INTEGRATED Services of Kalamazoo
Community • Independence • Empowerment

Jeffrey W. Patton
Chief Executive Officer
www.iskzoo.org
(269) 553-8000
Administrative Services:
610 South Burdick Street
Kalamazoo, MI 49007

AGENDA

INTEGRATED Services of Kalamazoo Board of Directors HAS SCHEDULED ITS MEETING FOR MONDAY, November 27, 2023, BEGINNING @ 4:00PM via *Microsoft* TEAMS or in-person at 610 S. Burdick Street/Kalamazoo, MI., (2nd Floor/Board Conference Room).

- CLOSED SESSION/MOTION/ROLL CALL – Jeff Patton, CEO/Annual Performance Evaluation @ 3:30PM
- Special Presentation – *Alan Bolter*, Associate Director, Community Mental Health Ass of Michigan

I. CALL TO ORDER – CITY & COUNTY DECLARATION

II. AGENDA

III. CITIZEN TIME

IV. RECIPIENT RIGHTS
   a. Recipient Rights Monthly Report

V. PROGRAM SERVICE REPORT
   a. *Dusty Jepkema*, Program Supervisor, Care Coordination & Community Health Workers/AFFIRM Caregiver Report
   b. *Beth Ann Meints*, Administrator of Clinical Services/CCBHC/Power BI Encounter Data System

VI. CONSENT CALENDAR/VERBAL MOTION
   a. Minutes October 23, 2023/November 13, 2023
   b. Communication and Counsel to The Board (Policy)
   c. Governing Style (Policy)
   d. Emergency Executive Succession (Policy)
   e. Corporate Compliance and Risk Management (Policy)
   f. Compliance & Risk – FY24 Status (Report)

VII. MONITORING REPORTS
   a. Compliance & Risk – FY Annual Plan (Report)

VIII. FINANCIAL REPORTS
   a. Financial Condition Report
   b. Utilization Report
   c. OCTOBER 2023 Disbursement/MOTION

IX. ACTION ITEMS - NEW or REVISITED/VERBAL MOTION

X. CHIEF EXECUTIVE OFFICER VERBAL REPORT
   a. CEO Report

XI. CITIZEN TIME

XII. BOARD MEMBER TIME
   a. SWMBH (Southwest Michigan Behavioral Health) Updates/Erik Krogh
   b. Decision to hold or cancel the December Board meeting/ VERBAL MOTION

XIII. ADJOURNMENT

INTEGRATED
Services of Kalamazoo

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Integrated Services of Kalamazoo
MOTION

Subject:	CLOSED SESSION - *Chief Executive Officer Evaluation*	
Meeting Date:	November 27, 2023	Approval Date:
Prepared by:	*Jeff Patton*	November 27, 2023

RECOMMENDED MOTION:

"I MOVE THAT THE ISK BOARD GO INTO CLOSED SESSION PURSUANT TO SECTION 8 (a) OF THE OPEN MEETINGS ACT TO CONDUCT THE CHIEF EXECUTIVE OFFICER'S EVALUATION."

ROLL CALL VOTE:

ISK Board Member	Yes	No
Chair Karen Longanecker		
Vice Chair Michael Seals		
Member Nkenge Bergan		
Member Sarah Carmany		
Member Patrick Dolly		
Member Pat Guenther		
Member Erik Krogh		
Member Monteze Morales		
Member Michael Raphelson		
Member Sharon Spears		
Member Ramona Lumpkin		
Member Melissa Woolsey		
MOTION PASSED		

Need 8 yes votes (2/3 of currently appointed board) no matter how many members are in attendance.

Budget: FY2023/2024
Staff:_____

Date of Board
Consideration: November 27, 2023

IV.a.

Office of Recipient Rights
Report to the Mental Health Board
On Complaints/Allegations
Closed in: October 2023

Office of Recipient Rights Report to the Mental Health Board
Complaints/Allegations Closed in October 2023

	October 2023	FY 23-24	October 2022	FY 22-23
Total # of Complaints Closed	**33**	**33**	**37**	**37**
Total # of Allegations Closed	**51**	**51**	**72**	**72**
Total # of Allegations Substantiated	**15**	**15**	**25**	**25**

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 2023**		**October 2022**	
Category	**TOTAL**	**SUBSTANTIATED**	**TOTAL**	**SUBSTANTIATED**
Consumer Safety	1	0	5	0
Dignity/Respect of Consumer	14	3	10	2
Treatment Issues/Suitable Services (Including Person Centered Planning)	10	1	14	3
Abuse I	0	0	0	0
Abuse II	2	2	7	2
Abuse III	8	2	9	4
Neglect I	0	0	0	0
Neglect II	1	0	3	3
Neglect III	6	4	11	9
	42	**12**	**59**	**23**

APPEALS	**October 2023**	**FY 23-24**	**October 2022**	**FY 22-23**
Uphold Investigative Findings & Plan of Action	0	0	0	3
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 2023

Re: October 2023 Abuse/Neglect Violations

October

Abuse Violations

- There were two substantiated Abuse II violations in October 2023.
    - The remedial actions for this violation were Employment Termination (2) and Training (2).

      The 2 violations occurred at different agencies.

- There were two substantiated Abuse III violations in October 2023.
    - The remedial actions for these violations were Employment Termination (1), and Written Reprimand (1).

      The 2 violations occurred at different agencies.

Neglect Violations

- There were four substantiated Neglect III violations in October 2023.
    - The remedial actions for these violations were Employee left agency (1), Training, Written Reprimand (4), Policy Revision/Development (1), and Training (5)

      The 4 violations occurred at 3 different agencies. The 2 violations occurring at the same agency occurred at different program sites. There were 2 employees for 1 violation.

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).

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AFFIRM
For Caregivers

AFFIRM Caregiver Report

AFFIRM Caregiver is an 8-session group program designed to help parents & caregivers build the confidence & skills they need to best support their LGBTQ+ youth. The model is evidence-informed and is working toward evidence-based status. Staff at ISK applied for and received funds from SAMHSA to cover the training of staff and the materials needed for the group. ISK is working with the National SOGIE (Sexual Orientation, Gender Identity and Expression) Center, who developed the model. The University of Connecticut is collecting data from the groups, which is helping to establish evidence for the effectiveness of the model.

All people who parent and support LGBTQ+ young people are welcome, including adoptive parents, kinship/family members, chosen family, foster & resource parents. We have hosted two cohorts of this training with 7 caregivers' total. Groups have been hosted in the family space at ASK Family Services. The model comes with manuals for the facilitators as well as the caregivers who participate. The group works through the manual together which covers topics of LGBTQ identities, minority stress, traumatic impacts of anti-LGBTQ experiences, the coming out process, affirming behaviors for parents, and overcoming barriers in the youth and caregivers' lives to build affirming communities and support systems.

We are continuing to work with community partners to expand who we offer the model to. We started with small groups of ISK families, which have received positive support. We are looking at expanding this in order to support families throughout Kalamazoo County, as a step toward preventing disparate outcomes for LGBTQ youth and young adults by preemptively working with families to create affirming homes. We are in the process of working with OutFront Kalamazoo to start a group with families who have reached out to them for support.

We currently have five staff trained in the AFFRIM Caregiver model. We would like to expand and send staff to be trained in the AFFIRM Youth model. AFFIRM Youth is the same model but directed toward helping youth people affirm their own identities. Our desire is that AFFIRM will help the Kalamazoo community at large continue to be a welcoming and affirming place for the LGBTQ community.

