INTEGRATED
Services of Kalamazoo

Community • Independence • Empowerment

Jeffrey W. Patton
Chief Executive Officer

www.iskzoo.org

Administrative Services
2030 Portage Street
Kalamazoo, MI 49001
(269) 553-8000

Access Center
615 East Crosstown Pkwy
Kalamazoo, MI 49001
(269) 373-6000
(888) 373-6200
MI Relay Center: 711

Integrated Health & Psychiatric Services
615 East Crosstown Pkwy
Kalamazoo, MI 49001
Adults: (269) 553-7037
Youth: (269) 553-7078

Office of Recipient Rights
2030 Portage Street
Kalamazoo, MI 49001
(269) 364-6920

Services for Adults with Mental Illness
2030 Portage Street
Kalamazoo, MI 49001
(269) 553-8000
(888) 373-6200

Services for Adults with Intellectual and Developmental Disabilities
418 West Kalamazoo Ave
Kalamazoo, MI 49007
(269) 553-8060
MI Relay Center: 711

Services for Youth and Families
418 West Kalamazoo Ave
Kalamazoo, MI 49007
(269) 553-7120

Substance Use Disorder Services
(800) 781-0353

Training
2030 Portage Street
Kalamazoo, MI 49001
(269) 364-6952

AGENDA

INTEGRATED Services of Kalamazoo BOARD HAS SCHEDULED ITS MEETING FOR MONDAY, *November 22, 2021*, BEGINNING @ 4:00PM via *Microsoft* TEAMS.

- CLOSED SESSION/MOTION/ROLL CALL VOTE – *Jeff Patton*, CEO/Annual Performance Evaluation @ 3:30PM.

I. CALL TO ORDER - CITY & COUNTY DECLARATION
II. AGENDA
III. MINUTES
IV. CITIZEN TIME

V. RECIPIENT RIGHTS
  a. Recipient Rights Monthly Report

VI. CONSENT CALENDAR Monitoring Reports/NOVEMBER/ MOTION/ROLL CALL VOTE
  a. Communication & Counsel to the Board (Policy)
  b. Governing Style (Policy)
  c. Corporate Compliance and Risk Management (Policy)
  d. Compliance & Risk FY Annual Plan
  e. Compliance & Risk Status Report
  f. FSAC Family Support Advisory Group (Report)

VII. PROGRAM SERVICES REPORT/Welcome Tyrone Thrash & David Anderson/VERBAL
  a. Program Services Report – Keystone Veterans Transitional House Therapy Garden Project: Tyrone Thrash/Housing Coordinator/ISK Keystone Veterans Transitional House & David Anderson/Director/ISK Facilities & Housing

VIII. FINANCIAL REPORTS
  a. Financial Condition Report
  b. Utilization Report
  c. *October Disbursements* MOTION

IX. ACTION ITEMS NEW & REVISITED
  a. Open Meetings Act (§ 15.263) – Return to in-person meetings MOTION
  b. Emergency Executive Succession (Board Policy V.05) VERBAL MOTION
  c. Endowment Fund (Board Policy VI.03) VERBAL MOTION

X. CHIEF EXECUTIVE OFFICER REPORT/VERBAL
  a. CEO Report

XI. CITIZEN TIME

XII. BOARD MEMBER TIME
  a. SWMBH (Southwest Michigan Behavioral Health) Updates/Erik Krogh
  b. Verbal motion to cancel or have the December 2021 ISK Board meeting

XIII. ADJOURNMENT

INTEGRATED Services of Kalamazoo

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RE FOCUS CONNECT COVER

A community recovery initiative in partnership with INTEGRATED

III.

INTEGRATED Services of Kalamazoo (*ISK*) *October 25, 2021*

ISK Board Member	Board Members PRESENT	Declaration of Location City/County	Board Members ABSENT
Erik Krogh, *CHAIR*	X	Kalamazoo/Kalamazoo	
Karen Longanecker, *VICE CHAIR*	X	Kalamazoo/Kalamazoo	
Nkenge Bergan	X	Kalamazoo/Kalamazoo	
Sarah Carmany			X
Ituha Cloud			X
Patrick Dolly	X	Kalamazoo/Kalamazoo	
Pat Guenther	X	Kalamazoo/Kalamazoo	
Michael Raphelson	X	Kalamazoo/Kalamazoo	
Sharon Spears	X	Kalamazoo/Kalamazoo	
Michael Seals	X	Kalamazoo/Kalamazoo	
Veronica McKissack, *COMMISSIONER*			X
Jenna Verne	X	Kalamazoo/Kalamazoo	

ISK - KCMHSAS Staff Present:

Jeff Patton, *CEO*
Roann Bonney
Charlotte Bowser
Wanda Brown
Pat Davis
Sheila Hibbs
Dianne Shaffer
Amy Rottman
Michael Schlack, *CORPORATE COUNSEL*
Alecia Pollard
Demeta Wallace

ISK - KCMHSAS Staff Absent:

Lisa Brannan
Kathy Lentz
Beth Ann Meints
Pat Weighman

Providers:

Fi Spalvieri
Chief Executive Officer
Community Living Options

Call to Order:
Chair Krogh welcomed all in attendance to the October 25, 2021, INTEGRATED Services of Kalamazoo Board meeting. The meeting was called to order at 4:02PM.

Agenda:
Board members reviewed the agenda for changes. Vice Chair Longanecker asked that item VI.e. "Guidelines for Board Member Appointments (Policy)" on the agenda be removed for further discussion on the policy during the Consent Calendar review. Board members agreed with this change.

Minutes:
Member Seals, "I MOVE TO ACCEPT THE MINUTES FROM September 27, 2021." Supported by Member Guenther.

ROLL CALL:

NAME	YEAS	NAYS
Erik Krogh, *CHAIR*	X	
Karen Longanecker, *VICE CHAIR*	X	
Nkenge Bergan	X	
Patrick Dolly	X	
Pat Guenther	X	
Sharon Spears	X	
Michael Raphelson	X	
Michael Seals	X	
Jenna Verne	X	

MOTION PASSED.

Citizen Time: No citizens came forth.

Recipient Rights:
Recipient Rights Monthly Report:
Roann Bonney, ISK, ORR Director, presented the complaints/allegations closed in September 2021.

Abuse Violations:
There were 2 substantiated Abuse II violations in September 2021.

- The remedial actions for these violations were Employment Termination (1), Contract Action (1), Training (1), and Verbal Counseling (1). There was one staff involved in each citation.

The 2 violations occurred at different agencies.

There was one substantiated Abuse III violation in September 2021.

- The remedial action for this violation was Employment Termination (1).

Neglect Violations:
There was one substantiated Neglect II violation in **September 2021**. It was a Neglect II, Failure to Report violation.

- The remedial action for this violation was Employment Termination (1).

There were four substantiated Neglect III violations in September 2021.

- The remedial actions for these violations were Employment Termination (1), Training (1), Verbal Counseling (2), Contract Action (1), and Written Reprimand (2). There was one staff involved in each of three citations.

The 4 violations occurred at 2 agencies. The 3 violations occurring at the same agency occurred at 3 different program sites.

All the ORR case information is forwarded to the ISK Population Directors monthly for any tracking/trending of the RR information in their areas of authority * (Agencies can include ISK).

Consent Calendar (MOTION/ROLL CALL VOTE):
Chair Krogh, "Are there any materials that the ISK Board would like to have removed from the Consent Calendar before we proceed with the ROLL CALL vote?" No materials were requested to be removed. However, Vice Chair Longanecker recommended that in our role as ISK Board Members, compliance oversight is essential and mandatory. Therefore, let's give specific attention to the requirement of a Candidate Selection Committee in the Guidelines for Board Member Appointments Board Policy I.03.

