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Owner	Kelly Myricks: SUD Initiatives Administrator
Policy Area	Substance Use Disorders
Applicability	Detroit Wayne Integrated Health Network
References	SAMSHA, SAPT Block Grant: 45 CFR Part 96

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Annual Audit of SUD-Funded Programs Standard Operating Procedure

PROCEDURE PURPOSE

It is the policy of Detroit Wayne Integrated Network (DWIHN) to establish a consistent process to plan, conduct, report, and follow-up on annual fiscal, programmatic, environmental, and compliance audits of: Recovery Support Services, Recovery Homes, Programs funded by Substance Abuse Prevention and Treatment (SAPT) Block Grant, State Opioid Response (SOR), Public Act 2 (PA2) funds, and Opioid Settlement funds.

EXPECTED OUTCOME

A standardized, transparent, and compliant audit process will ensure consistent evaluation of SUD-funded programs, strengthens accountability and supports data-driven improvements in service quality.

KEY TERMS

- **Recovery Support Services (RSS)**: Nonclinical recovery supports (e.g., peer recovery support,

recovery coaching, transportation, basic needs) consistent with Michigan practice conventions for publicly funded recovery services

- **Recovery Homes**: Recovery residences that meet recognized recovery housing standards
- **Women's Specialty Services (WSS)**: Specialized services for pregnant women and women with dependent children funded under the SAPT Block Grant. WSS programs must ensure priority admission, enhanced case management, coordination with medical, behavioral health, and child welfare systems, access to parenting supports, and activities that promote family stability and recovery. WSS providers must meet all federal and state requirements for priority populations and documentation standards.
- **Funding Streams**:
    - **SAPT Block Grant**: Supports prevention, treatment, and recovery services; includes set aside and priority populations (e.g.; pregnant women, women with dependent children)
    - **SOR**: Supports evidence-based treatment and recovery, rapid access to MOUD and outcomes reporting consistency.
    - **Public Act 2 (PA2) Funds**: Support prevention, treatment, recovery, outreach, SUD workforce education, SUD conferences, SUD events and promotion.
    - **Opioid Settlement Funds**: Must align with approved remediation strategies, maintain transparency, and be segregated from other funding streams.

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ROLES & RESPONSIBILITIES

1. **SUD Initiatives Administrator**: Approves annual audit plan and final audit reports
2. **SUD Program Managers**
    a. Coordinate provider communication, documentation collection, and grant-specific compliance
    b. Perform reviews, document evidence, issue findings and recommendations, validate corrective actions
    c. Oversees CAP Implementation and Completion
3. **Providers / Recovery Home Operators**:
    a. Supply documentation
    b. Ensure facility readiness
    c. Implement CAPs
    d. Maintain compliance

PROCEDURE

1. **Annual Audit Planning**:
    A. SUD Program Managers will:
        - Compile the list of all DWIHN contracted approved RSS providers and Recovery Homes, SAPT, SOR, or Settlement funded services at the start of each fiscal year.

- Publish an annual audit calendar
- Prioritize audits using risk factors: prior findings, complaints, expenditure volume, staff turnover, performance results, and environmental safety indicators
- Determine modality: desk review, virtual, or onsite (onsite required for Recovery Homes)

B. Provider Notification
- SUD Program Managers within 30 calendar days prior to the scheduled review date will send an official letter notifying the provider of the upcoming review date (**except for Environmental Audit Reviews**), as well as provide a copy of the audit tool that will be utilized.

2. **Providers Pre-Audit Documentation Gathering Process**:

A. **RSS Providers**:
- Organizational chart, staff roster with credentials, and training logs
- Service descriptions, policies for: peer services, boundaries, crisis response, and transportation
- Monthly service logs and outcome/satisfaction data
- Policies on: confidentiality, grievance, incident reporting

B. **Recovery Homes**: Recovery Housing Providers must submit the following documentation prior to the audit review:
- House rules, resident agreements, grievance and incident procedures
- Emergency plans, safety checklists, occupancy documents
- MOUD accommodation policy, naloxone access practices, medication storage procedures
- Staff/house manager background checks, resident census and turnover records, drug testing policy

C. **Funding Stream-Specific**:
- **SAPT**: Budgets; prevention set aside documentation, priority population logs, 45 CFR Part 96 aligned reporting documents
- **SOR**: Budgets, GPRA aligned outcomes reporting, fidelity tools, MAT access protocols, stimulant response documentation
- **Opioid Settlement**: Spending plans, public reporting documents, procurement records, documentation tying expenditures to approved remediation categories, controls showing segregation from SAPT/SOR