AFFIRM Caregiver: A Compassionate Approach for Caregivers of Lesbian, Gay, Bisexual, Transgender & Questioning (LGBTQ+) Populations

Program Description: AFFIRM Caregiver is an evidence-informed, seven session, manualized intervention to enhance affirmative parenting practices that promote the safety and wellbeing of LGBTQ+ youth. The AFFIRM Caregiver model emerged from AFFIRM Youth, an evidence-based, affirmative Cognitive Behavior Therapy intervention which has been scientifically shown to reduce psychosocial distress and improve coping skills among LGBTQ+ youth (Austin, Craig, & D'Souza, 2017; Craig & Austin, 2016).

AFFIRM Caregiver

- ✓ Is manualized
- ✓ Provides training to new practitioners
- ✓ Requires fidelity adherence
- ✓ Requires data collection
- ✓ Provides expert coaching to new implementers

AFFIRM is rooted in an affirmative practice framework and utilizes best practice research on LGBTQ+ youth wellbeing and has growing empirical research base for its effectiveness (Austin et al. 2018, Craig et al., 2020; Craig et al., 2021). The developers adapted their model for use with parents by creating the AFFIRM Caregiver model. Seminal literature on family acceptance (Ryan et al., 2010), and compassionate parenting (Kirby, 2019) were utilized to build the seven-session model. Preliminary data support the feasibility and effectiveness of AFFIRM Caregiver in US foster care settings (Austin et al., in Press).

Program Delivery: As a manualized intervention, AFFIRM Caregiver is typically delivered by trained and certified counselors, social workers, and other mental health professionals in a group-based format. The seven modules are designed for flexible implementation with all populations, making them easy to integrate into existing service settings (e.g., into existing counseling groups or parenting programs).

Who is the program for? AFFIRM Caregiver is designed to work with all caregivers of LGBTQ+ children and youth. This includes biological and adoptive parents, kinship/family members of origin, chosen family, foster/resource parents, and all other people who parent and support LGBTQ+ young people. The intervention is best implemented when cohorts are customized to specific types of caregivers, for example, biological and adoptive parents would attend their own group while foster parents might attend another.

Program Evidence: Data from AFFIRM Caregiver studies shows effectiveness for improving affirmative caregiving attitudes and behaviors, as well as confidence in caregiver abilities to engage in affirmative caregiving skills with LGBTQ+ youth. Data show statistically significant improvements in affirmative attitudes and behaviors toward both LGB and transgender youth, as well as statistically significant improvements in affirmative caregiving competence for LGBTQ+ youth.

> *"This program has definitely changed me and helped me be more open and accepting and knowing that we're all humans and we all deserve to be able to be loved and respected."* - Caregiver Graduate

How do I get AFFIRM Caregiver to my organization?

To implement AFFIRM Caregiver in your practice or within your organization, please email the National Quality Improvement Center on Tailored Services, Placement Stability, and Permanency for LGBTQ2S Children and Youth in Foster Care at SOGIECENTER@UConn.edu or contact the AFFIRM co-creators directly at mail@affirmativeresearch.net.

Austin, A. & Craig, S. L. (2015). Transgender affirmative cognitive behavioral therapy: Clinical considerations and applications. Professional Psychology: Research and Practice, 46(1), 21-29. https://doi.org/10.1037/a0038642

Austin, A., Craig, S. L., & D'Souza (2018). An AFFIRMative cognitive behavioral intervention for transgender youth: Preliminary effectiveness. Professional Psychology: Research and Practice DOI: 10.1037/pro0000154

Austin, A., Craig. S. L., Matarese, M., Greeno, E. J., Weeks. A., & Betsinger, S. A. (In Press). Preliminary effectiveness of an LGBTQ+ affirmative parenting intervention with foster parents. Children and Youth Services Review.

Craig, S.L., & Austin, A. (2016). The AFFIRM Open Pilot Feasibility Study: A Brief Affirmative Cognitive Behavioral Coping Skills Group Intervention for Sexual and Gender Minority Youth. Child and Youth Services, 64,136-144. https://doi.org/10.1016/j.childyouth.2016.02.022

Craig, S. L., Austin, A., & Alessi, E. (2013). Gay affirmative cognitive behavioral therapy for sexual minority youth: A clinical adaptation. Clinical Social Work Journal, 41(3), 258-266. https://doi.org/10.1007/s10615-012-0427-9

Craig, S. L., Leung, V. W. Y. Pascoe, R., Pang, N., Iacono, G., Austin, A., & Dillon, F. (2021) AFFIRM Online: Utilising an Affirmative Cognitive–Behavioural Digital Intervention to Improve Mental Health, Access, and Engagement among LGBTQA+ Youth and Young Adults. International Journal of Environmental Research and Public Health, 18, https://doi.org/10.3390/ijerph18041541

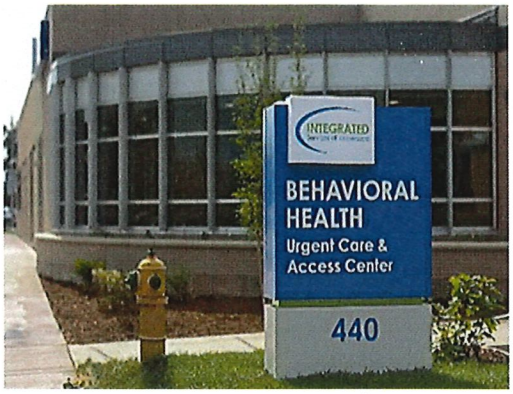
Craig, S. L., Yang, W., & Austin, A. (2020). Promoting the sexual self-efficacy of sexual and gender minority youth through groups. Groupwork, 28 (2), 5–22.

Kirby, J. N. (2020). Nurturing family environments for children: compassion-focused parenting as a form of parenting intervention. Education Sciences, 10(1), 1-15. https://doi.org/10.3390/educsci10010003

Ryan, C., Russell, S.T., Huebner, D., Diaz, R. & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. Journal of Child and Adolescent Psychiatric Nursing, 23(4), 205–213. https://doi.org/10.1111/j.1744-6171.2010.00246.x

V.b.

Will be reviewed at the meeting. There are no materials to review in advance.



INTEGRATED Services of Kalamazoo (*ISK*) Board of Director's Meeting

INTEGRATED Services of Kalamazoo
610 South Burdick Street
Kalamazoo MI 49007

October 23, 2023 VI.a.