Monitoring Reports:
OCTOBER:

- **Board Purpose and Business Description (Policy)**
- **Treatment of Persons Served w/Substantiated Complaints (Policy & Report)**
- **Ends Development Process (Policy)**
- **Ends for Individuals Served (Policy)**
- **Guidelines for Board Member Appointments (Policy)**
- **Customer Services (Report)**
- **Customer Advisory Council Annual (Report)**

Vice Chair Longanecker recommended that a Candidate Selection Committee be established to review the applications and selection of potential new ISK Board Members. The Guidelines for Board Member Appointments Board Policy I.03, requires that such a committee be established. After discussion amongst the ISK Board Members regarding the proposed recommendation, it was determined that this committee would be established and the members will be appointed by the ISK Board Chair, Erik Krogh. Chair Krogh in agreement with the ISK Board Members appointed the following individuals to serve on the Candidate Selection Committee:

- Pat Guenther, Michael Raphelson, Michael Seals

Chair Krogh, "I MOVE TO APPOINT PAT GUENTHER, MICHAEL RAPHELSON AND MICHAEL SEALS TO SERVE ON THE CANDIDATE SELECTION COMMITTEE TO REVIEW THE APPLICATIONS AND SELECTION OF NEW ISK BOARD MEMBERS. I ALSO MOVE TO ACCEPT THE OCTOBER MONITORING REPORTS CONSENT CALENDAR." Supported by Vice Chair Longanecker.

ROLL CALL:

NAME	YEAS	NAYS
Erik Krogh, *CHAIR*	X	
Karen Longanecker, *VICE CHAIR*	X	
Nkenge Bergan	X	
Patrick Dolly	X	
Pat Guenther	X	
Sharon Spears	X	
Michael Raphelson	X	
Michael Seals	X	
Jenna Verne	X	

MOTION PASSED.

Program Services Report:
Dianne Shaffer, ISK, Senior Executive for Policy, Planning, and Innovation presented the October Program Services Report that was submitted by Patricia J. Weighman, LMSW/ACSW, Senior Executive, Youth and Family Services.

Youth and Family Department - Program Highlight: SAMHSA System of Care Grant

The Youth and Family Department is implementing the third 4-year SAMHSA System of Care (SOC) grant. The grant award is $1 million per year. The focus of this grant is to work closely with Department of Health and Human Services (DHHS) child welfare for youth in foster care or at risk of removal by DHHS to help coordinate and deliver needed mental health services. This primarily occurs through the structured process at DHHS using Team Decision Making (TDM) and Family Team Meetings (FTM). TDM- Team Decision Making involves removals, placements, change of placements, or stability meetings. FTM- Family Team Meetings are for families to discuss with CPS (Child Protective Services) staff or FC (Foster Care) staff a plan for action with services, failed drug tests, need for additional supports, further court involvement, or plans with the case closing/being transitioned.

An effective strategy has been to have Erin Hetrick, an ISK intake specialist, attend the DHHS FTMs and TDMs. Erin provides an immediate intake or schedules a time that is more convenient for the family. There are several other ISK employees who have participated, including Danielle Sackrider, and they have participated in over 450 TDMs/FTMs since August 2020. The meetings are effective in

linking youth in Foster Care (FC)/Protective Services (PS) to needed services, return youth to the community from residential placement to community-based services, and reducing number of failed foster care placements, and help to divert removal. Outcomes of the meetings include intakes for services, community resource referrals by ISK Community Health Workers, referrals for substance use treatment for caregivers, or Mobile Crisis Response Team (MCR) crisis planning. When a youth has current services, frequent outcomes include additional or more frequent support for the family, crisis planning with MCR or that an additional referral made (e.g., Family Support Partner, Psychological Assessment Team (PATS), or the STREET program.

Another effective strategy is that MCR attends some planned removals or follow-up on removals using trauma informed interventions. A planned removal happens following a FTM and is when a family has been working with Ongoing Protective Services and supports have not been sufficient to assure the child's safety. MCR provides the youth immediate support on the loss of family and placement with foster parents whom the youth does not know. They are also able to help the youth and foster parent understand the next service and how to contact MCR. MCR described one removal that became acrimonious. Police and protective services were working with the parents and the youth was left alone in the police vehicle. MCR immediately began to provide a trauma informed intervention to help the youth understand what was happening, what would happen next, what "removal" means, what happens with siblings, and when they would be able to talk to their family again.

ISK continues to work with DHHS State and local leadership and staff to identify improvements in communication and coordination. The desired outcome is to assure youth and families involved with CPS or FC have access to the mental health assessments, supports, and services needed.

Financial Condition Report:
Pat Davis, ISK, Deputy Director, Administrative Services, presented the Financial Condition report for the period ending September 30, 2021.

SWMBH:
Revenues:
Revenues for the twelve-month (12) period are projected to be $74,204,004 compared to budgeted revenues of $76,038,659. Consequently, revenues are in an un-favorable position by approximately $1,834,615.

Expenditures:
Expenditures for the twelve-month (12) period are projected to be $74,204,044 compared to budgeted expenditures of $76,038,659. Consequently, expenditures are in a favorable position by approximately $1,834,615.

ISK:
Revenues:
Revenues for the twelve-month (12) period are $20,300,372 compared to budgeted revenues of $21,658,323. Consequently, revenues are in an un-favorable position by approximately $1,357,951.

Expenditures:
Expenditures for the twelve-month (12) period are $19,459,483 compared to budgeted expenditures of $21,105,418. Consequently, expenditures are in a favorable position by approximately $1,645,935.

Utilization Reports:
Pat Davis, ISK, Deputy Director, Administrative Services, presented the September 30, 2021, Utilization Report.

- Youth Community Inpatient Services is unfavorable by $115,935
- MI Adult Community Inpatient Services is at (1,518) days and unfavorable at $1,438,543
- Community Living Supports, Personal Care, and Crisis Residential is favorable at $209,851

Investment Report:
Pat Davis, ISK, Deputy Director, Administrative Services, presented the September 30, 2021, Investment Report.

PNC Bank has 74.96% cash, U.S. Federal Government (via PNC) 13.66% and DCAR's & DC (via Independent Bank) 11.38%. Investments remain consistent.

September 2021 Disbursements (MOTION):
Member Spears, "BASED ON THE BOARD FINANCE MEETING REVIEW, I MOVE THAT ISK APPROVE THE SEPTEMBER 2021 VENDOR DISBURSEMENTS OF $8,415,856.99." Supported by Member Raphelson.

ROLL CALL:

NAME	YEAS	NAYS
Erik Krogh, *CHAIR*	X	
Karen Longanecker, *VICE CHAIR*	X	
Nkenge Bergan	X	
Patrick Dolly	X	
Pat Guenther	X	
Sharon Spears	X	
Michael Raphelson	X	
Michael Seals	X	
Jenna Verne	X	

MOTION PASSED.

Chief Executive Officer Report (VERBAL):
On Friday, October 22, 2021, Pat Davis, officially retired from ISK. However, she will remain with us on a contractual basis for a limited amount of time. Pat has been extremely instrumental for ISK and her involvement/work at the state level with cost allocations and the standard fee schedule was remarkable.

Pat Davis expressed her gratitude for the opportunity to serve and work at ISK. She mentioned that the work was rewarding.

