



Community • Independence • Empowerment

QUALITY IMPROVEMENT PROGRAM & PLAN

PERFORMANCE MEASUREMENT AND MANAGEMENT PLAN

FISCAL YEAR 2023/24

Amendment #1

INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) have a quality assessment and performance improvement program (QAPI) which meets the specified standards in the contract with MDHHS. In addition to the QAPI, MDHHS requires each Community Mental Health Services Program (CMHSP) to have a Quality Improvement Program (QIP). The description that follows provides the QIP for the Integrated Services of Kalamazoo (ISK) for fiscal year 2023/24. Aside from this QIP, ISK participates in and contributes to the QAPI of our PIHP – Southwest Michigan Behavioral Health.

CARF International, the accrediting body for ISK, requires a Performance Measurement and Management Plan to be established. This Plan outlines the intent and expectations of the ISK Performance Measurement and Management Plan. Specific measures and identified outcomes are to be established by ISK leadership and program staff. Results of the Performance Measurement and Management Plan shall be reported to the ISK Board of Directors as established within this plan.

PURPOSE

The purpose and assurances of the QIP for ISK is as follows:

1. Continually evaluate and enhance organizational processes that most influence organizational effectiveness and efficiency. Each Continuous Quality Improvement (CQI) project implemented will include documentation of the reason for the project and measurable progress achieved. All improvement activities will be evaluated for effectiveness, including tracking of issues and identified barriers.
2. Monitor and evaluate the systems and processes related to the quality of clinical care and non-clinical services that can be expected to affect the health status, quality of life and satisfaction of individuals served. All improvement activities will be evaluated for effectiveness.
3. Focuses on indicators related to improved behavioral and physical health outcomes and takes action to demonstrate improved performance.
4. Monitor and evaluate quality of care reflected through the populations served in terms of age group, disease categories, special risk status, and other areas identified. This shall be monitored at least annually through a Year-End report that is reviewed by IQIC and the ISK Board.
5. Identify and assign priority to identified opportunities for performance improvement. Addresses priorities for improved quality of care and individuals served safety.
6. Create a culture that has a focus on the individuals we serve and includes their input and participation in problem solving.

The purpose and assurances of the Performance Measurement and Management Plan for ISK is as follows:

The Performance Measurement and Management Plan is intended to guide the organization in demonstrating a culture of accountability by developing and implementing performance measurement plans that produce information an organization can act on to improve results for individuals served, other stakeholders, and the organization itself. The Performance Measurement and Management Plan is to be developed and operationalized to produce the following results:

1. Demonstration of accountability for the performance measurement and management in Service Delivery and Business Functions. Performance measurement objectives and indicators shall be established and monitored for each program service that is accredited through CARF International.
2. Identification of gaps and opportunities through assessment and stakeholder feedback, including consideration of:
 - a. Input from:
 - Individuals served
 - Personnel
 - Other stakeholders
 - b. The characteristics of the individuals served
 - c. Expected results
 - d. Extenuating and influencing factors that may impact results
 - e. The comparative data available
 - f. Communication of performance information
 - g. Technology to support implementation of the performance measurement and management plan
3. Identification of objectives and measures leading to achieved results in:
 - a. Measure results achieved for the Person served (Effectiveness)
 - b. Experiences of services received from individuals served
 - c. Experience of services and other feedback from other stakeholders
 - d. Measurement of resources used to achieve results (Efficiency)
 - e. Measurement of service access
4. Measurement of business functions through:
 - a. Identifying objectives in priority areas determined by the organization
 - b. Each objective shall identify:
 - What the indicator(s) will be applied to
 - Person(s) responsible for collecting the data
 - The source(s) from which the data will be collected
 - Identification of relevant timeframes for collection of data
 - A performance target that is based on the organization's performance history and establishment of benchmarks
5. Monitor and evaluate the systems and processes related to the quality of clinical care and non-clinical services that can be expected to affect the health status, quality of life and satisfaction of individuals served by each affiliate member. All improvement activities will be evaluated for effectiveness.

MISSION, VISION, VALUES

This Quality Improvement Program and Plan and the Performance Measurement and Management Plan is tailored to help achieve the agency's mission and vision. Our activities will be guided by those organizational values we believe to be critical to our success.