ISK Board Member	Board Members PRESENT	Declaration of Location City/County	Board Members ABSENT
Karen Longanecker, *CHAIR*	X	Kalamazoo/Kalamazoo	
Michael Seals, *VICE CHAIR*	X	Kalamazoo/Kalamazoo	
Nkenge Bergan		Kalamazoo/Kalamazoo	X
Sarah Carmany	X	Kalamazoo/Kalamazoo	
Patrick Dolly	X	Kalamazoo/Kalamazoo	
Pat Guenther	X	Kalamazoo/Kalamazoo	
Ramona Lumpkin		Kalamazoo/Kalamazoo	X
Michael Raphelson	X	Kalamazoo/Kalamazoo	
Sharon Spears	X	Kalamazoo/Kalamazoo	
Erik Krogh	X	Kalamazoo/Kalamazoo	
Melissa Woosley	X	Kalamazoo/Kalamazoo	
Montez Morales, *COMMISSIONER*	X	Kalamazoo/Kalamazoo	

ISK - KCMHSAS Staff Present:

Jeff Patton, *CHIEF EXECUTIVE OFFICER*
Amy Rottman
Charlotte Bowser
Wanda Brown
Sheila Hibbs
Beth Ann Meints
Michael Schlack, *CORPORATE COUNSEL*
Dianne Shaffer
Ed Sova
Alecia Pollard
Demeta Wallace

Providers:

Diane Marquess
Chief Executive Officer
Family & Children's Services

Latrevia Boston
Executive Director
ASK Family Services

Azzam Alfarrajo
Grand Valley State University
GRAD Student/class assignment

Hadhil Alsubaie
Grand Valley State University
GRAD Student/class assignment

INTEGRATED Services of Kalamazoo
Community • Independence • Empowerment

Call to Order
The Board of Directors (Integrated Services of Kalamazoo) held their meeting on Monday, October 23, 2023. It began @ 4:00pm and was presided over by Chair, *Karen Longanecker*.

Agenda
MOTION
Vice Chair Seals moved to approve the agenda for the meeting. Supported by Member Guenther and carried without dissent.

Citizen Time No citizens came forth.

Recipient Rights Monthly Reports
Due to the absence of Lisa Smith, Jeff Patton, presented the complaints/allegations closed in September 2023.

Abuse Violations

- There were two substantiated Abuse II violations in September 2023.
    - The remedial actions for these violations were Written Reprimand (3), Training (3), and Plan of Service Revision (1). There were two staff involved in one citation.

      The 2 violations occurred at the same agency but different program sites.
- There was one substantiated Abuse III violation in September 2023.
    - The remedial actions for this violation were Written Reprimand (2), and Training (2).

Neglect Violations

- There were two substantiated Neglect II violations in September 2023. One was a Failure to Report.
    - The remedial actions for these violations were Written Reprimand (3), and Training (3). There was one staff involved in one citation and two staff involved in the second citation.

      The 2 violations occurred at 2 different agencies.
- There were five substantiated Neglect III violations in September 2023. One was a Failure to Report.
    - The remedial actions for these violations were Employee Termination (1), Written Reprimand (4), Training (4), and Policy Revision/Development (1).

      The 5 violations occurred at 2 different agencies. One agency had 2 violations at the same program site and same staff. The other agency the 3 violations occurred at different program sites.

All of the ORR case information is sent 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).

Program Service Report
Wanda Brown, Senior Executive, Integrated Health Services Clinic/Psychiatric Services
The Integrated Health Services Clinic at ISK continues to elevate to new heights in the quality of care that is provided for members of our community. Our goal is to strive for excellence and to deliver exceptional experiences for each individual/patient that we serve at every interaction. We continue to look for quality improvement initiatives that will enhance the services offered at ISK. ISK is committed to healthy equity for all, ensuring equal access to healthcare and providing education and training to the staff providing services to the community.

With the end of the federal COVID-19 Pandemic Public Health Emergency (PHE) on May 11, 2023; there have been many changes to insurance coverage for recipients of Medicaid, Medicare, and private insurances. Laboratory testing, vaccines, and other treatments for the COVID-19 virus remain available from various venues such as local and chain pharmacies, county health departments and physician offices. It is best practice to update the demographic information on file when presenting for a visit at ISK. This is required to ensure all insurance providers and facilities providing the services have current and matching information. The "unwind" period was provided to allow recipients time to re-enroll, update information, or establish care with their behavioral health provider and or insurance company. This has been a major undertaking in the healthcare arena. All individuals are encouraged to contact their provider of services prior to receiving services and get clarification on if there is a fee associated with receiving services. Medicaid, Medicare, and private insurances may cover a portion of, or all the expense related to the treatment of the COVID-19 virus.

ISK is one of the largest CCBHC organizations in Michigan. With the opening of the 24-hour Behavioral Health Urgent Care & Access Center on July 10, 2023, the Emergency Mental Health, and Access team members have relocated to the 440 W. Kalamazoo location. The office space has been reassigned to the NAVIGATE Team, the CAS (Client Access Specialist) Program Supervisor and team member, the ACT overflow office (Assertive Community Treatment Team) and a WMU Homer Stryker School of Medicine Department of Psychiatry/ISK Research Office, all nine offices are occupied. Our collaborative agreements with WMU Department of Psychiatry have expanded to include Dr. Eric Achtyes and team partner with the IHSC by participating in several evidenced based best practice research projects. Stay tuned for updates from the Research Team. We continue to have 3rd year residents who provide services to patients in the clinic on a weekly basis; there are also several medical school students participating in learning experiences with several team at ISK. There are a variety of Affiliation Agreements in place from colleges and universities for Nurse Practitioner students, that complete their clinical hours in the IHSC.

Since April 2023, we have filled the following positions: Practice Manager, Office Manager, Registered Nurse and three full time Practice Support Assistants. As of 10/9/23 we have filled the part time physician position with Dr. Vegas Coleman a Board-Certified Child Psychiatrist. Two of the three available Nurse Practitioner positions have been filled Kelsey Knapp and Tina Myers, who transferred to her new role of Nurse Practitioner from the ACT Team Nurse, both are located onsite at the IHSC and will provide services to adults and youth. There are 2 Locum Physicians and 1 Nurse Practitioner that provide telehealth services to ISK patients. Two of their contracts are through February-March 2024 and one through April 2024.

We continue to provide best practice learning and collaboration opportunities to the clinical team of physicians, nurse practitioners, physician's assistant, and registered nurses. The nursing team and Chief of Staff Dr. Valrie Honablue have collaborated monthly for the past year and will continue to meet monthly in 2024 over their lunch time, ISK provides lunch 😊. Each sixty-minute session has covered a broad range of behavioral/medical health topics such as the importance of hydration (drinking water) in mental health conditions, dangers in the use of marijuana with mental health patients and medications, and the dangerous interactions that can occur with individuals that have a mental health diagnosis and are taking certain medications. These sessions and topics both strengthen the nurse's knowledge and the physician nurse relationship. The Nursing team is also working with the COPE Network to provide individuals Narcan kits and resources when requested.

Dr. Honablue informed me that she has five patients that are currently attending KVCC and WMU. These individuals vary in age (19, 25, 32, 54); diagnoses include major depression and bipolar and schizophrenia. enrolled in the WHI, Navigate, ACT, Team. One of the individuals lives in an AFC Home. There is one who is majoring in Social Work, MSW, one writes poetry and has plans to make a movie about living with a diagnosis of mental illness. These are examples of great success stories and an example of Breaking The Stigma!

The physician's and mid-level staff meet monthly for the Peer Review sessions where Evidenced Based Best Practice concepts are discussed and shared by the team and other members like Arcadia pharmacy staff and the quality department. These sessions will also continue in the upcoming year with changes or improvements to the format. The IHSC has felt the results of being one of the first CCBHC organizations in the state, the volume has increased every year and is expected to continue this year.

<u>Beth Ann Meints, Administrator of Clinical Services, CCBHC/Urgent Care & Access Center and Senate Bill #2293 updates</u>

I would like to focus my report on the United States Senate Bill #2293. It is a bill to amend the Social Security Act and the Public Health Service Act to permanently authorize certified community behavioral health clinics, and for other purposes.

Senator Debbie Stabenow & Senator John Cornyn are the sponsors for this bill for Ensuring Excellence in Mental Health Act. This is a Bipartisan Bill. Therefore, we are still hopeful that it will be voted into law.

