BEHAVIORAL HEALTH: THE NEW FACE OF PACE

Development and Implementation of a Behavioral Health Program at PACE Southeast Michigan

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Objectives

1. Define Behavioral Health and Discuss the rationale for an integrated model.

2. Identify various factors that demonstrate a need for Behavioral Health in PACE.

3. Understand the methods, strategies and other considerations necessary for implementation of a Behavioral Health program into an existing PACE model.

4. Demonstrate the benefits of Behavioral Health in PACE through various outcome measures and case examples.
What is “Behavioral Health”?
Behavioral Health

- **Behavioral Health**: mental health activities performed within a primary care setting
  - Behavioral Health Services offer assistance when habits, behaviors, stress, worry, or emotional concerns about physical or other life problems are interfering with a person’s daily life and/or overall health.

- **Integrated Primary Care Behavioral Health**
  - A collaborative model in which BH and PCP’s work together in a shared system.
  - The behavioral health provider functions as a member of the primary care team to address the full spectrum of problems the patient brings to the PCP.

(Hunter, Goodey, Oordt, & Dobmeyer, 2012).
Illustration: A family tree of related terms used in behavioral health and primary care integration
See glossary for details and additional definitions

**Integrated Care**
Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Connotes organizational integration involving social & other services. "Altuities" of integration: 1) integrated treatments, 2) integrated program structure, 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

**Patient-Centered Care**
"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care"—or "nothing about me without me" (Birnberg, 2011).

**Coordinated Care**
The organization of patient care activities between two or more participants (including the patient) involved in care, to facilitate appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care" (AHRQ, 2007).

**Collaborative Care**
A general term for ongoing working relationships between clinicians, rather than a specific product or service (Doherty, McDaniel & Baird, 1996). Providers combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unutzer et al, 2002).

**Co-located Care**
BH and PC providers (i.e. physicians, NP's) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

**Shared Care**
Predominantly Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining 1 treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

**Integrated Primary Care or Primary Care Behavioral Health**
Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place—"no wrong door" (Blount). BH professional used as a consultant to PC colleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

**Behavioral Health Care**
An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

**Mental Health Care**
Care to help people with mental illnesses (or at risk)—to suffer less emotional pain and disability—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

**Substance Abuse Care**
Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

**Patient-Centered Medical Home**
An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient’s family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007).

**Primary Care**
Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Integrated Primary Care

American Psychological Association (APA)

- Reduce Risk, Improve Treatment, Lower Cost
- Eliminates Stigma
- Increase Access to Underserved
- Increase Awareness
When we break a bone: Sign my cast!

When we get a bad cut: Check it out! 12 stitches!

When we get the flu: Jibby McJibbers
Today at 5:32 AM.

I just threw up all over everything I own. I need an old priest and a young priest.
21 Likes

When we struggle with mental health issues: Hey.
Integrated Primary Care

Substance Abuse and Mental Health Service Administration (SAMHSA)

Outline of factors to promote successful advancement of behavioral health:

• Universality
• Integrative
• Preventative
• Trauma Informed Care
• Information and Data Driven
• Access
Integrated Primary Care

President’s New Freedom Commission Report

• Older adults with mental illness receive inadequate care

• Eliminate disparities and fragmentation; culturally competent care

State of Michigan’s Mental Health and Wellness Commission

• Integrated physical and behavioral health care for priority populations

• Enhance coordination to “keep people in their communities and in residential settings that support independence and personal freedom”
RATIONALE FOR AN INTEGRATED CARE MODEL

- Burdens of Behavioral and Mental Health Issues
- Integrated Primary Care Examples and Findings
Burdens of Behavioral and Mental Health Issues

- 26 percent (roughly 58 million) of adults in the United States in 2001-2003 (Kessler, Chiu, Demler, et al., 2005)

- Accounts for 15% of the overall disease burden (Murray & Lopez, 1996)

- 70% of primary care visits (Fries, Koop, & Beadle, 1993)

- 80% of all psychotropic medications are prescribed by non-psychiatric providers (Beardsley, Gardocki, Larson, & Hidalgo, 1988)

- Premature deaths, disability, lost productivity, and increase in health care costs (Unutzer, Patrick, Simon, et al., 1997)