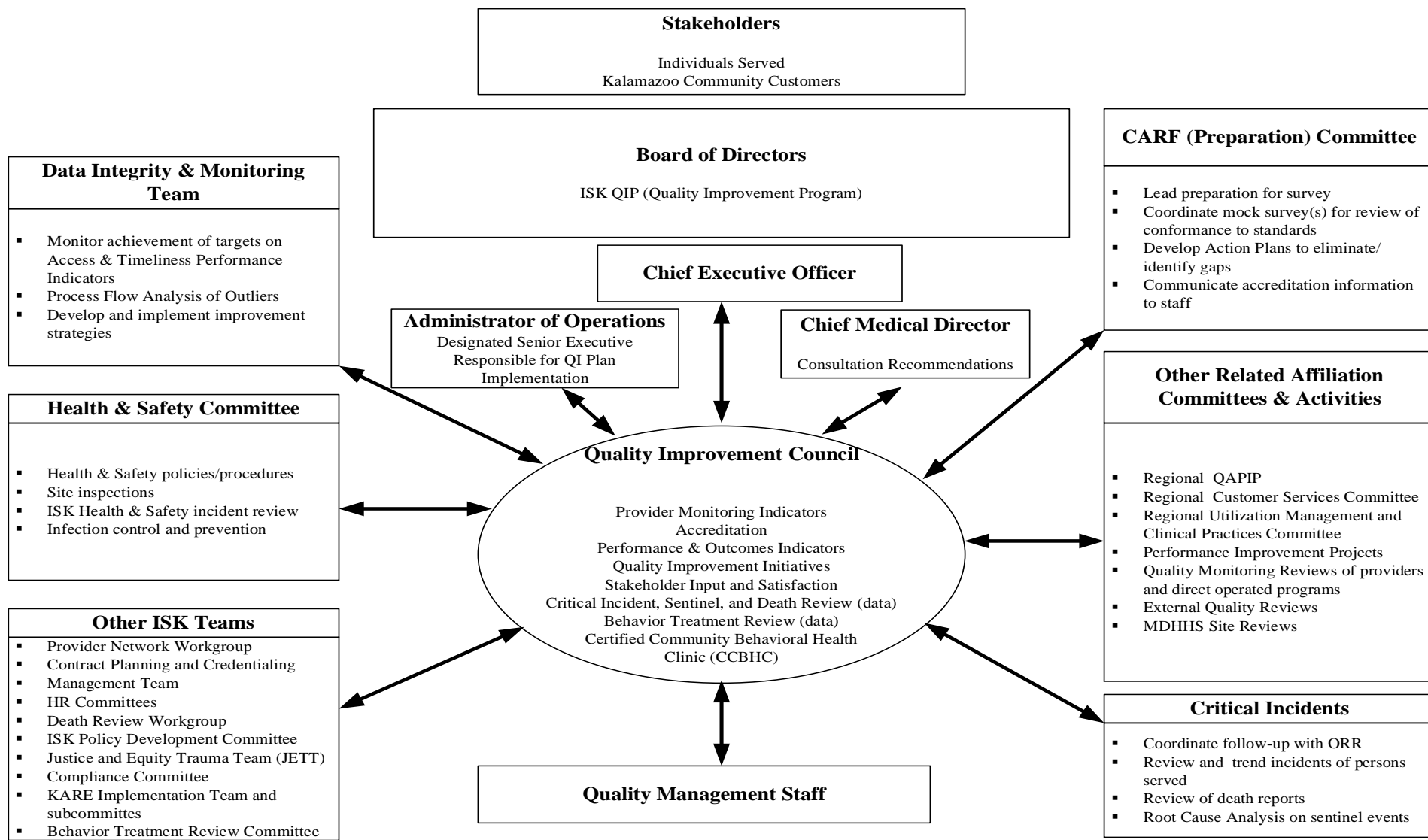
Mission	We promote and provide mental health, intellectual and developmental disability and substance use disorder supports and services that empower people to succeed
Vision	We provide a welcoming and diverse community partnership which collaborates and shares effective resources that support individuals and families to be successful through all phases of life

- Values
- Community
 - Competence
 - Diversity
 - Effectiveness
 - Integrity
 - Leadership
 - Recovery and Self-Determination
 - Respect
 - Responsibility
 - Teamwork
 - Trust

QUALITY IMPROVEMENT STRUCTURE

The Quality Improvement Structure for Integrated Services of Kalamazoo is outlined through a graphic presentation on the next page followed by a narrative description of key elements of the structure. ISK Administrator of Operations is the designated senior executive who is responsible for the QI Program implementation.