That concludes my report.

Consent Calendar

MOTION

Chair Longanecker, "Are there any materials that the ISK Board would like to have removed from the Consent Calendar before we proceed with the verbal motion?" No materials were requested to be removed.

a. Minutes September 25, 2023
b. Board Purpose and Business Description (Policy)
c. Treatment of Persons Served w/Substantiated Complaints (Policy & Report)
d. Guidelines for Board Member Appointments (Policy)
e. Customer Service (Report)
f. Customer Advisory Council (CAC) Annual (Report)
g. Family Support Advisory Council (FSAC) (Report)

Vice Chair Seals, "I MOVE TO ACCEPT THE CONSENT CALENDAR MONITORING REPORTS BOTH "AS-IS" OR WITH PROPOSED RECOMMENDED CHANGES." Supported by Member Guenther.

MOTION PASSED.

Financial Reports/Financial Condition Reports September 30, 2023

Amy Rottman, ISK, Chief Financial Officer, presented the Financial Condition Reports for September 30, 2023.

To review the financial and investment reports, please visit our website @ https://iskzoo.org/about-us/board/

Utilization Reports

Charlotte Bowser, ISK, Accounting Manager, presented the Utilization Report for the period ending September 30, 2023.

- Youth Community Inpatient Services is at (95) days and is favorable at $129,061
- MI Adult Community Inpatient Services is at (2,675) days and is favorable at $1,182,379
- Community Living Supports, Personal Care, and Crisis Residential is favorable at $1,690,965

September Disbursements

MOTION

Member Guenther, "BASED ON THE BOARD FINANCE MEETING REVIEW, I MOVE THAT ISK APPROVE THE SEPTEMBER 2023 VENDOR DISBURSEMENTS OF $13,597,941.28." Supported by Member Spears.

MOTION PASSED.

Action Items - NEW or REVISITED

MOTION

ISK Board of Directors to Enter into CLOSED SESSION

"I move that the ISK Board enter a closed session to discuss pending legal issues, as allowed under the Michigan Open Meetings Act, MCL 15.268(1)(e)."

Summary of Request

- The Michigan Open Meetings Act allows the ISK board to enter closed session to discuss pending litigation.
- 2/3 of the ISK board must vote to approve a closed session (8 members) and there must be a roll call vote.
- Once the closed session is completed, the board may conduct a voice vote to return to an open session.

ROLL CALL VOTE:

ISK Board Member	Yes	No
Chair Karen Longanecker	X	
Vice Chair Michael Seals	X	
Member Nkenge Bergan		
Member Sarah Carmany	X	
Member Patrick Dolly	X	
Member Pat Guenther	X	
Member Erik Krogh	X	
Member Monteze Morales	X	
Member Michael Raphelson	X	
Member Sharon Spears	X	
Member Ramona Lumpkin		
Member Melissa Woolsey	X	
MOTION PASSED	X	

Need 8 yes votes (2/3 of currently appointed board) no matter how many members are in attendance.

MOTION PASSED.

Chief Executive Officer Report

The CEO Report was given in CLOSED SESSION. Therefore, there is nothing to report.

Citizen Time

No citizens came forth.

SWMBH (Southwest Michigan Behavioral Health) Updates/Erik Krogh

Ed Meny, Board Chair, Southwest Michigan Behavioral Health (SWMBH) and Erik Krogh, Board Appointee, Southwest Michigan Behavioral Health Board, sent an email to Karen Longanecker and the ISK Board of Directors, requesting an opportunity to connect with the founding members of the CMH boards to engage in dialogue about SWMBH values, expectations and performance goals.

To begin this conversation, SWMBH is asking each CMH board to answer 5 predetermined questions to be explored at a future meeting where Brad Casemore, CEO, SWMBH and a consultant secured by SWMBH.

Below is the first email that was sent on Wednesday, September 20, 2023 @ 11:58AM from Mr. Meny.

*"**From:** Michelle Jacobs <Michelle.Jacobs@swmbh.org>*
***Sent:** Wednesday, September 20, 2023 11:58 AM*
***To:** Karen Longanecker <Klonga1073@gmail.com>*
***Cc:** Erik Krogh <karahelen@charter.net>; Edward Meny <edwardmeny0421@comcast.net>; Jeff Patton <jpatton@iskzoo.org>; Brad Casemore <Brad.Casemore@swmbh.org>; Ella Philander <ella.philander@swmbh.org>*
***Subject:** CMH Board Visit email*

In its efforts to govern well, the SWMBH Board is initiating an effort to solicit the expected impacts of SWMBH on each of its founding CMHs and their communities. The SWMBH Board has a governing duty to be the informed voice and agent of the member CMH Boards.

The SWMBH Board's intent is to connect with the founding member CMH boards to assure that SWMBH is aligning with the members' values and expectations about impacts and performance goals. We ask your cooperation and facilitation to the request below.

The SWMBH Board understands it has accountability to the CMH member Boards.

The SWMBH Board's hope is to have direct engagement with the CMH Boards over the coming months. We would like to send Susan Radwan, SWMBH Board Consultant and SWMBH CEO Bradley Casemore to engage with your board to gather input that will inform the SWMBH Board.

Our current plan is a two-step approach.

1. *Please watch this 7-minute video https://youtu.be/UHYqu76VPK0. The video is a summary overview of SWMBH and guiding questions for consideration to be reviewed at a CMH Board meeting.*

2. *Susan and Bradley would like to visit each CMH Board to facilitate the discussion and document input from your CMH board. Attached is a Power Point presentation to each CMH Board for viewing at an upcoming CMH Board meeting to set the stage for this activity. Following those meetings, the SWMBH Board will consider the input as it reviews and revises its Ends for further review and finalization. We estimate that this will take approximately 45 minutes of your Board time.*

We hope for your willingness to engage with us in this effort. Kindly direct logistic questions to Michelle Jacobs michelle.jacobs@swmbh.org and other questions to Ella Philander SWMBH Strategic Initiatives Project Manager ella.philander@swmbh.org.

Gratefully and respectfully, Ed Meny, SWMBH Board Chair"

Chair Longanecker reached a determination that the best course of action would be to appoint members from the ISK Board of Directors to function on a committee who will review the questions and then supply answers. Once that is completed, then invite members of the SWMBH Board to an ISK Board meeting in January 2024 for further discussion.

Chair Longanecker appointed: Erik Krogh, Pat Guenther, Michael Raphelson, Michael Seals and Sharon Spears.

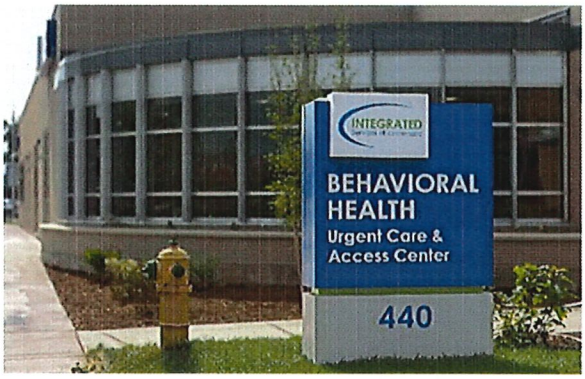
Meeting ended at 6:15PM.

Demeta J. Wallace
Administrative Coordinator & Board Liaison
INTEGRATED Services of Kalamazoo

VI.a.