I'm happy to introduce you to Ms. Amy Rottman. Amy will be assuming the position of Chief Financial Officer. Amy Rottman comes to us from Rehmann with an extensive background in Finance and the Public Sector working closely with Richard Carpenter who has been the Principal on some of our past audits.

I am very pleased to inform you that on Friday, October 1, 2021 we completed the transfer of certain InterAct programs and services under the direct operations of ISK. A total of 57 former InterAct employees are now employed by ISK. This would not have been accomplished without the tireless work of 45 ISK employees that not only put forward emergency arrangements to hire former InterAct staff but assured that services continued without any disruption.

ISK is leasing the Hinman building at 610 Burdick, which was formerly occupied by InterAct of Michigan, Inc. (InterAct). We just negotiated a lease with the Hinman Company to maintain many of the programs and services previously provided by InterAct. This is a large building of 24,000 square feet and allows us the flexibility to fit similar programs and departments together under one roof where possible. ACT Team, Case Management, Navigate, Supported Employment are some of the programs that will be housed in this facility.

On Friday, October 8, 2021, Heidi Oberlin, ISK, Director of the Integrated Health Services Clinic retired. I'm happy to introduce you to Ms. Wanda Brown. Wanda will be assuming the position of the Director of the Integrated Health Services Clinic.

On Friday, October 15, 2021, Heather Garcia, ISK, Director of Finance, accepted a new position with the Kalamazoo County Administration. I'm happy to introduce you to Ms. Charlotte Bowser. Charlotte will be assuming the position of Director of Finance.

I've already introduced the new titles/positions for Sheila Hibbs, Dianne Shaffer, and Beth Ann Meints.

Citizen Time: No citizens came forth.

Board Member Time:
SWMBH (Southwest Michigan Behavioral Health) Updates/Pat Guenther.
SWMBH is in very good shape financially. An excellent presentation was done on Corporate Compliance and on the Board's oversight responsibilities and role. It is essential to have written

policies and credentialing mechanisms in place to combat fraud, waste, and abuse. When the system of checks and balances is in motion, it truly can and does operate efficiently.

Karen Longanecker:
It is that time of the year again to begin preparation for the Annual CEO Performance Evaluation in November. Evaluation Packets will be sent to each ISK Board Member via the mail. Please take a moment to complete your survey and then mail it back to me via the enclosed postage paid envelope. Thank you in advance for your cooperation!

Nkenge Bergan:
Welcome Wanda Brown & Amy Rottman!

Sharon Spears:
Happy Halloween! 

Michael Seals:
Thank you, Jeff & ISK staff, for the critical resolution with the InterAct crisis. Your work along with our community knows how to produce positive outcomes and resolutions.

Jenna Verne:
Have a great month.

Patrick Dolly:
Have a great week!

Erik Krogh:
With the ISK Board approval and his (Michael Seals) agreement to serve, I would like to appoint Michael Seals to the ISK Board Compliance & Finance Committee. Michael Seals was willing to serve on that committee. Board members were also in agreement with his appointment.

Chair Krogh, "I MOVE TO APPOINT MICHAEL SEALS TO THE ISK BOARD COMPLIANCE AND FINANCE COMMITTEE." Supported by Member Guenther.

ROLL CALL:

NAME	YEAS	NAYS
Erik Krogh, *CHAIR*	X	
Karen Longanecker, *VICE CHAIR*	X	
Nkenge Bergan	X	
Patrick Dolly	X	
Pat Guenther	X	
Sharon Spears	X	
Michael Raphelson	X	
Michael Seals	X	
Jenna Verne	X	

MOTION PASSED.

ADJOURNMENT:
Vice Chair Longanecker, "I MOVE TO ADJOURN THE ISK BOARD PLANNING MEETING."
Supported by Member Bergan.

ROLL CALL:

NAME	YEAS	NAYS
Erik Krogh, *CHAIR*	X	
Karen Longanecker, *VICE CHAIR*	X	
Nkenge Bergan	X	
Patrick Dolly	X	
Pat Guenther	X	
Sharon Spears	X	
Michael Raphelson	X	
Michael Seals	X	
Jenna Verne	X	

MOTION PASSED.

Meeting was adjourned at 5:45PM.

Demeta J. Wallace
Administrative Coordinator
INTEGRATED Services of Kalamazoo

V.a.

Office of Recipient Rights
Report to the Mental Health Board
On Complaints/Allegations
Closed in: October 2021

Office of Recipient Rights Report to the Mental Health Board
Complaints/Allegations Closed in October 2021

	October 2021	FY 21-22	October 2020	FY 20-21
Total # of Complaints Closed	**35**	**35**	**48**	**48**
Total # of Allegations Closed	**69**	**69**	**81**	**81**
Total # of Allegations Substantiated	**19**	**19**	**15**	**15**

The data below represents the total number of closed allegations and substantiations for the following categories: **Consumer Safety, Dignity/Respect of Consumer, Treatment Issues, and Abuse/Neglect.**

ALLEGATIONS	**October 2021**		**October 2020**	
Category	**TOTAL**	**SUBSTANTIATED**	**TOTAL**	**SUBSTANTIATED**
Consumer Safety	6	2	2	1
Dignity/Respect of Consumer	11	3	12	3
Treatment Issues/Suitable Services (Including Person Centered Planning)	14	3	19	2
Abuse I	0	0	0	0
Abuse II	6	1	4	1
Abuse III	7	2	6	0
Neglect I	0	0	0	0
Neglect II	2	0	3	1
Neglect III	8	5	11	6
	54	**16**	**57**	**14**

APPEALS	**October 2021**	**FY 21-22**	**October 2020**	**FY 20-21**
Uphold Investigative Findings & Plan of Action	0	0	0	10
Return Investigation to ORR; Reopen or Reinvestigate	0	0	0	0
Uphold Investigative Findings but Recommend Respondent Take Additional or Different Action to Remedy the Violation	0	0	0	0
Request an External Investigation by the State ORR	0	0	0	0

ABUSE AND NEGLECT DEFINITIONS – SUMMARIZED

Abuse Class I means serious injury to the recipient by staff. Also, sexual contact between a staff and a recipient.
Abuse Class II means non-serious injury or exploitation to the recipient by staff and includes using unreasonable force, even if no injury results.
Abuse Class III means communication by staff to a recipient that is threatening or degrading. (such as; putting down, making fun of, insulting)
Neglect Class I means a serious injury occurred because a staff person DID NOT do something he or she should have done (an omission). It also includes failure to report apparent or suspected abuse I or neglect I of a recipient.
Neglect Class II means a non-serious injury occurred to a recipient because a staff person DID NOT do something he or she should have done (an omission). It also includes failure to report apparent or suspected abuse II or neglect II of a recipient
Neglect Class III means a recipient was put at risk of physical harm or sexual abuse because a staff person DID NOT do something he or she should have done per rule or guideline. It also includes failure to report apparent or suspected abuse III or neglect III of a recipient.

ORR ADDENDUM TO MH BOARD REPORT
November 2021

Re: October 2021 Abuse/Neglect Violations

October

Abuse Violations

- There was one substantiated Abuse II violation in October 2021.
  - The remedial actions for this violation was Employment Termination (1), and Verbal Counseling (1).
- There were two substantiated Abuse III violations in October 2021.
  - The remedial actions for these violations were Employment Termination (1), Verbal Counseling (1), and Written Reprimand (1).

  The 2 violations occurred at different agencies.

Neglect Violations

- There were five substantiated Neglect III violations in October 2021.
  - The remedial actions for these violations were Employment Termination (2), Training (3), Written Reprimand (3), Written Counseling (1), Environmental Repair/Enhancement (1), and Suspension (2). One was a Neglect III, Failure to Report violation.