ISK QUALITY MANAGEMENT STRUCTURE



ACCOUNTABILITY TO GOVERNANCE

The ultimate responsibility for the quality of organizational services is retained by the Governing Board. The role of the Board is to support and promote ongoing improvement in organizational processes and outcomes. The Board responsibilities for the QIP and the Performance Measurement and Management Plan include:

- Oversight of the QIP and the Performance Measurement and Management Plan, including documentation that the Board has approved the overall plans and annual QI plan and Performance Measurement and Management Plan.
- Review of QIP reports, including actions taken, progress in meeting Quality Improvement objectives and improvements made.
- Formal reviews on a periodic basis (but no less frequently than annually) a written report on the QIP that includes studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered to assess the QIP's continuity, effectiveness and current acceptability.
- Assures that the Executive Direction takes action when appropriate and directs that the operational QIP and the Performance Measurement and Management Plan be modified on an ongoing basis to accommodate review findings and issues of concern within ISK.

KEY CONTRIBUTORS IN QUALITY ACTIVITIES

THE QUALITY IMPROVEMENT COUNCIL

The role of the Integrated Services of Kalamazoo Quality Improvement Council (IQIC) includes the function of the organization's Quality Improvement Plan and Performance Measurement and Management Plan as established by the Board, including setting priorities for improvement efforts throughout the agency. The Quality Improvement Council (IQIC) is responsible for monitoring and reporting progress toward established goals to the Senior Executive team. It will also review and provide feedback and support on improvement efforts and projects reported by other ISK teams and committees. Additional IQIC activities are outlined above in the Quality Management Structure diagram. IQIC chair shall ensure that documentation is maintained and meetings occur at a frequency that is sufficient to demonstrate activities, findings, recommendations, and actions in accordance with the established committee charter.

INDIVIDUALS SERVED

The satisfaction of individuals receiving services with our agency will be greatly enhanced when we involve those individuals in the identification and prioritization of improvement opportunities. Likewise, we must continually measure trends in satisfaction levels of individuals served. In addition to input received from individuals served, many standing committees throughout the organization include the voice of individuals served through Peer Support Specialist representation. Peer Support Specialists play a key role on the relevant committees related to review of performance information and status, policy/procedure development, and strategic planning for the organization.

COMMUNITY STAKEHOLDERS

In addition to Individuals served, stakeholders are those individuals or organizations that have a valid interest in the agency's processes and outcomes. Some of our most important stakeholders are staff members, funding sources, regulatory bodies, and human service agencies in our community. Funding sources usually outline performance standards in written documents such as contracts and standards manuals. Input from staff and other community partners will be collected via surveys, focused groups, etc. Staff and stakeholders' input and satisfaction must be monitored on an ongoing basis.

ISK STAFF

Within the structure of this QIP and development of the Performance Measurement and Management Plan, staff will be key participants through participation in committees, providing feedback when presented with information, identifying process improvement opportunities, and submitting ideas to the IQIC, while continuing to provide medically necessary services to individuals served. Staff will promote Recovery concepts in their everyday work.

COMMUNICATION

This QIP will ensure that all groups described above receive information about prioritized agency needs, improvement projects and changes in performance to reinforce commitment to meaningful quality improvement. Feedback will be provided by means of Board reports, results of regulatory audits, interoffice communications, etc.

UTILIZATION MANAGEMENT

ISK's Utilization Management plan is a standalone document that is reviewed and updated as needed on an annual basis. ISK policies and procedures also outline utilization management activities and expectations for the organization and its provider network. This includes the evaluation of medical necessity, eligibility criteria used, information sources, and the process used to approve the provision of medically necessary services and supports. The Utilization Management Plan addresses components related to practices of retrospective and concurrent review of clinical and financial resource utilization, clinical and programmatic outcomes, other aspects of utilization management deemed appropriate by administration. The ISK Utilization Management Plan is also aligned with the PIHP Utilization Management Plan as reviewed and adopted by the region. In accordance with this plan, data is used to identify and address underutilization and overutilization throughout the network. Policy, procedure, and practices are in place to ensure that 1) review decisions are supervised by qualified medical professionals; 2) efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate; 3) reasons for decisions are clearly documented and available to consumers; 4) there are well-publicized and readily available appeal mechanisms for both providers and individuals served; notification of a denial includes a description of how to file an appeal; denials are made by appropriately qualified staff; 5) decisions and appeals are made in a timely manner as required; 6) there are mechanisms to evaluate the effects of the program using data on customer satisfaction, provider satisfaction, or other appropriate measures. 7) as utilization management is a delegated function to ISK, the organization shall ensure that it has mechanisms to ensure that these standards are met.