D. **Women's Specialty Services (WSS) — WSS** programs must submit the following documentation prior to audit review:
- Policies and procedures demonstrating compliance with priority admission requirements for pregnant women and women with dependent children

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- Case management protocols, including coordination with OB/GYN, pediatric services, and child welfare (when applicable)
- Documentation of parenting supports, family engagement activities, and linkage to community resources
- Staff credentials and training records demonstrating WSS-specific competencies (trauma-informed care, family-centered practice, perinatal substance use treatment, etc.)
- Service logs and outcome data specific to WSS, including timeliness of access, retention, and family support measures
- Documentation of childcare supports or referral partnerships, when required

3. **Audit Execution**

A. ***Programmatic Review***:

1. *RSS*:

i. *Confirm services are allowable under the funding stream*

ii. *Verify role clarity and peer supervision*

iii. *Check transportation and basic needs support documentation integrity.*

2. *Recovery Homes*:

i. *Conduct an environmental walk-through (onsite): fire safety, exits, sanitation, food storage, naloxone access, observe resident rights signage*

ii. *Review admission/discharge processes, grievance handling, house governance (resident meetings/peer accountability)*

iii. *Validate MOUD-friendly implementation (no denial/eviction based solely on MOUD use)*

B. ***Fiscal Review***:

1. *Test expenditures for allowable, reasonable, and allocable by funding stream*
2. *Verify segregation of SAPT, SOR, and Settlement funds*
3. *Validate procurement and contract compliance*

C. ***Compliance Review***:

1. *SAPT: Set aside, priority populations, clinical/prevention standards, and reporting alignment with 45 CFR Part 96*
2. *SOR: Fidelity to evidence-based practices. MOUD access, stimulant response strategies, and outcome reporting*
3. *Opioid Settlement: Alignment with approved remediation categories, transparency/public reporting obligations, and strict segregation from other funds*

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D. ***WSS Audit Review — WSS*** audits include the following required elements:

1. *Verification that priority admission is consistently implemented for pregnant women and women with dependent children*
2. *Review of case files confirming enhanced case management, including service coordination, follow-up, linkage to medical care, and family-centered support.*
3. *Evaluation of staff training and competency in WSS requirements*
4. *Confirmation of documentation showing childcare supports or referral pathways are in place and utilized when applicable.*
5. *Review of outcomes reporting specific to WSS, including access, retention, engagement with parenting supports, and family stability metrics*
6. *Validation that services align with SAPT Block Grant requirements for WSS priority populations.*

E. ***Environmental Facility Audit — Access*** the physical environment of provider locations to ensure safety, accessibility, and compliance with health and environmental standards. These reviews include:

1. *Fire safety, smoke detectors, carbon monoxide devices, and emergency exit access*
2. *Sanitation practices, waste disposal, cleanliness, and overall facility condition*
3. *Food storage, kitchen safety, and pest management (when applicable)*
4. *Hazardous materials handling and secure storage*
5. *Resident or member living spaces (for Recovery Homes), including sleeping quarters, privacy expectations, and adequate furnishings*
6. *Facility accessibility (ADA considerations), lighting, ventilation, State/City regulatory inspections, and temperature control*

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4. **Audit Reporting** - SUD Program Managers/Coordinators will:

A. Schedule an Exit Summation meeting with the provider to share preliminary audit findings and results

B. Complete the audit tools in MHWIN within 15 calendar days of the conclusion of the review and send results to Provider, Managed Care Operation (MCO), Associate Vice President of Clinical Operations:

1. *Providers that have successfully met compliance (audit score of **90% or greater**; Environmental = **95% or greater**) will receive official notice of successful completion of the audit with copies of the audit report(s)*
2. *Providers that have not met compliance (audit scores **below 90%**; Environmental **below 95%**) will receive notice of the need for a Corrective Action Plan (CAP) along with a copy of the audit report(s).*

5. **Corrective Action Plan (CAP) & Follow-up**

A. SUD Program Managers/Coordinators will complete the standardized CAP template

with findings from the review that identifies any standards that were scored as "Partial" and/or "Not Met"

B. Utilizing the CAP form received from the SUD Program Managers, providers will have **up to 15 calendar days** to respond in writing with the remedial actions they will implement to address the findings identified in the CAP. The provider must identify who at the organization will be responsible for ensuring remediation is completed as well as document the expected date for completion

    1. *Remedial actions should be completed **within 90 calendar days** of completion of the audit. Any remedial actions requiring longer than **90 calendar days** will need prior approval from the SUD Program Manager.*
    2. *For CAP actions requiring more than **90 calendar days**, a meeting will be scheduled with the provider to review the CAP and its monitoring process.*
    3. *A virtual meeting invitation will be sent to the provider to discuss the details of the request for the CAP extension beyond **90 calendar days. Upon** conclusion of the meeting, the provider must submit the CAP the following business day.*

C. SUD Program Manager/Coordinator will review the written plan received from the provider to ensure all findings have been addressed with remedial actions. The provider will receive an official letter within **7 calendar days** via email that will identify if the CAP has been approved or rejected.