  The 5 violations occurred at 3 different agencies. Three violations occurred at the same agency and 2 different program sites.

All of the ORR case information is forwarded to the ISK Population Directors on a monthly basis for any tracking/trending of the RR information in their areas of authority. *(Agencies can include ISK).

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY V.06

AREA:	Governance		
SECTION:	Board Governance Process	PAGE:	1 of 2
SUBJECT:	COMMUNICATION AND COUNSEL TO THE BOARD	SUPERSEDES: REVISED:	01/24/2012 10/29/2018

PURPOSE/EXPLANATION

To establish limitations of means regarding the Chief Executive Officer's (CEO) communication and counsel to the Board.

POLICY

I. With respect to providing information and counsel to the Board, the CEO may not permit the Board to be uninformed. Accordingly, he/she may not:

A. Neglect to submit monitoring data required by the Board (see policy on Monitoring Executive Performance) in a timely, accurate and understandable fashion, directly addressing provisions of the Board policies being monitored.

B. Let the Board be unaware of relevant trends, anticipated adverse media coverage, material external and internal changes, particularly changes in the assumptions upon which any Board policy has previously been established.

C. Fail to advise the Board if, in the CEO's opinion, the Board is not in compliance with its own policies on Governance Process and Board-Staff Relationship, particularly in the case of Board behavior which is detrimental to the work relationship between the Board and the CEO.

D. Fail to use a process that utilizes as many internal and external points of view, issues and options as needed for fully informed Board choices.

E. Present information in unnecessarily complex or lengthy form.

F. Fail to provide a mechanism for official Board, officer or committee communications.

G. Fail to deal with the Board as a whole except when (a) fulfilling individual requests for information or (b) responding to officers or committees duly charged by the Board.

H. Fail to report in a timely manner any actual or anticipated non-compliance with any policy of the Board.

II. This policy will be monitored through internal mechanisms on an annual basis.

CHIEF EXECUTIVE OFFICER

Jeff Patton
Chief Executive Officer

APPROVED

Erik Krogh
Board Chair

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY II.02

AREA:	Governance		
SECTION:	Board Governance Process	PAGE:	1 of 2
SUBJECT:	**GOVERNING STYLE**	SUPERSEDES: REVISED:	01/23/2012 10/29/2018

PURPOSE/EXPLANATION

To establish the Board's governing style.

POLICY

The Board will govern with an emphasis on outward vision as well as an awareness of internal operations, encouragement of diversity in viewpoints, strategic leadership more than administrative detail, clear distinction of Board and Chief Executive roles, collective rather than individual decisions, future rather than past or present, and pro-activity rather than reactivity.

The Board will:

A. Cultivate a sense of group responsibility. The Board, not the staff, will be responsible for governance. The Board will be an initiator of policy, not merely a reactor to staff initiatives. The Board will use the expertise of individual members to enhance the ability of the Board as a body, rather than to substitute the individual judgements for the Board's values.

B. Direct, control, and inspire the organization through the careful establishment of broad written policies reflecting the Board's values and perspectives. The Board's major focus will be to establish policy that is aimed at having a positive long-term impact on the community.

C. Enforce upon itself whatever discipline is needed to govern with excellence. Discipline will apply to matters such as attendance, preparation for meetings, policy-making principles, respect of roles, and ensuring the continuity of governance capability. Continual Board development will include orientation of new members in the Board's governance process and periodic Board discussion of process improvement. The Board will allow no officer, individual or committee of the Board to hinder or be an excuse for not fulfilling its commitments.

CHIEF EXECUTIVE OFFICER

Jeff Patton
Chief Executive Officer

APPROVED

Erik Krogh
Board Chair

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY V.11

AREA:	Governance		
SECTION:	Board Governance Process	PAGE:	1 of 4
SUBJECT:	CORPORATE COMPLIANCE AND RISK MANAGEMENT	SUPERSEDES: REVISED:	11/24/2014 10/29/2019

PURPOSE/EXPLANATION

Integrated Services of Kalamazoo (ISK) is committed to identifying and complying with local, state and federal laws and regulations as they apply to health care delivery managed by ISK. The purpose of this policy is to authorize the establishment of a comprehensive Corporate Compliance Program, including an annual Risk Assessment and a Compliance Plan, designed to minimize risks associated with operational activities and service delivery.

DEFINITIONS

Corporate Compliance
The mechanisms, including the written Compliance Program and Policies, training efforts, resources and activities that are collectively intended to prevent and detect unethical and/or illegal business practices and violations of law.

Corporate Compliance Program
The specific compliance principles, components and activities of ISK and its provider network. These include activities ISK performs both for itself as a healthcare management entity and as a service provider as well as for its provider network.

Risk Assessment
The US Sentencing Guidelines of 2004 listed elements of an "effective compliance program" include promotion of ethics and a commitment to compliance with ongoing risk assessment as part of the program. Annual Risk Assessment information will include input from ISK leadership. The objectives of the annual ISK Risk Assessment are as follows:

1. Enhance ISK's compliance and ethics program to meet internal and external requirements and "best practices".
2. Identify and prioritize risks/gaps and monitor/review performance against requirements.
3. Meet US Sentencing Guidelines for "risk assessment" and other requirements
4. Inform the Annual Corporate Compliance Plan.

Corporate Compliance Plan
The Annual Corporate Compliance Plan include goals and objectives based on current themes gleaned from the Annual Risk Assessment. It is presented to the Board each year

for approval with progress reported at least every six months.

Seven Elements of an Effective Compliance Program
The US Sentencing Guidelines of 2004 listed seven elements of an effective compliance program, which have become the benchmark for corporate compliance. The seven elements are as follows:

1. Implementing written policies, procedures, and standards of conduct
2. Designating a compliance officer and compliance committee
3. Conducting effective training and education
4. Developing effective lines of communication
5. Conducting internal monitoring and auditing
6. Enforcing standards through consistent, well-publicized guidelines
7. Responding promptly to detected offenses and undertaking corrective action

POLICY

I. ISK is dedicated to the delivery of behavioral health services in an environment characterized by strict conformance with the highest standards of accountability for administrative, business, clinical, financial and marketing management.

II. The leadership of ISK shall be fully:

A. Aware of and committed to the need to prevent and detect fraud, waste, abuse, fiscal mismanagement and misappropriation of funds and to the strict adherence of all federal and state laws, rules and regulations through the development and implementation of a formal Corporate Compliance Program that addresses all required elements promulgated by the Michigan Department of Health and Human Services/Office of Inspector General (MDHHS/OIG) for an effective Compliance Program.

B. Committed to the development and implementation of comprehensive policies, procedures and other corporate compliance measures to provide regular monitoring and conformance with all legal and regulatory requirements.

III. All persons who provide services within, or are formally affiliated with ISK (e.g., officers/board members, employees, consultants, volunteers, students, internal contractors, agents, etc.) must sign an attestation agreeing to conduct themselves in a manner that promotes the ISK Mission/Vision and Code of Ethics. All are expected to abide by the ISK Compliance Program and immediately report suspected compliance issues to the ISK Compliance Officer.

IV. With respect to the delivery of services to those affected with mental illness, emotional disturbance, co-occurring substance use disorder and developmental disabilities, the Chief Executive Officer shall not cause or allow conditions which are not in strict conformance with laws and regulations governing administrative, business, clinical,

financial and marketing practices. The Chief Executive Officer shall not fail to create and implement a comprehensive Corporate Compliance Program and a Risk Management Plan that includes ongoing risk assessment activities.