The ISK Utilization Management department works in conjunction with the Quality Management department to review and evaluate level of care of individuals served at times of unexpected incidents and events occur to assure appropriate level of care and continuous quality improvement. Examples of these reviews include but are not limited to readmissions for psychiatric or substance use related reasons, the death of an individual served, and other reported events that would warrant a review of the individual's service level and care.

PROVIDER QUALIFICATION AND SELECTION

ISK and its provider network shall adhere to Policy 02.09 Credentialing, Re-Credentialing and Criminal History Screening, ensuring that all physicians and health care professionals are qualified to perform their services. The ISK Credentialing Committee is the appointed oversight committee for assurances in credentialing and re-credentialing practices of direct operated services. Monitoring and oversight activities occur of the ISK provider network and direct operated services. Provider Network and Credentialing staff provide representation and reporting to the IQIC committee. ISK Policy and Procedures shall outline methods and activities to ensure:

1. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for the following:
 - a. Education background
 - b. Relevant work experience
 - c. Cultural competence
 - d. Certification, registration, and licensure as required by law
2. New personnel shall be trained with regard to their responsibilities, program policy, and operating procedures.
3. Staff trained needs will be identified and in-services provided for continuing education and staff development purposes.

PERFORMANCE IMPROVEMENT

Quality improvement activities are person serve focused and committed to improving the quality of clinical care and outcomes of individuals served. Ongoing input must be collected from both individuals receiving services as well as other stakeholders using a variety of methods. Methods to collect input include surveys, monitoring of progress individuals served, tracking of rights violations and incident reports, community forums, and performance reports generated by stakeholders such as the MDHHS.

ISK will demonstrate an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and utilize disaggregated data from the CCBHC quality measures and, as available, other data to track and improve outcomes for populations facing health disparities. The ISK QI Council will collaborate closely with the ISK Justice Equality and Trauma Team (JETT) to ensure that data is monitored and utilized to improve systems, access to care, and treatment of individuals served.

Data is used to determine performance levels and must be accurate, valid, and reliable to produce meaningful performance information. This assures that our conclusions are accurate, and resources are properly allocated to improvement opportunities that are most important to the individuals served and other stakeholders.

Quality indicators are those measures that reflect performance in areas that are most important to individuals we serve and other ISK stakeholders. Quality indicators include the areas of effectiveness of care, efficiency of operations, accessibility to services and satisfaction among individuals served and other stakeholders. These indicators are more meaningful when compared to established standards, trends over time and/or comparison with performance of similar organizations. *ISK adheres to the MDHHS and CCBHC quality and performance indicator requirements.*

Quality and performance indicators reports are used to determine significant trends and to plan, design, measure, assess and improve services, processes, and systems. Quality improvement activities monitor the quality of care against established standards and guidelines. Improvement strategies are used to eliminate undesired outliers, ensure the proper use of practice guidelines, and optimize the desired outcomes of individuals served. Remedial action is taken and documented whenever inappropriate or substandard services are furnished as determined by substantiated recipient rights complaints, clinical indicators, or other quality indicators. ISK will ensure that practices are updated as necessary based on any relevant updated standards/guidelines. Established methods are utilized by responsible subject matter leads to monitor implementation of corrective action and evaluate its effectiveness.

Sources of quality and performance indicators include:

- MDHHS Performance Indicator System Reports (also referenced as the Michigan Mission-Based Performance Indicator System [MMBPIS])
- MDHHS Boilerplate Reports
- CCBHC Quality Indicators,
- Behavioral Health Treatment Data and Reports
- Health & Safety Reports
- Utilization Management Reports, including under-utilization and overutilization based on medical necessity and other established criteria and the mechanisms to correct under-utilization and overutilization
- Accreditation Survey Report
- Quality Improvement Reports
- Incident and Event Reports
- Performance Indicator and Outcomes Reports, such as CAFAS (Child and Adolescent Functional Assessment Scale) and other implemented functional assessment tools
- MDHHS Contract Compliance Reports (e.g., MDHHS Site Review, Rights System Assessment, Compliance Examination)
- Stakeholder Survey Reports, such as, Customer Satisfaction Survey, Employee Survey, and Community Needs Assessment Survey
- Quality Monitoring Reviews (including clinical records review, claims verification, and the verification of provider and individual qualifications and credentials)
- Compliance and Risk Management activities
- Demographic, Encounter, and Claims Reports on Individuals Served (SWMBH Tableau, Care Connect 360, Behavioral Health [BH] TEDS, ISK EHR (Electronic Healthcare Record) reports, etc.)
- Reports focusing on Enrollee (Customer) Rights and Protections. Such data may be provided by the Office of Recipient Rights or the Customer Services Office and be related to the number and type of complaints/grievances/appeals and investigations completed along with summary of the outcomes of complaint activities.

- Source demographic and treatment data exported from the ISK Electronic Health Record system

EVENT, CRITICAL INCIDENT, AND SENTINEL EVENT REPORTING RESPONSIBILITIES

Integrated Services of Kalamazoo shall meet MDHHS requirements regarding the processing and reporting of Sentinel Events for individuals enrolled in the Children’s Waiver (CW), the Children with Serious Emotional Disturbance Waiver (SEDW), and who receive services funded by these programs from CMHSPs. Processes are followed in accordance with ISK Policy 03.06 – Incident, Event, and Death reporting, including reporting timelines, root cause analyses, and documentation reviewed. Aggregation of mortality data over time to identify possible trends is reviewed through the ISK Death Review committee and reported to IQIC at least annually. This review activity by IQIC will include both qualitative and quantitative analysis of critical incidents, sentinel events, and risk events. The ISK Sentinel Event oversight committee shall review and analyze each Sentinel Event and will produce applicable recommendations for system improvement to decrease future occurrences as able.

ISK, in accordance with the MDHHS CCBHC Handbook, will specifically review and addresses the following:

1. *CCBHC individuals served suicide deaths or suicide attempts.*
2. *Fatal and non-fatal overdoses*
3. *All cause mortality among people receiving CCBHC services.*
4. *CCBHC individuals served 30-day hospital readmissions for psychiatric or substance use reasons.*
5. *Such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of the ISK QI plan.*

RIGHTS AND RESPONSIBILITIES

The following are assessment activities conducted by or in conjunction with the local Office of Recipient Rights, who is responsible for compliance with requirements of Chapter 7 of the Michigan Mental Health Code and found in substantial compliance with stated requirements as evidenced by site reviews conducted by the state agency, and will occur for Enrollee Rights and Responsibilities:

- Monitor and ensure that individuals served have all the rights established in Federal and State law.
- Investigate and follow-up on rights complaints;
- Review incident, accidents and sentinel events and investigate as needed;
- Look for trends and making suggestions to prevent reoccurrence;
- Review death reports of individuals served and investigating any unexpected death to identify potential system improvements; and
- Share trends and process improvements made with stakeholders

ISK will conduct periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the individuals served and the services and supports offered.

1. The assessments must address the issues of the quality, availability, and accessibility of care.
2. As a result of the assessment, the organization:
 - a. Takes specific action on individual cases as appropriate;
 - b. Identifies and investigates sources of dissatisfaction;

- c. Outlines systemic action steps to follow-up on the findings; and
 - d. Informs practitioners, providers, recipients of service, and the governing body as assessment results.
3. The organization evaluates the effects of the above activities.
 4. The organization ensures the incorporation of individuals served receiving long-term supports or services (e.g., individuals receiving case management) into the review and analysis of the information obtained from quantitative and qualitative methods.

The ISK Office of Recipient Rights shall submit an annual report of the CMHSP's Office of Recipient Rights to the state office as required by Chapter 7 of the Michigan Mental Health Code.

The Quality Improvement Council will determine any quality and performance indicators in addition to those established by the PIHP that will be monitored. The performance indicators may depend on each department's specific consumer group, service delivery activities, and requirements of the State Department of Health and Human Services and the Commission on Accreditation of Rehabilitation Facilities (CARF) standards.

ANNUAL REVIEW OF PLAN

The Integrated Services of Kalamazoo Quality Improvement Plan will be evaluated and revised on at least an annual basis by the IQIC and then formally reviewed and approved by the ISK Board. At least annually, the status of goals and objectives will be evaluated and goals for the next fiscal year will be created based on the status of previous goals and current agency priorities.