November 13, 2023

ISK Board Minutes for Special Meeting



INTEGRATED Services of Kalamazoo (*ISK*) Board of Director's Meeting

INTEGRATED Services of Kalamazoo
610 South Burdick Street
Kalamazoo MI 49007

November 13, 2023 VI.a.

ISK Board Member	Board Members PRESENT	Declaration of Location City/County	Board Members ABSENT
Karen Longanecker, *CHAIR*		Kalamazoo/Kalamazoo	X
Michael Seals, *VICE CHAIR*	X	Kalamazoo/Kalamazoo	
Nkenge Bergan		Kalamazoo/Kalamazoo	X
Sarah Carmany	X	Kalamazoo/Kalamazoo	
Patrick Dolly	X	Kalamazoo/Kalamazoo	
Pat Guenther	X	Kalamazoo/Kalamazoo	
Ramona Lumpkin	X	Kalamazoo/Kalamazoo	
Michael Raphelson	X	Kalamazoo/Kalamazoo	
Sharon Spears	X	Kalamazoo/Kalamazoo	
Erik Krogh	X	Kalamazoo/Kalamazoo	
Melissa Woosley	X	Kalamazoo/Kalamazoo	
Montez Morales, *COMMISSIONER*	X	Kalamazoo/Kalamazoo	

ISK - KCMHSAS Staff Present:
Jeff Patton, *CHIEF EXECUTIVE OFFICER*
Michael Schlack, *CORPORATE COUNSEL*
Alecia Pollard
Demeta Wallace

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Call to Order

The Board of Directors (Integrated Services of Kalamazoo) held their meeting on Monday, November 13, 2023. It began @ 4:00pm and was presided over by Vice Chair, *Michael Seals*.

Agenda

MOTION

Member Carmany moved to approve the agenda for the meeting. Supported by Member Guenther and carried without dissent.

MOTION
Member Raphelson, "I move that the ISK Board enter a closed session @ 4:03PM to discuss pending legal issues, as allowed under the Michigan Open Meetings Act, MCL 15.268(1)€." Supported by Commissioner Morales.

ROLL CALL VOTE:

ISK Board Member	Yes	No
Chair Karen Longanecker		
Vice Chair Michael Seals	X	
Member Nkenge Bergan		
Member Sarah Carmany	X	
Member Patrick Dolly	X	
Member Pat Guenther	X	
Member Erik Krogh	X	
Member Monteze Morales	X	
Member Michael Raphelson	X	
Member Sharon Spears	X	
Member Ramona Lumpkin	X	
Member Melissa Woolsey	X	
MOTION PASSED	X	

Need 8 yes votes (2/3 of currently appointed board) no matter how many members are in attendance.

MOTION PASSED.

MOTION
Member Raphelson, "I move to come out of closed session @ 4:43pm to continue the meeting and to conduct further ISK Board of Directors business." Supported by Commissioner Morales.
MOTION PASSED.

MOTION
Member Dolly, "I move that ISK accept the advice of ISK's litigation counsel as discussed in closed session today regarding the litigation entitled Lesley Benson vs. Integrated Services of Kalamazoo." Supported by Commissioner Morales.
MOTION PASSED.

Citizen Time No citizens came forth.

Meeting ended at 4:45PM.
Demeta J. Wallace, *Administrative Coordinator & Board Liaison*, INTEGRATED Services of Kalamazoo

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, they 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

~~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:	11/22/2021
		REVISED:	~~11/28/2016~~11/27/2023

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 C~~hief~~ E~~xecutive~~ O~~fficer~~ may not have fewer than two other executives familiar with board and C~~hief~~ E~~xecutive~~ O~~fficer~~ issues and processes.

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

A. Chief Executive Officer

~~A.~~B. Administrator of Operations

~~B.~~C. Administrator of Clinical Services

D. Chief Medical Officer

~~C. 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

Karen Longanecker
Board Chair

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY V.11

AREA:	Governance		
SECTION:	Board Governance Process	PAGE:	1 of 54
SUBJECT:	**CORPORATE COMPLIANCE AND RISK MANAGEMENT**	SUPERSEDES:	10/29/2019 ~~11/24/2014~~
		REVISED:	~~10/29/2019~~ 11/27/2023

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 2021, section §8B2.1. - Effective Compliance and Ethics Program, identifies elements of an "effective compliance program\" and includes 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 adhere to other requirements
4. Inform the Annual Corporate Compliance Plan.

~~**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

In accordance with the US Sentencing Guidelines of 2021 and the Office of Inspector General (OIG), ISK shall be in compliance with seven elements of an effective compliance programs, which have become the benchmark of corporate compliance. The seven elements are as follows:

1. Implementing written policies, procedures, and standards of conduct
2. Governance & Oversight: 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 and disciplinary action through consistent, well-publicized guidelines
7. Responding promptly to detected offenses and undertaking corrective action~~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:~~

~~Implementing written policies, procedures, and standards of conduct~~
~~Designating a compliance officer and compliance committee~~
~~Conducting effective training and education~~
~~Developing effective lines of communication~~
~~Conducting internal monitoring and auditing~~
~~Enforcing standards through consistent, well-publicized guidelines~~
~~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~~they 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 **APPROVED**

Jeff Patton
Chief Executive Officer

~~Erik Krogh~~Karen Longanecker
Board Chair

INTEGRATED SERVICES OF KALAMAZOO COMPLIANCE PLAN
FY 24 – GOALS / OBJECTIVES

#	GOAL	OBJECTIVES / ACTION STEPS	MEASURES
1	ISK will sustain strong direct run and Provider Network programming with 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 monitor and address areas of poor performance and low utilization. Monitoring will include follow-up, utilization management reviews, corrective action, and sanctioning as necessary. Concurrent collaboration with Leadership to mitigate risk as needed will occur. 2. Compliance Officer 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 fiscal responsibility and sustainability to ensure direct operated programs and Provider Network are sustainable and operational in times of crisis and need. Compliance Officer will ensure Provider Network is allocating direct care wage (DCW) dollars appropriately and in accordance with law.	1. Identify changes to organizational and clinical practices through data mining of high/low utilizers of identified services with strong focus on mitigating potential for fraud, waste, and abuse. 2. Number of training opportunities, educational communications, and support provided during FY will increase. 3. Number of direct-operated programs and Provider Network agencies who communicate financial insecurity or request additional resources to provide services will decrease.
2	ISK will remain involved in the oversight, monitoring, and implementation of changes to rules/regulations pursuant to post-Public Health Emergency (PHE) policy implementation.	1. Ongoing involvement in state-level workgroups (EDIT) to obtain updates to rules/regulations and inform direct-operated programs and Provider Network of upcoming 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 related to post-PHE policy implementation.	1. Formal quarterly updates from workgroup members to appropriate committees with implementation of ISK sub-workgroups and Corporate Compliance as necessitated. 2. Number of QMRs identifying direct-operated programs and/or Provider Network agency compliance with updated rules/policies, codes/modifier reporting will increase. 3. Establish monitoring plan of revised policies/procedures related to post-PHE policy implementation. Successful implementation of monitoring plan and follow-up as needed.
3	ISK will monitor and identify high-risk areas related fraud, waste, and abuse and work toward successfully mitigating such occurrences.	1. ISK Compliance Officer and Provider Network Managers will work to oversee implementation and operationalization of one-on-one enhanced staffing. 2. Utilize Michigan Medicaid Provider Manual guidance to ensure internal controls are implemented to disallow lack of appropriate implementation of one-on-one enhanced staffing. 3. Mitigate fraud, waste, and abuse through monitoring and investigation of high-risk programming and ensure follow-up is reflective of training, education, and guidance of compliant documentation and reporting of services and encounters.	1. Identify individuals receiving one-on-one enhanced staffing services with contracted service providers by December 31, 2023. 2. Development of Compliance Monitoring Plan and implementation of targeted audits to assess for appropriate implementation of one-on-one enhanced staffing on quarterly basis. 3. Deploy Compliance Monitoring Plan and ensure follow-up/communication/remediation with Providers, internal teams, SWMBH, MDHHS and OIG as necessitated.