V. Accordingly, he/she shall not fail to:

A. Reduce the agency's likelihood of exposure to identified risks.

B. Comply with the mandated federal and state regulations

C. Prevent and detect fraud, abuse, fiscal mismanagement and misappropriation of funds (corporate compliance program).

D. Respond to events that could pose a risk to the ISK.

VI. The ISK Board of Directors shall delegate, by formal resolution or policy, the overall responsibility for ISK Compliance Program to its Chief Executive Officer (CEO). The CEO shall ensure the retainment of a Compliance Officer (CO) capable of managing the functions of the Compliance Office as contained in this policy guideline and other ISK operating policies.

VII. The ISK Board of Directors shall be notified in writing prior to any change in the Compliance Officer's role, capacity or employment status.

VIII. Implementation and effectiveness of the corporate compliance and risk management strategies shall be monitored internally at a minimum, quarterly by the Compliance Committee. Additionally, necessary recommendations for actions shall be made to the Chief Executive Officer and/or the Board Members.

REFERENCES

- Federal Laws
  a. Deficit Reduction Act, United States Code, Vol. 42, Sec. 1396a (a)(68) (Section 6032 of the Deficit Reduction Act of 2005)
  b. False Claims Act, United States Code, Vol. 31, Secs. 3729-3733
  c. Program Fraud and Civil Remedies Act, United States Code, Vol. 31, Secs. 3801-3812 (Program Fraud Civil Remedies Act of 1986)
  d. Anti-Kickback Statute
  e. United States Organizational Sentencing Guidelines (1991)
  f. Stark Laws I (1989) and Stark Laws II (1993)
  g. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
  h. Balance Budget Act of 1997 (BBA)
  i. Social Security Act, specifically 1903(m)(95)(i)
  j. Affordable Care Act (Public Law 111-148; 111-152 of 2010)
  k. Whistleblowers Protection Act of 1980

l. HITECH Act of 2009
m. 42 CFR, Parts 400 and 438 (Balanced Budget Act)
n. 45 CFR Part 164 (Health Information Portability and Accountability Act)

- Michigan Laws
  a. Medicaid False Claims Act, Michigan Compiled Laws, Annotated Sections 400.601-613
  b. HIPAA Privacy Rule Preemption Analysis Matrix for the Michigan Medical Records Access Act, Public Act 47 of 2004 (revised 11/04)
  c. Michigan Mental Health Code, PA 258, as amended
  d. Michigan Public Health Code, PA 368, as amended

- Michigan Department of Health and Human Services (MDHHS)
  a. MDHHS/PIHP Medicaid Managed Specialty Supports and Services Contract – Section 6.9 Regulatory Management
  b. MSA-Medicaid Provider Manual
  c. MDHHS: Application for Participation, Section 4.0

- PIHP
  a. Southwest Michigan Behavioral Health Compliance Program
  b. Southwest Michigan Behavioral Health Policy
     i. 10.2 (Compliance Policy Development)
     ii. 10.3 (Code of Conduct Distribution and Training)
     iii. 10.4 (Compliance Oversight Committee)
     iv. 10.5 (Compliance Education and Training)
     v. 10.6 (Compliance Reporting and Responsibilities)
     vi. 10.7 (Compliance Auditing and Monitoring)
     vii. 10.8 (Compliance Reviews and Investigations for Reporting)
     viii. 10.9 (Compliance Enforcement and Discipline)
     ix. 10.11 (Fraud and Abuse)

CHIEF EXECUTIVE OFFICER

Jeff Patton
Chief Executive Officer

APPROVED

Erik Krogh
Board Chair

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Corporate Compliance Program

Ashley Esterline, LMSW, CHC
ISK Corporate Compliance Officer

PURPOSE

ISK is committed to identifying and complying with local, state, and federal laws and regulations as they apply to health care delivery. The Annual Report provides stakeholders, the Board of Directors, network providers and other interested parties with a summary of the effectiveness of the Compliance Program as it pertains to the functions and activities carried out during FY21 (October 1, 2020 through September 30, 2021) and plan for FY22 (October 1, 2021-September 30, 2022).

PROGRAM PURPOSE

The ISK Compliance Program is designed to provide safeguards to ensure the agency's and the provider network's compliance with laws and regulations relating to regulatory compliance, including fraud, waste, and abuse.

The purposes of the Corporate Compliance Program are as follows:

- To prevent noncompliance with applicable laws, whether accidental or intentional;
- To detect any noncompliance which may occur;
- To ensure the discipline of individuals and entities when involved in noncompliance, including the sanctions and/or disbarment when warranted; and
- To prevent the reoccurrence of noncompliance

The scope of the Compliance Program extends to all activities funded by federal healthcare dollars. Each Board Member, Officer, employee, provider, contractor, subcontractor and/or agent operating within the provider network is expected, through its direct employment or contractual involvement in the provider network, to comply with ISK compliance activities.

PROGRAM DESIGN

ISK's Compliance Program is structured around technical guidance issued by the Michigan Department of Health and Human Services (MDHHS), the Office of the Inspector General (OIG), as well as the Department of Justice (DOJ) and operates with core management centralized in the Compliance Committee.

The key components of the Compliance Program are as follows:

- **Corporate Compliance Officer**
  The Corporate Compliance Officer (CCO) operates under the authority of the ISK Board of Directors and has unobstructed access to the Chief Executive Officer (CEO). The CCO is responsible for the development of the Compliance Program, completing inquiries/investigations, facilitation of financial remediation and developing staff/stakeholder trainings.

- **Compliance and Quality Improvement Coordinator**
  The Compliance and Quality Improvement Coordinator supports the Corporate Compliance Officer through assigned responsibilities related to the implementation of the ISK Corporate Compliance Program and annual Corporate Compliance Plan. The Compliance and Quality Improvement Coordinator completes inquiries/ investigations in conjunction with the Corporate Compliance Officer, supports the ISK Risk Management Program, and assists in the development and monitoring of the annual Risk Management Plan

- **PHI Integrity Team**
  The PHI Integrity Team (PHIIT) consists of the Corporate Compliance Officer, Compliance and Quality Improvement Coordinator, HIPAA Security Officer, HIPAA Privacy Officer, Michigan Mental Health Code (MMHC) expert, Health Information Manager and Manager of Human Resources.

- **Compliance Committee**
  The Compliance Committee has representatives from the major departments within the agency (e.g., finance, clinical, quality, information technologies, Office of Recipient Rights, and network management).

- **Annual Plan**
  The Annual Compliance Plan, which is reviewed and approved by the Board of Directors, contains the main areas of focus, goals, and compliance improvement activities to be undertaken either by the Corporate Compliance Officer, Compliance Committee, PHI Integrity Team and/or network providers.

- **Semi-Annual Plan**
  This report summarizes the effectiveness of the Compliance Program including a summary of all compliance inquiries, investigations, monitoring, program development and improvement activities over the last six months.

PROGRAM ELEMENTS

To maintain an effective Compliance Program, ISK engages in seven (7) core functions on an on-going basis.

Program Elements are summarized as follows:

- **Assessment of Risk and Establishing Audit Priorities**
  The CCO is responsible for ensuring that practices within ISK and its contracted service providers are conducted so that the risk of fraud, waste and abuse is understood and minimized.

- **Monitoring, Audits, and Investigations**
  The CCO, with assistance from the Compliance Committee and PHI Integrity Team, monitors the results of both internal and external audits for the purpose of identifying potential risk areas and recommending appropriate follow-up measures.