An analysis of the Performance Measurement and Management Plan shall be completed at least annually and reviewed within the timeframes outlined in the Performance Measurement and Management Plan identified measures.

A summary of the overall effectiveness of the ISK Quality Improvement Plan and the Performance Measurement and Management Plan will be presented to the ISK Board on an annual basis through an annual Year-End report.

QUALITY IMPROVEMENT GOALS FOR FY 2022/23

The QIP is completed within the framework of the current overall ISK Strategic Plan. Goals within the QIP will help support the direction and priorities of the agency. The broad quality improvement goals include:

1. Everyone shares responsibility for the continuous quality improvement of processes to be more efficient and/or effective.
2. We prioritize the processes that have the most impact on outcomes individuals served desire.
3. We work together as a team.
4. We aspire to meet or exceed all performance standards established by funding sources.

5. We maintain clear and ongoing communication, so internal staff are aware of improvements in performance and outcomes.
6. We share performance and outcome information with our individuals served and other stakeholders on an ongoing basis.
7. We actively engage in PIHP standing committees and ad hoc workgroups.

Attachments:

- A. QI Annual Goals and Objectives
- B. IQIC Charter

The following pages outline the specific quality improvement goals/objectives for 2023/24:

Attachment A

#	GOALS	OBJECTIVES / ACTION STEPS	MEASURES/TIMETABLE
1.	Remain informed and compliant with all performance indicators expected and maintain compliance with Accreditation and regulatory standards	<ol style="list-style-type: none"> 1. Review at least one performance report per IQIC meeting, including but not limited to: <ol style="list-style-type: none"> a. MMBPIS b. Encounters status c. BH TEDS d. SWMBH Board Metrics 2. Ensure knowledge of current accreditation standards and changes within the CARF manual. 	<ol style="list-style-type: none"> 1. Number of improvement efforts and/or projects related to performance measure data review 2. Number of improvement efforts resulting from audit results and outcomes
2.	Ensure effective implementation of Certified Community Behavioral Health Clinic (CCBHC) state demonstration	<ol style="list-style-type: none"> 1. Meet MDHHS incentive thresholds for all Quality Bonus Payment (QBP) metrics (IET, SRA, FUH, SAA) 2. Ensure that CCBHC implementation, outreach and engagement efforts are effectively expanding access to services 3. Successfully submit all required materials and proofs to achieve CCBHC re-certification 	<ol style="list-style-type: none"> 1. Report and review QBP metrics during IQIC committee meeting. Trending and analysis of QBP metrics completed within CCBHC subgroups. 2. Increase the number of individuals receiving CCBHC services that have not been in CMH service in the last 3 years. 3. ISK is re-certified as a CCBHC by September 30, 2024
3.	Further promote cultural competency, equity, inclusion, and trauma informed approaches to respond to the needs of individuals served, workforce and the community.	<p>As facilitated, monitored, and implemented through JETT:</p> <ol style="list-style-type: none"> 1. Enhance training for staff to include concepts of historical/racial trauma and resilience-oriented principles 2. Increase and enhance organization’s ability to prevent, identify and appropriately respond to workforce concerns/ stressors 3. Educate ourselves on equity principles and apply those principles on the activities of training, hiring and self-care 4. Develop, adopt, and implement FY24 JETT Workplan which shall serve as the organization’s Cultural Competency & Diversity Plan 	<ol style="list-style-type: none"> 1. JETT committee will report to IQIC trainings completed and other areas for improvement identified by the committee 2. JETT will report projects and improvement efforts launched and implemented quarterly 4. IQIC will provide feedback and improvement ideas to JETT as needed 5. JETT representative will provide status update to IQIC on progress and barriers to the FY24 JETT Workplan at least every 6 months
4.	Ensure future financial sustainability.	<ol style="list-style-type: none"> 1. Define and develop plan for organizational financial sustainability, including but not limited to: <ol style="list-style-type: none"> a. Diversification of funding b. Department and staff level tracking of billable service 	<ol style="list-style-type: none"> 1. Percentage of clean encounters passed through SWMBH to MDHHS should be equivalent to ISK’s encounter submission, successfully resulting in receiving CCBHC PPS1 payment. 2. Number of grants or amount of additional revenues obtained through grant awards per fiscal year