    1. *If the written CAP is not approved, the rationale for not approving the CAP along with recommendations will be provided. The provider will have **7 calendar days** to revise the CAP and return it to the SUD Program Manager.*
    2. *Revised CAPs not receiving approval will require an additional meeting with the provider, SUD Program Manger/Coordinator and the SUD Initiatives Administrator.*

D. Provider will submit evidence of CAP implementation at the end of each month until the CAP remedial actions have successfully been implemented and/or completed.

E. SUD Program Manager/Coordinator will review the evidence submitted validating that remediation was completed.

    1. *For any CAP evidence not submitted by the specified due date, SUD Program Manager will send via email a notice of missing CAP remediation evidence. The provider must respond within **two business days** with the expected date the evidence will be submitted (extension requests beyond **7 calendar days** must receive prior approval from the SUD Program Manager/ Coordinator)*

F. Upon successful completion of the CAP, SUD Program Managers/Coordinators will send the provider, MCO, and Associate VP of Clinical Operations a notice that they have successfully implemented their CAP.

6. **Non-Compliance & Escalation Procedure — When** a CAP is not submitted, submitted late, or actions are not implemented, a formal non-compliance and/or escalation procedure is triggered:

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A. **Informal**: Procedural Steps to avoid escalation. The following steps will be taken by the SUD Program Manager:

1. *SUD Program Manager/Coordinator will contact the provider to identify areas of non-compliance.*
2. *SUD Program Manager/Coordinator and provider will develop an Action Plan to address areas of non-compliance.*

B. **Formal**: If the Provider continues to exhibit non-compliance with meeting Procedural Steps, the following steps will occur:

1. **Initial Notice**: Provider will be issued a Notice of Violation or Deficiency Letter detailing the failure to meet timelines and will have **7 calendar days** to respond with appropriate documentation
2. **Management Escalation**: Escalation from line management to Provider Senior Leadership and DWIHN's Compliance, MCO, and legal departments to schedule a meeting within 5 business days to identify the following:
    i. Clear Accountability Assignment — Leadership should identify:
        a. *Who is responsible for each CAP action item*
        b. *Who will oversee the internal monitoring*
        c. *Identify a single point of contact for communication with the organization*
    ii. Revise/create a realistic Corrective Action Timeline — Leadership will develop:
        a. *New and firm completion date for all CAP items*
        b. *Interim check-ins (weekly or biweekly) meetings with compliance team*
    iii. Root Cause Analysis — Provider Leadership must identify the actual reason the CAP deadlines were missed (e.g., staffing shortages, leadership turnovers, poor internal communication, etc.)
    iv. Assignment of Specific and Measurable Action Steps — Provider Leadership must identify clear and immediate plans for correction (e.g., Policy updates, staff retraining, workflow changes, etc.)
    v. Development of the Escalation and Risk Mitigation Plan — DWIHN Leadership will identify and Provider must acknowledge the Escalation Plan if deadlines are missed, which could include but not limited to:
        a. ***Formal Sanctions**: Suspension of new referrals, increased monitoring, up to a recoupment of funds*
        b. ***External Reporting**: Reporting non-compliance to the appropriate state, federal, or regulatory bodies*
        c. ***Final Action**: Non-renewal of contract or in case of*

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gross non-compliance Contract termination

MONITORING STEPS

Who monitors this procedure:	Kelly Myricks SUD Initiatives Administrator
Department:	SUD, MCO, Access
Frequency of monitoring:	Annually
Reporting provided to:	SUD Director
Comments:	

Approval Signatures

Step Description	Approver	Date
VP of Clinical	Erik Hutchison: Vice President of Clinical Operations	Pending
Unit Review and Approval	Matthew Yascolt: Director of Substance Use Disorder	09/2026

Applicability

Detroit Wayne Integrated Health Network

Standards

No standards are associated with this document