- Americans over the age of 65 with psychiatric disorders projected to double from 2000-2030, from 7 million to 15 million (Jeste, Alexopoulos, Bartels, et al., 1999)
Integrated Primary Care Examples and Findings

• Veterans Affairs & On-Lok (PACE)
  • Patient’s prefer integration; yields more effective sharing of information
  
  • Mental health problems are often missed or misattributed to physical illness in primary care, particularly with older patients
  
  • Patients are more likely to receive treatment for mental health issues when identified in primary care
  
  • Increased timely access to mental health service
  
  • Reduced in psychiatric inpatient utilization
  
  • Reduced anxiety/stress of staff

(Zeiss & Karlin, 2008; Ginsburg & Eng, 2009)
PACE SOUTHEAST MICHIGAN

- Demographics
- Changing face of pace
- Need for Behavioral Health
PACE: Demographics

PACE SEMI

74 % Female
26 % Male

93% African American
7% Caucasian

N = 423

National

54% Caucasian
30% Black
8% Hispanic
2% Asian
1% Native Americans
5% other/unknown

Adapted from Bloom, S. (2014). PACE Policy and Strategic Issues Update
## PACE SEMI Demographics vs. National Average

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<tbody>
<tr>
<td>Avg. Age</td>
<td>81</td>
<td>73</td>
<td>65 (Aug 31)</td>
<td>77</td>
</tr>
<tr>
<td>Census</td>
<td>255</td>
<td>309</td>
<td>423 (Oct 1)</td>
<td>275</td>
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Adapted from Bloom, S. (2014). PACE Policy and Strategic Issues Update
The Changing Face of PACE

Age Groups

1998: 85%
2014: 95%

5% in 1998
15% in 2014

65+
55-64

Adapted from Bloom, S. (2014). PACE Policy and Strategic Issues Update
PACE SEMI LOCD STATISTICS

PACE Southeast Michigan 2015

Door 1: 30%
Door 2: 58%
Door 3: 9%
Door 4: 1%
Door 7: 2%
Need for Behavioral Health: Psychiatric Disorders

- Total Participants with any psychiatric diagnosis = 360 (85.1% of total census)
  - Average number of diagnoses among those Participants = 3.8

- Total Participants with dementia-related diagnoses (Dementia, Vascular Dementia, Alzheimer’s Dementia, Mild Cognitive Impairment) = 265 (62.6% of total census)

- Total Participants with dementia-related diagnoses + depressive disorder = 112 (42.3% of Participants with dementia)

- Total Participants with Schizophrenia, Schizoaffective Disorder, MDD, Bipolar, and/or Psychosis = 69 (16.3% of total census)
  - Schizophrenia and/or Schizoaffective Disorder = 24 (5.7% of total census, which is more than 5x greater the general population; .3-.7% and .3%, respectively)
Referral Sources

• Group and Boarding Homes
  • 31 Participants

• 19 have already been referred for Behavioral Health Services

• All have at least 1 mental illness diagnosis
  • Dementia = 19
  • Schizophrenia + Schizoaffective = 11
  • Bipolar = 3
  • TBI = 4
  • Sub Abuse = 8

• Average number of diagnoses per participant = 3.8
Behavioral Health Care in PACE: Changing Needs for a Changing Population

- In general, older adults with mental illness have been identified as receiving an inadequate amount of care (Hogan, M. F., 2003; Garfield, et al., 2001)

- PACE, intended to manage an older frail population, is now beginning to see increasingly younger dual eligible participants with mental illness due to this population living longer, becoming less marginalized, and demonstrating a need for an alternative forms of care

- This requires a new approach to holistic and integrated care (i.e., staff specializing in this area)

- Training existing staff to promote awareness, reduce stigma, dispel common misinformation and provide education regarding mental health issues, ultimately better preparing them to care for this population
IMPLEMENTATION AT PACE SEMI

- PACE SEMI Model Overview
- Behavioral Health Services
PACE SEMI Model Overview

- Integrated PCBH Model – for the elderly
- Culturally Competent (i.e., patient-centered)
- Trauma-Informed
- Preventative
- Data and Information Driven
Integrated Primary Care for the Elderly

• Tailored approach (e.g., cognitive decline, adjustment, caregiver stress)

• Integrated care model:
  • More visits to PC and fewer emergency room visits
  • Better self-reported health status and lower costs

(Bartels, 2004)
Culturally Competent

• Patient-centered

• Ways of thinking, communicating, interacting and views on roles, relationships, customs and values (Betancourt, Green, & Carillo, 2002)

• Empathy, responsiveness, and compassion regarding the values, needs, and preferences of the individual

• Example: meanings assigned to mental/behavioral health care (e.g., selection of measures and considerations of physiological manifestations of depression)
DO ANY OF YOUR RELATIVES SUFFER FROM MENTAL ILLNESS?