- **Policy and Procedure Review, Revision and Development**
  Policies and procedures are subject to initial and on-going organizational assessment. Areas of high risk are reviewed and revised by the Corporate Compliance Officer with the input of the Compliance Committee and other resources in order to augment and strengthen provisions to make them consistent with law and regulation.

- **Prevention Activities: Training of Staff and Dissemination of Information Regarding Corporate Compliance Program and Expectations**
  The Compliance and Quality Improvement Coordinator conducts initial orientation and ongoing training activities with staff and providers which ensure all employees receive the necessary information on Corporate Compliance.

- **Detection Activities**
  The system for detecting noncompliance has two components. The first is auditing and reviews conducted by ISK staff of the provider network and internal services. The second is a mechanism for confidential reporting of suspected fraud, waste, or abuse by employees, contract providers and agents. All staff must know that failure to report suspected fraudulent behavior is unethical and thus itself is noncompliance with agency expectations. Allegations made will be held in confidence, to the limit allowed by law and staff will not be penalized for reporting suspected incidents. A fair and objective investigation of all allegations will be conducted prior to any action.

- **Investigation, Disciplinary Activity, Disclosure Activities**
  The Corporate Compliance Officer undertakes investigative activities when a preliminary review of audit and monitoring data or a report of suspected noncompliance indicates reasonable cause to suspect noncompliance is occurring. Should an investigation determine noncompliance, effective corrective and reporting action is taken, including necessary disciplinary steps.

- **Assessment and Evaluation**
  The annual assessment and evaluation of the Compliance Program determines whether the required elements have been implemented as well as whether activities have resulted in meeting the goals established.

ANNUAL REPORT SUMMARY

The remaining sections of the Compliance Annual Report details the monitoring function results, compliance investigations results, plan status (goal status, outcomes, and deliverables) and Compliance Plan focus areas with goals for FY22.

Contained in this report are the following attachments:

- FY21 Compliance and Risk Management Status Report
- FY22 Compliance Plan with Goals and Objectives

INTEGRATED SERVICES OF KALAMAZOO COMPLIANCE PLAN
FY 22 – GOALS / OBJECTIVES

#	GOAL	OBJECTIVES / ACTION STEPS	MEASURES
1	ISK will sustain strong direct run and Provider Network programming with sound fiscal responsibility and sustainability to ensure direct run programs and Provider Network are providing high quality care and consistently meeting compliance standards.	1. ISK will consistently monitor and address issues of poor performance and repeated compliance issues. Monitoring will include follow-up, corrective action, and sanctioning as necessary. Collaborate with Leadership to mitigate risk as needed 2. Compliance Officer and/or Compliance and Quality Improvement Coordinator will assess and identify at-risk and/or new services and programs. Meetings will be held with program staff to review procedures, standards, and protocols to ensure compliance 3. ISK will maintain sound fiscal responsibly and sustainability to ensure direct operated programs and Provider Network are sustainable and operational in times of crisis and need	1. Compliance plans of correction that demonstrate measurable improvement for identified areas for improvement over time 2. Number of training opportunities, educational communications, and junctures of support provided during FY 3. Number of direct-operated programs and Provider Network agencies who are fiscally sound and maintain resources to provide services to consumers
2	ISK will remain involved in the oversight and implementation of changes to rules/regulations pursuant to updated codes, modifiers and post-COVID telehealth allowances.	1. Ongoing involvement in state-level workgroups to obtain updates to rules/regulations and inform direct-operated programs and Provider Network of affected changes 2. Timely response to changes in policies, procedures, rules, and regulations evidenced through communications, updated ISK policies, and continuous oversight and monitoring 3. ISK will create and implement a monitoring plan to identify direct-operated programs and/or Provider Network agencies who may fall out of compliance with updates to changes	1. Formal quarterly updates from workgroup members to appropriate committees with implementation of ISK sub-workgroups as necessitated 2. Number of QMRs identifying direct-operated programs and/or Provider Network agency compliance with updated rules/policies, codes/modifier reporting 3. Establish monitoring plan of revised processes for code changes by January 31, 2022. Successful implementation of monitoring plan
3	ISK will continue to monitor and identify high risk areas of programming to ensure Fraud, Waste, and Abuse are detected and effectively assuaged.	1. ISK Compliance Committee and Utilization Monitoring Workgroup will work to determine areas of significant risk affecting agency, as determined by department and/or population 2. Implement MDHHS-driven updates to programming through guidance of technical assistance, workgroups, and/or subject matter experts 3. Mitigate fraud, waste, and abuse through oversight and monitoring of high-risk programming, such as ABA services for Youth & Families through the course of on-going Utilization Monitoring Reviews	1. Identify area(s) within ISK that pose significant risk to agency through FY22 Risk Assessment by January 1, 2022. 2. Identify changes to organizational and clinical practices through data mining of high/low utilizers of identified services with strong focus on mitigating potential FWA 3. Development of Compliance Monitoring Plan and implementation of targeted audits for identified services with high risk for potential of FWA.
4.	ISK will maintain continuous oversight of potential and	1. ISK Compliance Committee and ISK PHI Integrity Team will work in tandem to identify and mitigate any potential or actual cyber security	1. ISK's PHI Integrity Team will meet on a monthly basis to review submission of

INTEGRATED SERVICES OF KALAMAZOO COMPLIANCE PLAN
FY 22 – GOALS / OBJECTIVES

#	GOAL	OBJECTIVES / ACTION STEPS	MEASURES
	actual HIPAA breaches caused by impermissible use or disclosure of Protected Health Information (PHI)	attacks, phishing attempts, and/or breaches of information as they are discovered. 2. Multi-factor authentication will be implemented for all direct-operated staff to assist in the mitigation of cyber attackers inappropriately accessing secure and protected client information. 3. Continuous user education and training opportunities will be offered to all staff to inform of the dangers of cyber security attacks and their implications for clients, staff, and stakeholders.	suspected breaches of information. Actual breaches will be reported to DHHS within identified timeframes. 2. Electronic devices (laptops and cell phones) will have multi-factor authentication installed for all staff members by March 1, 2022. 3. The number of staff members clicking on phishing e-mails and potentially exposing client PHI will decrease by half by December 31, 2022.

Integrated Services of Kalamazoo

Corporate Compliance / Risk Management
Q4 Report
FY 2021

Program Name:	**COMPLIANCE & RISK MANAGEMENT**	**Report Period:**	☒ October ☐ January ☐ April ☐ July
Person Completing Report:	Ashley Esterline, LMSW, Corporate Compliance Officer		

Brief Report Overview:	Contained in this Status Report is a summary of the Compliance Program's goals and activities for FY 2021 as of October 2021.	
Current Committee goals and deliverables per work plan	Project Goal/Task	Status:
	1. **Identifying and mitigating fraud, waste, and abuse trends and risks for Direct-Operated and Provider Network Services.** ISK will sustain strong direct run programs and Provider Network with sound fiscal responsibility and sustainability to ensure programs and Provider Network are providing high quality care and consistently meeting compliance standards.	1. Direct Care Wage was extended via the Governor's budget to $2.35/hour. Rate increases allocated throughout FY21 for applicable providers are demonstrated in FY22 Provider Contract Rate Pages. If additional rate increases are necessitated, Providers will receive amendments to their FY22 contracts. ISK worked closely with InterAct to transition supports/services into Direct-Operated Services and hire many InterAct staff. Compliance continues to oversee and communicate COVID telehealth allowances as afforded by the Michigan Department of Health and Human Services (MDHHS) and provide ongoing updates and trainings related to codes and modifier changes.
	2. **Code/Modifier Changes.** ISK will continue to stay abreast to and involved in the oversight of changes to rules/regulations down streamed from MDHHS, CMS, SWMBH, etc.	2. Q4 focused on understanding and communicating updates/changes to multiple codes that are no longer allowable/limited use, along with understanding and providing guidance to direct-operated and Provider Network staff regarding significant modifier updates and changes. Training was provided and continued guidance is given both internally and externally.
	3. **Mitigating fraud, waste, and abuse trends and risks for Self-Directed Arrangements.** ISK will monitor and identify high risk areas and abide by technical assistance put forth by MDHHS.	3. Technical Advisory for Self-Directed services remains in draft-format. Compliance continues to work closely with ISK Self-Directed Department and SWMBH to monitor and ensure that policies/procedures are updated and congruent with the updated contracts between SWMBH/fiscal intermediaries and the Technical Advisory once it is finalized in contracts with the Regional Entities/PIHPs. Compliance worked on quarterly monitoring of Respite services to ensure documentation meets Medicaid billing standards.