**INTEGRATED SERVICES OF KALAMAZOO QUALITY IMPROVEMENT COUNCIL
TEAM CHARTER
2023/2024**

I. PURPOSE

A. TASKS

1. To review, revise and recommend for approval ISK Administrative policies and procedures (excludes PIHP policy and procedure).
 - a. To appoint a committee, Kalamazoo Policy Development Committee, to examine complex policy issues and make recommendations to the full committee.
2. To support the accreditation preparation process and ongoing conformance to accreditation standards.
3. To lead the quality improvement effort across the organization:
 - a. Assure quality improvement principles are consistently used and applied throughout ISK.
 - b. Review, approve and support the ISK Quality Improvement Plan (QIP), including setting annual goals and objectives to meet the ISK mission.
 - c. Maintain responsibility and oversight for the ISK continuous quality improvement (CQI) program.
 - d. Promote the solicitation and facilitation of improvement ideas from stakeholders to improve ISK systems and processes.
 - e. Determine and support improvement projects/teams, task forces or subcommittees for an ISK performance improvement project, accreditation preparation or another more focused project related to the purpose of IQIC.
 - f. Utilize and promote data-driven decision-making. Review ISK performance indicators and other data and provide recommendations for improvement. Including:
 - ~ MMBPIS & Outliers
 - ~ Board Ends
 - ~ Outcome reports such as CAFAS
 - ~ Dashboard reports
 - ~ Stakeholder Survey Reports (i.e., consumer, staff, etc.)
 - ~ Critical Incidents Trends
 - ~ Progress reports on ISK Quality Management objectives.
 - ~ External Review Reports (MDHHS Site Review, Certification Review, etc.) & CARF Report
 - ~ Grant evaluation reports as requested
4. To review the recommendations from the ISK Root Cause Analysis reports of sentinel events

5. To support the ISK Data Integrity & Monitoring Team, Health & Safety Committee, and all Other ISK Teams in their work involving QI functions and program improvements within ISK.

B. SCOPE

The scope of the team is primarily defined by the Annual ISK Quality Improvement Program and Plan, ISK policies and procedure and Senior Executive Team. (Note: This is a team specific to ISK)

C. OUTCOMES

The committee serves as the central point for the overarching review and alignment to standards and requirements within the annual Quality Improvement Plan for ISK quality improvement related reports and initiatives. Assure consistent application of the standardized PIHP policies and processes across ISK. Reviews improvement data (i.e., surveys, data collection and provider monitoring review tools) and policies (i.e., Quality Management, Performance Improvement and Critical Incidents) and offers improvements in processes within ISK and across the provider network.

D. SPONSOR, TENURE & AUTHORITY

Team Sponsor	Approved by the ISK Chief Executive Officer and reports to the Senior Executive Team
Team Tenure	Permanent/Ongoing
Team Authority	Makes decisions within scope and refers other improvement recommendations to other teams as needed

II. MEMBERSHIP

Members (Name/Title/Email Address)	Stakeholder Group Represented (include consumer population when relevant)	Type of Membership (R) Core, (A) Ad hoc, (C) Consultant	Membership Term (i.e., 2 years or ongoing)
Amy Galick, Manager agalick@iskzoo.org	Analytics	R	ongoing
Amy Rottman, Chief Financial Officer arottman@iskzoo.org	Finance	R	ongoing
Angela Thompson, Program Coordinator athompson@iskzoo.org	Quality Management	R	ongoing
Ann Klimp, Quality Improvement Manager/ Privacy Officer aklimp@iskzoo.org	Quality Management & Privacy	R	ongoing
Ashley Esterline, Director of Network Compliance aesterline@iskzoo.org	Network Compliance	R	ongoing
Becky Gorton, Senior HR Generalist rgorton@iskzoo.org	Human Resources	R	ongoing
Beth Ann Meints, Administrator – Clinical Services bmeints@iskzoo.org	Senior Leadership	A	Ongoing
Chantel Graham, Director of Human Resources cgraham@iskzoo.org	Human Resources	A	ongoing
Charles Thomas, Program Coordinator cthomas@iskzoo.org	Quality & Compliance	R	ongoing
Charlotte Bowser, Director of Finance cbowser@iskzoo.org	Finance	R	ongoing
Cheryl Nebedum, Program Manager and Contracts, Agency, System cnebedum@iskzoo.org	Clinical / Youth & Family Services	R	ongoing