NO.... THEY ALL SEEM TO ENJOY IT!!!
## Patient Health Questionnaire-9 (PHQ-9) vs. Geriatric Depression Scale (GDS)

<table>
<thead>
<tr>
<th>PHQ-9</th>
<th>GDS</th>
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<tbody>
<tr>
<td>• PHQ-9 the ‘gold standard’ in primary care settings</td>
<td>• GDS commonly used with elderly patients</td>
</tr>
<tr>
<td>• PHQ-9: 9-item depression screen</td>
<td>• GDS: 30-item depression screen, also offered in 15-item short form (GDS-SF)</td>
</tr>
<tr>
<td>• PHQ-9 items represent DSM diagnostic criteria for diagnosis of MDD</td>
<td>• GDS does not represent diagnostic criteria for any specific diagnosis</td>
</tr>
<tr>
<td>• PHQ-9 taps into physiological manifestations of depression (e.g., sleep disturbance, change in appetite)</td>
<td>• GDS represents a greater focus on feeling and thought content</td>
</tr>
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Overall, the PHQ-9 has demonstrated to perform comparably to the GDS in detection of depression in an elderly primary care population. (Phelan, Williams, Meeker, Bonn, et al., 2010)
Trauma-Informed Care

• The National Center for Trauma-Informed Care

• Supportive, comprehensively integrated, and empowering

• Services and programs designed to be more supportive and avoid re-traumatization

• 83% of primary care patients report at least 1 traumatic event (Bruce, Weisberg, Dolan, et al., 2001)

• 36% of patients with major depression also screen positive for PTSD (Campbell, Felker, Liu, et al., 2006)
Data and Information Driven

• Outcome Measures and Reporting
  • Use of psychotropic medications (e.g., atypical antipsychotics)

• Depression Scores (i.e., PHQ-9)

• Inpatient psychiatric admissions

• Education Assessments
PACE SEMI Behavioral Health Services

1. Evaluation and assessment

2. Treatment

3. Aftercare

4. Education
Evaluation and Assessment

• Brief vs. Full

• Behavioral, Cognitive, Emotional
  • Semi-structured clinical interview
  • MoCA (DRS available as deemed appropriate)
  • PHQ-9
  • GAD-7
  • PCL-C

• Aid in Treatment Planning
# Cognitive Impairment Screening Severity Levels

<table>
<thead>
<tr>
<th></th>
<th>MMSE</th>
<th>MoCA</th>
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<tbody>
<tr>
<td>Mild</td>
<td>21-26</td>
<td>Mild</td>
</tr>
<tr>
<td>Moderate</td>
<td>11-20</td>
<td>Moderate</td>
</tr>
<tr>
<td>Severe</td>
<td>Less than 11</td>
<td>Severe</td>
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Treatment

• **Short-term Interventions**
  • Consultation/Liaison
    • Primary Care (e.g., curbside consultations)
    • Formal Referral (e.g., cognitive decline; behavioral and/or emotional disturbance)
    • Behavioral Medicine (e.g., pain management; smoking cessation, etc.)
    • Education (e.g., management of behavioral issues)

• **Long-Term Interventions**
  • Individual Psychotherapy
  • Group Psychotherapy
  • Psychiatric medication evaluation and monitoring
Aftercare

• “Booster” sessions

• Referrals to outside services (e.g., CMH)

• Bereavement programs
Education

• Offered to staff, participants, and caregivers

• All-Day Alzheimer’s and Dementia Care Seminar for staff

• All-Day Mental Health First Aid Training for staff

• In-services:
  • Trauma-informed care
  • Motivational interviewing
  • Behavioral Medicine (e.g., deep breathing/relaxation)
  • Suicide
PROGRAM EXPANSION