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Jeffrey W. Patton
Chief Executive Officer

www.iskzoo.org

Administrative Services
2030 Portage Street
Kalamazoo, MI 49001
Phone: (269) 553-8000

Access Center
615 East Crosstown Parkway
Kalamazoo, MI 49001
Phone: (269) 373-6000
(888) 373-6200
Michigan Relay Center: 711

Integrated Health & Psychiatric Services
615 East Crosstown Parkway
Kalamazoo, MI 49001
Phone (Adults): (269) 553-7037
Phone (Youth): (269) 553-7078

Office of Recipient Rights
201 W. Kalamazoo Ave, Ste 301
Kalamazoo, MI 49007
Phone: (269) 364-6920

Services for Adults with Mental Illness
2030 Portage Street
Kalamazoo, MI 49001
Phone: (269) 553-8000
(888) 373-6200

Services for Adults with Intellectual and Developmental Disabilities
418 West Kalamazoo Ave.
Kalamazoo, MI 49007
Phone: (269) 553-8060
Michigan Relay Center: 711

Services for Youth and Families
418 West Kalamazoo Ave.
Kalamazoo, MI 49007
Phone: (269) 553-7120

Substance Use Disorder Services
Phone: (800) 781-0353

Training
2030 Portage Street
Kalamazoo, MI 49001
Phone: (269) 364-6952

To: **Integrated Services of Kalamazoo (ISK) Board**
From: **Family Support Advisory Council (FSAC)**
Date: 11/22/2021
Re: Annual Report to the ISK Board
FSAC respectfully submits the annual report for the period of 10/01/20-9/30/21

Board Appointees include:
Kathy Hunt (CHAIR)
Stephanie Stratton
Paula Shane
Jeff Poliak
Charlie Stewart
Antionette Sandum

Pending Appointees:
No current pending appointees.

Activities:
1. FSAC members participated in the System of Care (SOC) Conference planning.
2. FSAC members authored information to seek new members. The product includes information on how to apply, meeting schedule, and a link to the application. The information is now sent via email to all primary clinicians in the network quarterly.
3. FSAC received information of the impact and changes in services as a result of the COVID pandemic. FSAC provided input that telehealth is challenging for youth and provided positive feedback on the continued in person sessions. They also discussed the stress on the ongoing pandemic on families-youth and parents.
4. FSAC received a presentation on Dialectal Behavior Therapy (DBT) and provided input that it is a good service for youth to receive.
5. FSAC received information from Carlos Brown, ISK Director on suicide prevention and provided input from a family perspective.
6. FSAC invited staff from ASK Services for Families to a meeting to discuss support groups for parents. Lisa Coleman attended and

discussed options through ASK and how information is made available. FSAC received information and provided input.

7. FSAC discussed the challenges for families accessing internet services and working devises. FSAC recommended partnering with KPS and the use of the laptops assigned to children. KPS allows use of the Laptops to participate in telehealth.
8. FSAC received a presentation on Kalamazoo Wraps System of Care. FSAC asked and received information on the current grant and coordination with protective services and foster care. FSAC provided recommendations for types of sessions for the annual conference.
9. FSAC members participated in the 8th Annual Kalamazoo System of Care Conference held September 23rd and 24th 2021.
10. FSAC made recommendations to update the FSAC brochure.
11. FSAC received and approved the updated FSAC brochure. It is posted to the ISK public website.
12. FSAC requested a presentation on the Certified Community Behavior Health Clinic (CCBHC).
13. FSAC received a presentation from Dianne Shaffer on the CCBHC. They were able to ask questions. FSAC feedback included that the ability to receive services regardless of insurance is desperately needed in the community. FSAC recommended that there be ongoing opportunities for parent/consumer input.
14. FSAC members participated in the Suicide prevention walk held September 25, 2021.
15. FSAC reviewed the Youth and Families Handbook and made recommendations on changes that were included. FSAC also recommended that the handbook be posted on the ISK public website.

Recommendations:

Prolonged covid and resulting disruptions have placed additional strain on families. Additional respite and CLS options would help families and youth.

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MOTION

Subject:	Return to in-person Board Meetings	
Meeting Date:	November 22, 2021	**Approval Date:**
Prepared by:	Jeff Patton	November 22, 2021

Recommended Motion:

"I move that the ISK Board return to in-person board meetings starting with the January 2022 meeting.

I further move that ISK should develop and adopt accommodations that comply with the Michigan Open Meetings Act and ISK Board policies for a small number of board members to request a separate space during a meeting at the meeting's location.

I further move that ISK explore options for continuing to allow public participation at board meetings through remote as well as in person attendance."

Summary of Request

During the COVID pandemic the Open Meetings Act was amended to allow the ISK board to meet remotely. That Act also provides that ISK must return to in-person meetings in January 2022 and provides that board members are not allowed to participate in board actions at meetings if the member attends remotely after December 31, 2021. In addition, ISK board policies state board member responsibilities to the Agency and to stakeholders that are inconsistent with long-term remote meeting attendance.

Due to continuing concerns about close contact, some board members may be hesitant to sit in the same room with others who attend in-person meetings. In order to follow Open Meetings Act and ISK board policy requirements a board member may request to sit in a separate area of the building where the meeting is being held, which is away from others attending the meeting, but which is not a remote location as identified in the Act. Such an accommodation will allow meeting participation. ISK has determined that areas in the building could be sanitized and set up for members to use for this purpose; however, such an accommodation should only be used by a very small number of board members. Requests from a larger number of board members to sit away from the main meeting would undermine the requirements of the Open Meetings Act and board policies.

The Open Meetings Act does not have the same requirements for in person attendance by the public as are stated for the Board. The overriding requirement is that the public have access to participate at the meetings. In order to allow more public participation and perhaps reduce the number of people gathered in the board room ISK can seek options for continued remote participation by individuals who are not required to physically be at the meetings, while also allowing public in person attendance.

Budget: _____
Staff: _____

Date of Board
Consideration: November 22, 2021

~~KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES~~INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY V.05

AREA:	Governance		
SECTION:	Executive Limitations	PAGE:	1 of 1
SUBJECT:	**EMERGENCY EXECUTIVE SUCCESSION**	SUPERSEDES:	~~05/27/2014~~ 07/26/2021
		REVISED:	~~11/28/2016~~11 /22/2021

PURPOSE/EXPLANATION

To establish limitations of means regarding emergency executive succession.