Members (Name/Title/Email Address)		Stakeholder Group Represented (include consumer population when relevant)	Type of Membership (R) Core, (A) Ad hoc, (C) Consultant	Membership Term (i.e., 2 years or ongoing)
Dana Foltz, Program Manager	dfoltz@iskzoo.org	Clinical / Adult Mental Health Services	R	ongoing
David Anderson, Senior Executive	danderson@iskzoo.org	Housing Recovery Center	A	ongoing
Ed Sova, Chief Information and Security Officer	esova@iskzoo.org	Information Technology Services	R	ongoing
Elizabeth Schlott, Program Coordinator	eschlott@iskzoo.org	Quality Management	R	ongoing
Gopal Bedi, Chief Medical Officer	gbedi@iskzoo.org	Psychiatric Services	A	ongoing
Greg Paulsen, Peer Support Specialist	gpaulsen@iskzoo.org	Customer Services	R	ongoing
Hazel Lynn James, Data Analyst	hjames@iskzoo.org	Analytics	A	ongoing
Jeannie Madsen, Program Manager - Support Services for Persons with Developmental Disabilities	jmadsen@iskzoo.org	Clinical / Adult with Developmental Disabilities	R	ongoing
Jeff Patton, Chief Executive Officer	jpatton@iskzoo.org	Executive Leadership	A	ongoing
Jennifer Garver, Provider Network Coordinator	jgarver@iskzoo.org	Clinical / Adult with Developmental Disabilities	R	ongoing
Karyn Bouma, Manager of Health Information and Risk Oversight	kbouma@iskzoo.org	Risk Oversight and Medical Records	R	ongoing
Kathy Lentz, Senior Executive	klentz@iskzoo.org	Clinical / Adult with Developmental Disabilities	A	ongoing
Kim White, Practice Manager	kwhite@iskzoo.org	Psychiatric Services	R	ongoing
Leona Ziring, Program Coordinator	lziring@iskzoo.org	Utilization Management	R	ongoing
Lindsey O'Neil, Program Manager	loneil@iskzoo.org	Corrections	R	ongoing
Lisa Smith, Recipient Rights Director	lsmith@iskzoo.org	Recipient Rights	R	ongoing
Sheila Hibbs, Administrator of Operations	shibbs@iskzoo.org	Senior Leadership	R	ongoing
Teresa Lewis, Manager Customer Services	tlewis@iskzoo.org	Customer Services	R	ongoing
Timothy Kelly, Program Manager	tkelly@iskzoo.org	Clinical / Adult Mental Health Services	R	ongoing
Tracey Culpepper, Quality Specialist	tculpepper@iskzoo.org	Quality & Compliance	R	ongoing
Tracy Free, Facilities Coordinator	tfree@iskzoo.org	Facility Management	R	ongoing
Wanda Brown, Senior Executive	wbrown@iskzoo.org	Psychiatric Services	A	ongoing

III. PROCESS

A. ROLES

Role	Assigned Team Member	Responsibilities
Team Leader/Chair	Administrator of Operations	[May use the “Team Member Roles and Responsibilities” - otherwise list specific responsibilities for each role]
Team Facilitator	Quality Improvement Manager/Privacy Officer	
Recorder	Quality Program Specialist	

B. LOGISTICS

Location of Meetings (bldg/conference room)	Microsoft Teams or 610 S. Burdick St. Kalamazoo, MI 49007
Frequency	2nd Thursday, every other month
Time/Duration	1:00pm – 3:00 pm

C. AGENDA

1. Approval of minutes
2. Additions/Revisions to Agenda
3. QI Ideas
4. Customer Services
5. CARF
6. Organizational Plans
7. QI Plan Goals / Objectives
8. Committee Report Out
9. Data Review / Monitoring
10. Policy / Procedure Review
11. Agenda Items for the Next Meeting

D. DECISION MAKING

Consensus will be used whenever possible. If consensus cannot be reached, the issue will be referred to the Senior Executive Team.

E. REPORTING

IQIC minutes will be the main reporting vehicle. They are distributed to all core and ad hoc members, to the Senior Executive Team as necessary, and is available via the ISK portal. Members are expected to communicate proposed policy/procedure changes and other pertinent information with relevant staff members in their unit/department. An annual summary of the results on the Quality Improvement Plan, Year End report, and Dashboard Indicators will be prepared for the ISK Board, leadership and other stakeholders.