INTEGRATED SERVICES OF KALAMAZOO COMPLIANCE PLAN
FY 24 – GOALS / OBJECTIVES

#	GOAL	OBJECTIVES / ACTION STEPS	MEASURES
4.	ISK will strengthen policies and procedures to mitigate potential and actual HIPAA breaches caused by impermissible use or disclosure of Protected Health Information (PHI)	1. ISK Compliance Committee and ISK PHI Integrity Team will work in tandem to identify and mitigate any potential or actual cyber security attacks, phishing attempts, and/or breaches of information as they are discovered. 2. Penetration testing and cybersecurity oversight and guidance will occur throughout fiscal year 2024 to identify areas of risk and improvement. 3. Continuous user education and training opportunities will be offered to ISK workforce to inform of the dangers of cyber security attacks and their implications for clients, staff, and stakeholders.	1. ISK's PHI Integrity Team will meet monthly to review submission of suspected and actual breaches. Privacy Officer will complete Breach Risk Assessment to determine reportable breaches to DHHS. 2. Penetration testing and cybersecurity consultation will continue to be implemented September 30, 2024. 3. The number of staff members clicking on phishing e-mails and potentially exposing client PHI will decrease by half by September 30, 2023.

INTEGRATED
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Corporate Compliance Program
FY24

Ashley Esterline, LMSW, CHC
ISK Director of Network Compliance/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 FY23 (October 1, 2022 through September 30, 2023) and plan for FY24 (October 1, 2023-September 30, 2024).

PROGRAM PURPOSE

The ISK Compliance Program is designed to provide safeguards to ensure that ISK and the Provider Network are in 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 persons and components of the Compliance Program are as follows:

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

- **Manager of Health Information and Risk Oversight**
  The Manager of Health Information and Risk Oversight supports the Director of Network Compliance/Corporate Compliance Officer with the assigned responsibilities related to the implementation of the ISK Corporate Compliance Program and annual Corporate Compliance Plan. The Manager of Health Information and Risk Oversight oversees the operations of ISK Medical Records, liaison to the Provider Network, completes inquiries/investigations in conjunction with the Director of Network Compliance/Corporate Compliance Officer and supports the ISK Risk Management Program.

- **Compliance and Quality Improvement Coordinator**
  The Compliance and Quality Improvement Coordinator supports the Director of Network Compliance/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 Manager of Health Information and Risk Overisght, 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 Director of Network Compliance/Corporate Compliance Officer, Compliance and Quality Improvement Coordinator, Administrator of Operations, HIPAA Security Officer, HIPAA Privacy Officer, Michigan Mental Health Code (MMHC) expert, Manager of Health Information and Risk Oversight, and Director of Human Resources. This team monitors, reviews, and processes reported breaches, HIPAA violations and mitigates privacy concerns impacting the agency.

- **Compliance Committee**
  The Compliance Committee has representatives from major departments within the agency (e.g., finance, clinical, quality, information technologies, Office of Recipient Rights and Administration) and serves as the oversight committee for compliance-related activities.

- **Annual Plan**
  The Annual Compliance Plan, that 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 Director of Network Compliance/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, goal attainment, 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 Director of Network Compliance/Corporate Compliance Officer is responsible for ensuring that practices within ISK and its Network Providers are conducted so that the risk of fraud, waste, and abuse is understood and minimized.

- **Monitoring, Audits, and Investigations**
  The Director of Network Compliance/Corporate Compliance Officer, 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 ongoing organizational assessment. Areas of high risk are reviewed and revised by the Director of Network Compliance/Corporate Compliance Officer, with the input of the Compliance Committee and other resources in order to augment and strengthen provisions to ensure they are consistent with laws and regulations.

- **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 ensuring all employees receive necessary information and training 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 direct-operated, internal services. The second is a mechanism for confidential reporting of suspected fraud, waste, or abuse by employees, Network Providers and agents. All staff must know that failure to report suspected fraudulent behavior is unethical and thus itself is noncompliant 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 taken by the Director of Network Compliance/Corporate Compliance Officer.

- **Investigation, Disciplinary Activity, Disclosure Activities**
  The Director of Network Compliance/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 measures 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 FY24.

Contained in this report are the following attachments:

- FY23 Compliance and Risk Management Status Report
- FY24 Compliance Plan with Goals and Objectives

Integrated Services of Kalamazoo

Corporate Compliance / Risk Management

Q3 Report

FY23

Program Name:	**COMPLIANCE & RISK MANAGEMENT**	**Report Period:**	☒ October ☐ January ☐ April ☐ July
Person Completing Report:	Ashley Esterline, LMSW, CHC – Corporate Compliance Officer		
Brief Report Overview:	Contained in this Status Report is a summary of the Compliance Program's goals and activities for FY23 as of September 30, 2023.		

Current Committee goals and deliverables per work plan	Project Goal/Task	Status:
	1. ISK will sustain strong direct run and Provider Network programming with fiscal responsibility and sustainability to ensure direct run programs and Provider Network are providing high quality care and consistently meeting compliance standards.	1. FY24 Contract Planning commenced and ISK implemented a 3% rate increase for most providers. ABA rates remained flat pursuant to the MDHHS Fee Schedule. Conversations with SWMBH/regional CMHSPs ensued regarding inpatient rates and ABA rates. A workgroup is reviewing rates. Pursuant to MDHHS directive, ISK is providing DSPs with an $.85 DCW increase plus allocating additional dollars for overtime expenses.
	2. ISK will remain involved in the oversight, monitoring, and implementation of changes to rules/regulations pursuant to the COVID Public Health Emergency (PHE).	2. Post PHE oversight focused on implementation of CCBHC codes and preparation for FY24 changes. T1040:TF and the logic associated were of utmost importance. Continued oversight and guidance were given to the MDHHS Code Chart and Provider Qualifications and updates to telehealth allowances were communicated to direct-op programs and the Provider Network.
	3. ISK will monitor and identify high-risk areas (e.g., incorrect billing practices) pursuant to the establishment of the KARE electronic health record to successfully mitigate fraud, waste, and abuse.	3. Director of Network Compliance and Chief Information Officer oversee updates to the Michigan Department of Health and Human Services' (MDHHS) Code Chart and liaison with the MDHHS Encounter Data Integrity Team (EDIT). There is continuous, ongoing communication with internal staff and Provider Network to advise on updates to codes, modifiers, and/or programmatic changes/updates. End of year updates focused on ensuring FY24 codes and modifiers were accurate in the electronic health record and Provider contracts.
	4. ISK will strengthen policies and procedures to mitigate potential and actual HIPAA breaches caused by impermissible use or disclosure of Protected Health Information (PHI).	4. Southwest Michigan Behavioral Health has requested their Notice of Privacy Practices be provided to all individuals at intake. ISK and SWMBH are working on process implementation. Cyber Security Task Force meets on monthly basis to work on Privacy/Security PHI safeguard strategies.