POLICY

I. In order to protect the Board from sudden loss of Chief Executive Officer (CEO) services, the ~~Chief Executive Officer~~ may not have fewer than two other executives familiar with board and ~~Chief Executive Officer~~ issues and processes.

II. The order of succession in an emergency is as follows:

A. Chief Executive Officer

B. Administrator of System Performance and Programs

C. Administrator for CCBHC (Certified Community Behavioral Health Clinic) Operations and Adult Behavioral Health Services

D. Chief Medical Officer

~~A. Chief Executive Officer~~

~~B. Deputy Director Program Services~~

~~C. Deputy Director Administrative Services~~

~~D. Chief Medical Officer~~

III. This policy will be monitored through internal mechanisms on an annual basis.

CHIEF EXECUTIVE OFFICER **APPROVED**

Jeff Patton
Chief Executive Officer

Erik Krogh
Board Chair

~~KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES~~INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY VI.03 / ORGANIZATIONAL POLICY 08.10

AREA:	*(Board)* Governance		
APPLICATION:	*(Organizational)* ~~KCMHSAS~~ ISK Staff & Contract Providers		
SECTION:	*(Board)* System Governance *(Organizational)* Financial Management	PAGE:	1 of 4
SUBJECT:	**ENDOWMENT FUND**	SUPERSEDES:	~~06/26/2017~~ 08/23/2018
		REVISED:	~~08/23/2018~~ 11/22/2021

PURPOSE/EXPLANATION

The ~~Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS)~~Integrated Services of Kalamazoo (ISK) Endowment Fund was established in response to the very real needs faced by people. The purpose of the fund is to coordinate grant opportunities for persons who receive services through ~~KCMHSAS~~ISK, when other means of increasing and/or sustaining independence have been exhausted. Fund dollars are not to be utilized for services and/or supports provided through the community mental health service system.

DEFINITIONS

Dollars Available to Grant
This amount is determined by the Kalamazoo Community Foundation (KCF) and is derived from endowment fund earnings and earmarked donations made to KCF on behalf of ~~KCMHSAS~~ISK.

Yearly Grant Allocation
Through a yearly award process these funds will be made available to Providers and ISK~~KCMHSAS~~ direct operated programs for persons who receive services through ISK~~KCMHSAS~~. All expenditures must fall within the specific intent of the grant award. A maximum of $5,000, excluding emergency grant awards, can be granted to any Provider or ISK~~KCMHSAS~~ direct operated program. Whenever grant funds are applied for and utilized, it is anticipated that the applicant/awarded provider/program will coordinate with other CMH programs to ensure that fund dollars are not inadvertently spent when other resources are also available.

Emergency Grant Award
Through an "as needed award process" emergency-grants will be awarded for specific

requests for an individual's emergency needs that had been previously unknown and cannot be provided for through any other means. Emergency Grant Awards are limited to a maximum of $500.00 per individual.

POLICY

A. Through the ISK~~KCMHSAS~~ Endowment Fund we are committed to combating the stigma of mental illness, developmental disabilities, and substance ~~ab~~use disorders, and to prioritize our grant giving in key areas, which will assist persons served by ISK~~KCMHSAS~~ in taking positive steps toward independence and integration in the community.

~~A.~~ Those areas of emphasis for grant giving will be, but not limited to:

1. Assistance with setting up and maintaining Independent Residence
2. Assistance with clothing, transportation, or other needs related to supporting vocational pursuits related to Competitive Employment
3. Assistance with crucial Health Care Needs necessary to make community living feasible and not otherwise funded by insurance benefits or other means
4. Assistance with costs related to supporting Educational Pursuits - including books, tuition/fees, equipment
5. Support for Community Events that promote education of mental health-related matters, and/or celebrate customer successes, and/or integration of customers in the community and are promoting the reduction of stigma

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B. Of the total dollars available to grant, 90% will be made available for expenditure during the ISK~~KCMHSAS~~ fiscal year through a Yearly Grant allocation award process. A maximum of $5,000 can be awarded to any Provider or ISK~~KCMHSAS~~ direct operated program for the following purposes:

1. Independent Living Arrangements
2. Competitive Employment Assistance
3. Community Living / Health Care Needs
4. Educational Support
5. Community Events (cannot exceed $1,000)

Of the total dollars available to grant 10% will be made available for expenditure during the ISK~~KCMHSAS~~ fiscal year through an emergency discretionary determination by the Endowment Fund Committee. Applications will be accepted throughout the fiscal year. Emergency Grant awards cannot exceed $500.00 per individual. The Endowment Committee will evaluate each request for Emergency Grant within 10 calendar days of receipt of the application.

The Yearly Grant Allocation process will begin at least two months before the start

of the fiscal year. The Fund applications due date is to allow for fund dollars to be available at beginning of the fiscal year for agencies/departments that receive an award.

Grant Allocations to providers and ISK~~KCMHSAS~~ direct operated programs shall be limited to a maximum of $500 per individual customer/person served. Grant allocations for Community Events promoting integration are limited to $1,000 per event. Emergency discretionary funding is limited to $500 per individual.

C. Disbursements, accounting, and reporting for Yearly Grant Allocations and Emergency Grants awarded to providers are the responsibility of said provider. A complete accounting for the fiscal year grant allocation shall be made within three months of the completion of the fiscal year on a form prescribed by KCMHSAS. Unexpended funds will be allowed to carry over for one fiscal year. Any remaining unexpended funds after this period will be returned to KCMHSAS.

D. The Endowment Fund Committee will consist of seven members and will include at least one Board member (appointed by the Board chair), one individual served by ISK~~KCMHSAS~~, the Customer Services Manager and service provider. The service provider representative will abstain from any voting in which their organization has a funding application. The Customer Services Manager will notify the ISK~~KCMHSAS~~ ~~Director~~ CEO of appointments to the committee and the ~~Director~~ CEO will notify the Board of Directors.

E. In selecting grant recipients from among the deserving applications, the Endowment Fund Committee will use the Board recommended characteristics for a successful grant proposal:
1. Shows evidence of potential impact of the grant on the life of the person served by ISK~~KCMHSAS~~
2. Shows evidence of how the grant would enable an individual to become more independent
3. Shows evidence of how the grant would improve the quality of life
4. Shows evidence of how the grant would improve community integrated living

F. The ISK~~KCMHSAS~~ Board of Directors is committed to the wise allocation of its charitable resources. Accordingly, all grantees will be asked to complete a brief summary report of grant activities and outcome. This report will be completed in a format prescribed by ISK~~KCMHSAS~~ and due dates will be told to awardees with the letter explaining their award.

G. The ISK~~KCMHSAS~~ Board of Directors will also establish an Oversight Committee for the specific purpose of making emergency grants from the principal funds in the Community Mental Health Endowment Fund held by the Kalamazoo Community Foundation.

The Oversight Committee will determine whether emergency circumstances exist to make grants from principal funds where allowed by the endowment stipulations.

Oversight Committee Composition

The Oversight Committee will consist of the ISK Board Chair, Board Finance & Compliance Committee Chair, Chief Executive Officer, Administrator of System Performance and Programs & Administrator for CCBHC Operations and Adult Behavioral Health Services.~~KCMHSAS Board Chair, Board Finance Committee Chair, Chief Executive Officer, Deputy Director of Administration and Program Services.~~

H. This policy will be monitored through internal mechanisms on an annual basis.

EXHIBITS

A. Endowment Fund Application (Emergency)

B. Endowment Fund Application (Full-Year)

CHIEF EXECUTIVE OFFICER

Jeff Patton
Chief Executive Officer

BOARD CHAIR

Erik Krogh
Board Chair