1. Bereavement Programming
2. Dementia Programming
Bereavement Programming

- Phone Contacts
- Individual Visits
- Support Groups
- Social Programs (e.g., Ladies Luncheon; Men’s Breakfast)
- Educational Series
- Memorial Tribute: A special memorial tribute is held quarterly for family members and loved ones to attend
- Special Anticipatory Programming: Individualized plans of care available to family members, caregivers, and loved ones who are experiencing difficulties anticipating the loss of a loved one
Dementia Programming

- Behavior Modification
  - ABC/ABIO Model

- Staff and Caregiver Education
  - Antecedents and consequences
  - Redirection

- All-Staff Dementia Training
  (i.e., Alzheimer’s Disease & Dementia Care Seminar)

- Friendship Park (i.e., Design and Montessori Programming)
OUTCOME MEASURES AND REPORTING

1. Behavioral Health Referrals and Services
2. Use of Psychotropic Medications (e.g., atypical antipsychotics)
3. Depression Scores (i.e., PHQ-9)
4. Inpatient Psychiatric Admissions
5. Education Assessments
Behavioral Health Referrals and Services

• **167** Participants referred for Behavioral Health Evaluation (39% of total census)

• **122** Participants followed on a regular basis (29% of total census)

• Others managed by Primary Care and/or other forms of intervention (e.g., SW supportive counseling; caregiver education/support groups)
Antipsychotic Medication Initiative

- **FDA ALERT [6/16/2008]**: “FDA is notifying healthcare professionals that both conventional and atypical antipsychotics are associated with an increased risk of mortality in elderly patients treated for dementia-related psychosis.”

- PACE workgroup to look at the use of antipsychotic medication in PACE participants with dementia (PACE SEMI’s Medical Director, Dr. Graddy is a member)

- PACE SEMI initiative aims to reduce the number of antipsychotics in elderly participants in order to minimize possible adverse effects

- 40 participants prescribed an antipsychotic; 29 appear to be utilized as a restraint (i.e., no history of psychosis and/or aggressive behavior prior to onset of dementia-related diagnosis)

- PACE SEMI has completed, or at least initiated, Gradual Dose Reductions (GDR) in 19 of these participants (65.5%)

- Behavioral modification techniques, education of staff, families and caregivers, contracted facilities
Depression Screening, Treatment, and Outcomes

- PHQ-9 scores ($N=63$)

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression Severity</th>
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<tbody>
<tr>
<td>1-4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
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- Average depression score for a participant referred for specialty treatment of depression (i.e., at time of first contact) = $11.83$ (indicative of Moderate Depression)

- Average of 15 visits

- Scores were reduced to an average score of $4.08$ (indicative of Minimal Depression), a change of $65.50\%$.

- Various other components are likely to help to reduce depression scores including the therapeutic milieu provided by the Day Health Center, the treatment and management of chronic health conditions, and the assistance with various life stressors including housing, financial, transportation, and food security.
Psychiatric Admissions

In line with the PACE model, the Behavioral Health Program seeks to prevent more intensive, higher cost interventions such as inpatient psychiatric admissions. Below are the combined numbers for both sites over the past 3 years:

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015 (As of October 1)</th>
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<tbody>
<tr>
<td>2013</td>
<td>1</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>2014</td>
<td>0.65% of All Admissions</td>
<td>4.14% of All Admissions</td>
<td>3.23% of All Admissions</td>
</tr>
<tr>
<td></td>
<td>0.34% of Census</td>
<td>2.03% of Census</td>
<td>0.47% of Census</td>
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Though we saw a rise in admissions in 2014, the increase parallels the rapid growth in both overall census and in participants with SPMI diagnoses at PACE SEMI (see below):

<table>
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<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015 (As of October 1)</th>
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<tbody>
<tr>
<td>RVT</td>
<td>RVT 129</td>
<td>RVT 173</td>
<td>DNW 205</td>
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<tr>
<td>DNW</td>
<td>DNW 161</td>
<td>DNW 171</td>
<td>RVT 218</td>
</tr>
<tr>
<td>Total</td>
<td>Total 290</td>
<td>Total 344</td>
<td>Total 423</td>
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Education Assessments

- **Alzheimer’s Disease and Dementia Care Seminar**
  - The National Council of Certified Dementia Practitioners (CDP) offers “extensive training in the area of Alzheimer’s and Dementia. Each student during training receives resources in the areas of Alzheimer’s and Dementia. These resources include key aspects of dementia care including communication techniques, disruptive behaviors interventions and tools for addressing concerns such as wandering, aggressive behaviors, poor nutrition, and sexuality (National Council of Certified Dementia Practitioners, 2014).

