Part 2 Consent Management

“To Whom”

Predominant Challenge:

- Development of a 42 CFR Compliant Consent that is Computable in a HIE Environment
- Awareness of What is Possible Today
- Planning for What Will be Possible in the Future
- Recognize we are in a Transition Period
  - Not all 42 CFR conditions can be fully met, however, patient still has complete control of consent
Our Approach:

- Build on What is Already Developed
- Coordinate with ONC & S&I Workgroups
- Coordinate with SAMHSA
- Ensure Legal Input
  - 3 of 5 HIEs have their legal experts regularly involved on the calls
- Identify current “Better Practices”
42 CFR Regs and SAMHSA FAQs 1 and 2 side by side as Consent developed
- HIEs obtained input from their Behavioral Health Workgroups
- HIEs invited their vendors to participate and comment as well
- Everything in “Black” was reviewed and found acceptable by everyone
- “Red” indicates problem areas not yet resolved (as of 6/29/12 still in process of determining a resolution)
A written consent to a disclosure under the Part 2 regulations must be in writing and include all of the following items (42 CFR § 2.31):

1) the specific name or general designation of the program or person permitted to make the disclosure;

2) the name or title of the individual or the name of the organization to which disclosure is to be made;

3) the name of the patient;

4) the purpose of the disclosure;

5) how much and what kind of information to be disclosed;

6) the signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient;

7) the date on which the consent is signed;

8) a statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; and

9) the date, event or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.
**PATIENT CONSENT AND AUTHORIZATION FORM FOR DISCLOSURE OF CERTAIN HEALTH INFORMATION**

***PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW***

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): ____________________________ Date of Birth (mm/dd/yyyy): ______

Address: ____________________________ City: ____________________________ State: ____ Zip: ______

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize access, use and disclosure of my:

Check all of the boxes to identify the information you authorize to disclose:

- Drug or alcohol abuse treatment information
- Mental health treatment information
**FROM WHOM**: Specific name or general description of person(s) or organization(s) who I am authorizing to release my information under this form:

- All health care providers involved in my care.
- All programs in which the patient has been enrolled as an alcohol or drug abuse patient, or
- Any drug or alcohol treatment program or other health care provider, pharmacy or organization providing care coordination that is affiliated with the XYZ HIO

- Only these providers

<table>
<thead>
<tr>
<th>Person/Organization Name:</th>
<th>Phone:</th>
<th>Address:</th>
<th>Secure email address:</th>
</tr>
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<tbody>
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</tbody>
</table>
**TO WHOM**: Specific person(s) or organization(s) permitted to receive my information:
- To the HIE [Name]
- The HIE and any provider(s) involved in my care in the HIE as of today’s date ONLY
- The HIE and only these specific providers
- Only these specific providers
- The HIE and any current and future provider(s) involved in my care in the HIE

<table>
<thead>
<tr>
<th>Organization Name:</th>
<th>Phone:</th>
<th>Address:</th>
<th>Secure email address:</th>
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<tbody>
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<tr>
<td><strong>ONLY THESE INDIVIDUAL PROVIDERS</strong></td>
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</table>

Most HIEs cannot manage only specific individual providers at this point in time.
States Recommended that this wording in the “To whom” Section

- The HIE and any current and future provider(s) involved in my care in the HIE

Be interpreted as acceptable in the same way that:

“Provider of On Call Coverage” is acceptable as the “name or title of the individual or the name of the organization to which disclosure is to be made”


A Patient/Client/Consumer would know who a provider “involved in their care” is but would not really know who “Provider of On-Call coverage” is.
**Amount and Kind of Information:** The information to be released may include but not be limited to: Laboratory, Medications, Medical Care & HIV/Aids, Alcohol & Substance Abuse and Mental or Behavioral Health information
**PURPOSE:** The information shared will be used:

- To help with my Treatment and Care Coordination
- To assist the provider or organization to improve the way they conduct work
- To help Pay for my Treatment

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Operations</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONLY USE WHAT IS APPROPRIATE FOR THE HIE. SOME HIEs ONLY PROVIDE EXCHANGE FOR “TREATMENT”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EFFECTIVE PERIOD: This authorization/consent/permission form will remain in effect until (enter date, event or condition upon which this authorization/consent expires):

__________________________

OR

This authorization/consent/permission form will remain in effect for (X Year(s) or X Month(s)) from the date the form is signed.

OR

This authorization/consent/permission will remain in effect until such time as XYZ HIO ceases to exist.

If there is no date entered the consent will be valid for one year from the date this form is signed.

Best practice is to always ask for a date any date. Events are not computable e.g. how to tell when someone dies. HIE would never know.
REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in the “To Whom” or “From Whom” sections “except to the extent the disclosure agreed to has been acted on.”
In addition:

• I understand that an electronic copy of this form can be used to authorize the disclosure of the information described above.

• I understand that there are some circumstances in which this information may be redisclosed to other persons according to state or federal law.

• I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.

• I have read all pages of this form and agree to the disclosures above from the types of sources listed.

“This HIE consent does not permit use of my protected health information in any criminal or civil investigation or proceeding against me without an express court order granting the disclosure unless otherwise permitted under state law.”
Signature of Patient or Patient’s Legal Representative (mm/dd/yyyy)

______________________________

Print Name of Legal Representative (if applicable)
Check one to describe the relationship of Legal Representative to Patient (if applicable):

☐ Parent of minor
☐ Guardian
☐ Other personal representative (explain: ________________________________
______________________________

NOTE: Under some state laws, minors must consent to the release of certain information. The law of the state from which the information is to be released determines whether a minor must consent to the release of the information.
This form is invalid if modified. You are entitled to get a copy of this form after you sign it.
Issues/Challenges:

- Some HIEs cannot process only specific providers in the “To Whom” Section
  - Is “All or Nothing”
- Is “All or Nothing” for “Type and Amount” of Data
  - Data Segmentation is not available in all systems today to support Data Segmentation
- HIEs cannot currently process “Only providers in the HIE as of the date of signing the form”

- Barriers due to technology, cost & operational issues for HIEs and providers
Possible Solutions:

- Use DIRECT only with a Provider Locator Service provided and supported by the HIE.
  - Can work in an HIE that is not storing any data and just providing the “pipes” e.g. IL HIE.

- Other solutions are in development.
Possible Solutions:

- Bring behavioral health data into the HIE but do not “render” it to the provider until the provider has attested with a second sign on that they have a treating relationship with the patient.

- 4 of the 5 HIEs do require this attestation.
  - All have audit trail capabilities to track access.

- Other solutions are in development.
ONC S&I Data Segmentation Workgroup

- Each Data element will be tagged at the EHR level with data describing the actual data to be delivered
  - “Metadata”

- Metadata will include attributes of the data to be shared in relation to consent e.g.
  - Is “Restricted” or “Confidential” in nature
  - Effective Date of consent
  - Termination date of consent
  - If not “all providers” which specific providers are allowed access etc.
Issues/Challenges:

- Some HIEs cannot process only specific providers in the “To Whom” Section
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• jeffc@thenationalcouncil.org
• 734.604.2591