INTEGRATED SERVICES OF KALAMAZOO

Period Ended
October 31, 2023

Monthly Finance Report

This financial report is for internal use only. It has not been audited, and no assurance is provided.

INTEGRATED SERVICES OF KALAMAZOO

Statement of Net Position
October 31, 2023

	October 2022 (unaudited)	October 2023
Assets		
Current assets		
Cash and investments	$ 28,554,828	$ 32,382,215
Accounts receivable	4,483,094	4,263,229
Due from other governments	8,359,068	22,768
Prepaid items	863,676	1,356,713
Total current assets	42,260,666	38,024,925
Non-current assets		
Capital assets, net of accumulated depreciation	9,563,560	13,405,602
Net pension asset, net of deferred outflows	7,339,625	7,339,625
Total non-current assets	16,903,185	20,745,227
Total assets	59,163,851	58,770,152
Liabilities		
Current liabilities		
Accounts payable	$ 8,559,319	$ 8,912,208
Due to other governments	1,151,732	1,338,106
Accrued payroll and payroll taxes	1,839,431	1,871,484
Unearned revenue	303,406	715,458
Total current liabilities	11,853,888	12,837,255
Net position		
Designated	9,472,779	8,671,891
Undesignated	28,273,625	27,987,225
Investment in fixed assets	9,563,560	9,471,053
Net gain (loss) for period	-	(197,272)
Net position	$ 47,309,964	$ 45,932,897

INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position

October 1, 2023 through October 31, 2023
Percent of Year is 8.33%

	Original 2024 BUDGET	YTD Totals 10/31/23	Remaining Budget	Percent of Budget - YTD
Operating revenue				
Medicaid:				
Traditional Capitation	$ 59,535,085	$ 6,810,174	$ 52,724,911	11.44%
Healthy Michigan Capitation	12,302,122	805,743	11,496,379	6.55%
Settlement	5,287,379	(720,644)	6,008,023	0.00%
State General Fund:				
Formula Fundings	3,705,491	325,043	3,380,448	8.77%
CCBHC Demonstration	27,297,101	692,713	26,604,388	0.00%
CCBHC Accrual	-	805,331	(805,331)	0.00%
County Allocation	1,550,400	129,200	1,421,200	8.33%
Client Fees	357,483	28,077	329,406	7.85%
SUD Block Grant	-	9,330	(9,330)	0.00%
Other grant revenue	7,071,254	636,946	6,434,308	9.01%
Other earned contracts	2,752,649	169,260	2,583,389	6.15%
Interest	1,000	15,738	(14,738)	0.00%
Local revenue	10,000	11,190	(1,190)	0.00%
Total operating revenue	$ 119,869,964	$ 9,718,102	$ 110,151,862	8.11%
Operating expenses				
Salaries and wages	27,984,525	2,260,320	$ 25,724,205	8.08%
Employee benefits	10,070,805	224,311	9,846,494	2.23%
Staff development	280,317	14,581	265,736	5.20%
Payments to providers	76,206,079	6,522,013	69,684,066	8.56%
Administrative contracts	7,769,913	671,785	7,098,128	8.65%
IT software and equipment	692,972	55,708	637,264	8.04%
Client transportation	41,100	2,943	38,157	7.16%
Staff travel	322,767	7,760	315,007	2.40%
Office expenses	515,667	48,325	467,342	9.37%
Insurance expense	128,035	1,761	126,274	1.38%
Depreciation expense	589,832	53,975	535,857	9.15%
Utilities	374,796	21,595	353,201	5.76%
Facilities	-	4,871	(4,871)	#DIV/0!
Local match	617,788	25,425	592,363	0.00%
Total operating expenses	$ 125,594,595	$ 9,915,374	$ 115,679,221	7.89%
Change in net position	(5,724,631)	(197,272)	$ (5,527,359)	
Beginning net position	46,130,169	46,130,169		
Ending net position	$ 40,405,538	$ 45,932,897		

INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position

October 1, 2023 through October 31, 2023

Percent of Year is 8.33%

	Specialty Services		Healthy Michigan		SUD Block Grant		Totals		
	Budget	YTD Totals 10/31/23	YTD Budget	YTD Totals 10/31/23	YTD Budget	YTD Totals 10/31/23	YTD Budget	YTD Totals 10/31/23	Variance
Operating revenue									
Medicaid:									
Traditional Capitation	$ 4,961,257	$ 6,810,174	$ -	$ -	$ -	$ 9,330	$ 4,961,257	$ 6,819,504	$ 1,858,247
Healthy Michigan Capitation	-	-	1,025,177	805,743	-	-	1,025,177	805,743	(219,434)
CCBHC Base Payment	-	(558,787)	-	(133,926)	-	-	-	(692,713)	(692,713)
Settlement Estimate	953,847	(1,199,550)	(668,919)	488,237	-	(9,330)	284,928	(720,644)	(1,005,572)
Client Fees	-	28,077	-	-	-	-	-	28,077	28,077
Total operating revenue	$ 5,915,104	$ 5,079,914	$ 356,258	$ 1,160,054	$ -	$ (0)	$ 6,271,362	$ 6,239,968	$ (31,394)
Operating expenses									
Internal services	$ 310,831	$ 133,148	$ 21,636	$ 1,777	$ -	$ -	$ 332,467	$ 134,926	(197,542)
External services	5,216,268	4,643,837	311,852	1,089,100	-	-	5,528,120	5,732,937	204,817
Delegated managed care	388,005	302,929	22,770	69,177	-	-	410,775	372,106	(38,668)
Total operating expenses	$ 5,915,104	$ 5,079,914	$ 356,258	$ 1,160,054	$ -	$ -	$ 6,271,362	$ 6,239,969	$ (31,393)
Change in net position	0	(0)	(0)	(0)	-	(0)	0	(1)	

INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position

October 1, 2023 through October 31, 2023

Percent of Year is 8.33%

	State General Fund		CCBHC		Other Funding Sources		Totals		
	YTD Budget	YTD Totals 10/31/23	YTD Budget	YTD Totals 10/31/23	YTD Budget	YTD Totals 10/31/23	YTD Budget	YTD Totals 10/31/23	Variance
Operating revenue									
General Fund	$ 308,791	$ 325,043	$ -	$ -	$ -	$ -	$ 308,791	$ 325,043	$ 16,252
Projected GF Carryforward	-	-	-	-	-	-	-	-	-
CCBHC Demonstration	-	-	2,284,483	2,190,756	-	-	2,284,483	2,190,756	(93,726)
Other Federal and State Grants	-	-	-	-	597,335	585,554	597,335	585,554	(11,781)
Earned Revenue	-	-	-	-	219,924	169,260	219,924	169,260	(50,663)
COFR Revenue	-	-	-	-	1,400	-	1,400	-	(1,400)
Interest	-	-	-	-	83	15,738	83	15,738	15,655
County Allocation	-	-	-	-	129,200	129,200	129,200	129,200	-
Local Revenue	-	-	-	-	833	11,190	833	11,190	10,357
Transfer from GF	-	-	-	143,105	175,753	-	175,753	143,105	(32,648)
Settlement Revenue (Expense)	-	-	-	-	-	-	-	-	-
Total operating revenue	$ 308,791	$ 325,043	$ 2,284,483	$ 2,333,861	$ 1,124,528	$ 910,943	$ 3,717,802	$ 3,569,847	$ (147,955)
Operating expenses									
Internal Programs	27,547	$ 44,604	$ 2,687,171	$ 1,910,970	$ 8,440	$ -	$ 2,723,158	$ 1,955,574	$ (767,584)
External Programs	96,988	126,984	-	545,415	-	59,852	96,988	732,251	635,263
Other Federal and State Grants	-	-	-	-	918,698	765,345	918,698	765,345	(153,354)
HUD Grants	-	-	-	-	106,652	96,729	106,652	96,729	(9,923)
Managed Care Administration	8,503	10,349	-	-	576	-	9,079	10,349	1,270
Homeless Shelter	-	-	-	-	44,094	25,127	44,094	25,127	(18,967)
Transfer from GF	175,753	143,105	-	-	-	-	175,753	143,105	(32,648)
Local match expense	-	-	-	-	108,717	25,427	108,717	25,427	(83,289)
Non-DCH Activity Expenditures	-	-	-	-	11,716	13,212	11,716	13,212	1,496
Total operating expenses	$ 308,791	$ 325,043	$ 2,687,171	$ 2,456,385	$ 1,198,893	$ 985,691	$ 4,194,855	$ 3,767,119	(427,735)
Change in net position	0	0	(402,688)	(122,524)	(74,365)	(74,749)	$ (477,053)	(197,272)	279,781

INTEGRATED SERVICES OF KALAMAZOO

CCBHC

October 1, 2023 through October 31, 2023
Percent of Year is 8.33%

	CCBHC Medicaid	CCBHC Healthy MI	CCBHC Non-Medicaid	CCBHC YTD Totals
Operating revenue				
Prepayment	$ -	$ -	$ -	$ -
CCBHC Base Payment Reclass	558,787	133,926	-	692,713
Remaining CCBHC revenue due	1,176,520	321,524	-	1,498,043
Total CCBHC Revenue (PPS-1 of $287.35 x encounters)	$ 1,735,307	$ 455,450	$ -	$ 2,190,756
Operating expenses				
Internal services	$ 1,368,522	$ 356,710	$ 185,738	$ 1,910,970
DCO Contracts	380,298	99,813	65,304	545,415
Total operating expenses	$ 1,748,820	$ 456,523	$ 251,042	$ 2,456,385
Operating change in net position	(13,513)	(1,074)	(251,042)	(265,629)
Reclassification to cover Non-Medicaid	-	-	143,105	143,105
Total change in net position	(13,513)	(1,074)	(107,937)	(122,524)

YOUTH COMMUNITY INPATIENT SERVICES
Report Period: October 1st, 2023 through October 31st, 2023

	UTILIZATION COMPARISONS FY 23/24									
	FY 22/23 Actual		FY 23/24 Budget		FY 23/24 Actual			Days Difference	Cost Difference	Cost YTD
MONTH	Days	Dollars	Days	Dollars	Days	Dollars		Favorable (Unfavorable)	Favorable (Unfavorable)	Favorable (Unfavorable)
OCTOBER	70	$72,791	46	$47,906	69	$72,587		(23)	($24,681)	($24,681)
NOVEMBER	63	$66,150	46	$47,906						
DECEMBER	37	$38,735	46	$47,906						
JANUARY	53	$55,661	46	$47,906						
FEBRUARY	55	$57,939	46	$47,906						
MARCH	78	$81,900	46	$47,906						
APRIL	90	$94,500	46	$47,906						
MAY	62	$65,100	46	$47,906						
JUNE	9	$9,450	46	$47,906						
JULY	41	$43,050	46	$47,906						
AUGUST	23	$24,087	46	$47,906						
SEPTEMBER	54	$56,312	46	$47,906						
TOTALS	635	$665,675	549	$574,872	69	$72,587		(23)	($24,681)	
MONTHLY AVERAGES	53		46		69					
GROSS ANNUAL COST		$665,675		574,872		$72,587			($24,681)	

Favorable/(Unfavorable): Total (24,681)

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COMMUNITY INPATIENT SERVICES
Report Period: October 1st, 2023 through October 31st, 2023

	UTILIZATION COMPARISONS FY 23/24									
	FY 22/23 Actual		FY 23/24 Budget		FY 23/24 Actual			Days Difference	Cost Difference	Cost YTD
								Favorable	Favorable	Favorable
MONTH	Days	Dollars	Days	Dollars	Days	Dollars		(Unfavorable)	(Unfavorable)	(Unfavorable)
OCTOBER	900	$905,756	654	$716,371	650	$684,493		4	$31,878	$31,878
NOVEMBER	686	$714,410	654	$716,371						
DECEMBER	704	$732,356	654	$716,371						
JANUARY	639	$663,945	654	$716,371						
FEBRUARY	656	$683,828	654	$716,371						
MARCH	635	$660,537	654	$716,371						
APRIL	543	$565,345	654	$716,371						
MAY	796	$829,300	654	$716,371						
JUNE	629	$655,218	654	$716,371						
JULY	757	$789,744	654	$716,371						
AUGUST	820	$854,847	654	$716,371						
SEPTEMBER	698	$727,339	654	$716,371						
TOTALS	8,463	$8,782,625	7,848	$8,596,454	650	$684,493		4	$31,878	
MONTHLY AVERAGES	705		654		650					
GROSS ANNUAL COST		$8,782,625		8,596,454		$684,493			$31,878	

Favorable/(Unfavorable): Total 31,878

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COMMUNITY LIVING SUPPORTS (CLS), PERSONAL CARE (PC) & CRISIS RESIDENTIAL
ALL POPULATIONS
Report Period: October 1st, 2023 through October 31st, 2023

					FY 23/24 Budget	FY 22/23 Actual	
SERVICE	Month	Avg. Daily Rate	No. Served	Days of Service	Dollars	Dollars	Favorable / (Unfavorable)
PC/CLS	Oct	$265	355	11,005	$2,888,488	$2,921,474	($32,986)
CRISIS RES.	Oct	$576	4	53	$80,591	$30,553	$50,038
CLS (SIP)	Oct	NA	278		$1,088,638	$1,083,489	$5,149
Annual Cost							$22,200

Personal Care (P.C.)-hands on of daily personal activities such as laundry, feeding, bathing, etc.

Community Living Supports (CLS)-services to increase or maintain personal self -sufficiency with a goal of community inclusion, independence and productivity.

Specialized Residential (S.R.)-Licensed setting where Personal Care and Community Living Supports occur.

Supported Independent Program (SIP)-more independent setting where Personal Care and Community Living Supports occur.

INTEGRATED
Services of Kalamazoo
Community • Independence • Empowerment

Integrated Services of Kalamazoo

MOTION

Subject:	October 2023 Disbursements	
Meeting Date:	**November 27, 2023**	**Approval Date:**
Prepared by:	Charlotte Bowser	**November 27, 2023**

Recommended Motion:

"Based on the Board Finance meeting review, I move that ISK approve the October 2023 vendor disbursements of $10,150,872.66."

Summary of Request:

As per the October 2023 Vendor Check Register Report dated 11/8/2023 that includes checks issued from 10/01/2023 to 10/31/2023.

I affirm that all payments identified in the monthly summary above are for previously appropriated amounts.

Staff: **C. Bowser, Finance Director**

Date of Board Consideration: **November 27, 2023**