  - *142 out of 172 employees completed the course (82.6%)*

- **Mental Health First Aid (MHFA)**
  - MHFA “teaches the public how to recognize the symptoms of mental health problems, how to offer and provide initial help, and how to guide a person toward appropriate treatments and other supportive help”. (Mental Health Association of Maryland, Missouri Department of Mental Health, and National Council of Behavioral Health, 2013)

  - *108 out of 201 employees completed the course (53.7%)*
Education Assessments: Alzheimer’s Disease and Dementia Care Seminar

• During the Dementia Care Seminar, employees were assessed pre- and post-training on three measures associated with managing disruptive behaviors associated with dementia:

  1. Employee Subjective Competence (i.e., knowledge and preparedness)
  2. Employee Subjective Confidence (i.e., comfort)
  3. Employee Objective Competence (i.e., assessment of responses to a case example)

• The Dementia Training Assessment yielded the following results:

  1. Subjective Competence increased by 38%
  2. Subjective Confidence increased by 32%
  3. Objective Competence increased by 43%

• Overall, the data suggests that as a result of the Dementia Training, staff members are significantly more comfortable and better prepared to work with disruptive behaviors associated with dementia.
Education Assessment: MHFA Training

- During MHFA Training, employees were assessed pre- and post-training on two measures associated with working with participants experiencing difficulties related to mental health:
  1. Employee Subjective Competence (i.e., knowledge and preparedness)
  2. Employee Subjective Confidence (i.e., comfort)

- The Mental Health Training Assessment yielded the following results:
  1. Subjective Competence increased by 61%
  2. Subjective Confidence increased by 60%

- Overall, the data suggests that as a result of the MHFA Training, staff members are significantly more comfortable and better prepared to work with participants experiencing difficulties related to mental health.
BEHAVIORAL HEALTH CASE EXAMPLES

1. Depression
2. Smoking Cessation
Case Example: Depression

Ms. H. is a 69 yo AAWF self-referred to BH for “someone to talk to” about issues related to depression and anxiety

Hx of trauma and loss

MoCA = 19/30; mild cognitive impairment

PHQ-9 = 19/27; moderately severe depression

PCL-C = 72/85; indicative of PTSD

Treatment focus: Pt’s tendencies to avoid and isolate, contributing to feelings of loneliness and needs going unmet. Working through Pt’s resistances and educating on the importance of effective communication and relying on social support

Outcome: Pt’s depression score dropped to a 5/30 or “mild depression” after 8 weeks

No psychotropic medications necessary!
Case Example: Smoking Cessation

• Ms. E. is a 70 yo AADF self-referred to BH for issues related to smoking cessation
• Pt reported smoking about ½ pack a day and failed attempts with various nicotine replacement therapies prescribed in the clinic.
• **Brief Assessment and Intervention**
  - Self-reproach and guilt
  - Utilized motivational interviewing to tap into Pt’s own reasons to quit
• **Ongoing Brief Weekly Follow-Up**
  - CBT to re-frame maladaptive patterns of thinking
  - MI to continue to provide support and reinforcement for ongoing efforts to cope
• **Outcome**: Smoke free in 6 sessions
Summary and Conclusions

- Integrated care, which includes **Behavioral Health Services**, better promotes the overall well-being of PACE participants.

- Care should be patient-centered, culturally competent, geriatric-specific, and **trauma-informed**.

- **Behavioral Health** is not only additive... it is also **AMPLIFYING**!
References


References


References

Missouri Department of Mental Health, and National Council of Behavioral Health. (2013). *Mental Health First Aid USA, Revised First Edition*. Lutherville, MD: Mental Health Association of Maryland, Inc.


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