YEAR-END SUMMARY

October 1, 2022 - September 30, 2023

TABLE OF CONTENTS

ACRONYM LIST

AFFIRM	=	Support group for parents of youth in the LGBTQIA community
BH TEDS	=	Behavioral Health Treatment Episode Data Set
CARF	=	The Commission on Accreditation of Rehabilitation Facilities
CCBHC	=	Certified Community Behavioral Health Clinic
CI	=	Critical Incident
CVCRR	=	Claims Verification / Clinical Record Review
IQIC	=	ISK Quality Improvement Council
DIMT	=	Data Integrity Monitoring Team
EMH	=	Emergency Mental Health
I/DDA	=	Adults with Intellectual / Developmental Disability
I/DDC	=	Children with Intellectual / Developmental Disability
ISK	=	Integrated Services of Kalamazoo
IQIC	=	ISK Quality Improvement Council
JETT	=	Justice Equity Trauma Team
LGBTQIA	=	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual
MAT	=	Medication Assistance Treatment
MDHHS	=	Michigan Department of Health and Human Services
MHSIP	=	Mental Health Statistics Improvement Program
MIA	=	Adults with Mental Illness
MIBHT	=	Mobile Integrated Behavioral Health Team
MMBPIS	=	Michigan Mission-Based Performance Indicator System
OPR	=	Organizational Practices Review
Psychiatric Services	=	Integrated Clinic / Psychiatric Services
QI	=	Quality Improvement
QMP	=	Quality Bonus Department
QMR	=	Quality Monitoring Review
QRR	=	Direct Operated Qualitative Quarterly Record Review
RCA	=	Root Cause Analysis
SAMHSA	=	Substance Abuse and Mental Health Services Administration
SE	=	Sentinel Event
SED	=	Children with Serious Emotional Disturbance
SMI	=	Serious Mental Illness
SOC	=	SAMHSA Children's System of Care
SUD	=	Substance Use Disorder
SWMBH	=	Southwest Michigan Behavioral Health
TIP	=	Transition to Independence Process
UCAC	=	Behavioral Health Urgent Care and Access Center
YYA	=	Youth and Young Adults
YSS	=	Youth Satisfaction Survey

I. EXECUTIVE SUMMARY

A. Vision, Mission, Guiding Values

Vision – Integrated Services of Kalamazoo provides 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.

Mission – Integrated Services of Kalamazoo promotes and provides mental health, intellectual and development disability and substance use disorder supports and services that empower people to succeed.

The **Guiding Values** of ISK are community, competence, diversity, effectiveness, integrity, leadership, recovery and self-determination, respect, responsibility, teamwork and trust.

ISK provides a welcoming and diverse community partnership to share effective resources that support individuals and families to be successful through all phases of life. For more than 30 years, ISK has served youth, families and adults with mental health challenges, intellectual and developmental disabilities and substance use disorders in Kalamazoo County. ISK provides services either directly through ISK service programs or through a network of provider agencies that contract with ISK. The agency is one of 46 Community Mental Health Services Programs in Michigan. ISK joined the State of Michigan Department of Health and Human Services (MDHHS) as part of the Certified Community Behavioral Health Clinic (CCBHC) demonstration in October 2021.

In addition, ISK provides expanded programming beyond traditional community mental health services to include comprehensive housing assistance and outreach to homeless persons, intensive crisis outpatient services, medication assistance treatment (MAT) for persons addicted to opioids, veteran services, stigma-reduction efforts, community training in Mental Health First Aid and many other initiatives to provide high quality services and supports to our community.

II. GRANTS

During FY22/23 ISK implemented several multi-year Federal Substance Abuse and Mental Health Services Administration (SAMHSA) grants:

- Certified Community Behavioral Health Clinics (CCBHC) – Improvement and Advancement
- Mobile Integrated Behavioral Health Team (MIBHT) (Treatment for Homelessness)
- Supported Employment
- Children's System of Care Expansion Grant
- Healthy Transitions Program (ended)
- National Strategy for Suicide Prevention (ended)
- Zero Suicide in Health Systems

ISK received its third Certified Community Behavioral Health Clinic grant. The primary aim of the CCBHC grant is to is to improve crisis mental health services and mental health/substance use disorder screening, assessment, and diagnosis services, and address disparities in accessing substance use disorder treatment, by developing and implementing a Behavioral Health Urgent Care and Access Center (UCAC). Additional intention and initiatives have been established in that

this center will increase black males access to ISK's crisis services and other substance use disorder treatment services to a level comparable to white individuals, decreasing disparities in overdose deaths.

Through the MIBHT grant, ISK expanded its work with individuals experiencing homelessness by partnering with Ministry with Community. The MIBHT grant has increased engagement and access to treatment and services, increased referrals to permanent sustainable housing and coordination to other community supports.

ISK's Supported Employment grant is transforming and elevating our systems implementation of the evidenced-based Individual Placement Services allowing increased access to supported employment services and benefits counseling by integrating these services within ISK's comprehensive mental health services provider system.

ISK received its third multi-year SAMHSA Children's System of Care (SOC) Expansion Grant. This is a 4 year, one million dollars per year grant. This follows previous grant awards in 2005 and 2015. The identified outcome of this System of Care Expansion Grant is to build the infrastructure and service and array for abused and neglected youth that are involved in the child welfare system. The SOC expansion initiative focuses on the need to improve the identification, referral, and delivery of mental health resources and services for youth and families involved in the child welfare system. Most of the referred youth are in residential, foster care, or protective services and need specialty mental health services. The identified goals are to:

1) Establish coordination and integration of local community mental health efforts with those of the Michigan Department of Health and Human Services (MDHHS) Child Welfare division who are at risk of out of home placements, or that have been removed from their biological homes.
2) Develop the system infrastructure and workforce capacity to deliver targeted behavioral in-home and supports through evidence-based practices that are designed to meet the needs of youth involved in the public child welfare system.
3) Develop a sustainable capacity to serve youth involved in the public child welfare system.

ISK was asked to partner on a State of Michigan awarded SAMHSA grant as a pilot site for the Healthy Transitions program. This grant has an ending date of September 30, 2023. This program implements the evidence-based service of Transition to Independence Process (TIP). It serves youth and young adults aged 16-25 with Serious Emotional Disturbance or Serious Mental Illness. ISK is also working closely with ASK Family Services, Inc., who employs the TIP certified transition peer supports. ISK directly provides the TIP certified Therapists for this initiative. Implementation required staff hiring, extensive training, and developing program expectations, as well as communication through the ISK service provider network. The identified goals are to:

1) Develop and maintain a formal, youth guided process to support Youth and Young Adults (YYA) with Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI) as they transition into adulthood.
2) Achieve site certification and implementation of the TIP Intervention with TIP certified Therapists and Youth Peer Support.
3) Use developmentally appropriate and culturally and linguistically competent outreach and engagement activities to target transition-aged youth and young adults and their families.
4) Evaluate, and report progress and outcome objectives as directed by SAMHSA and MDHHS to demonstrate the individuals enrolled in TIP demonstrate greater self-sufficiency and independence through improvements in living situation, educational performance, employment and career opportunities, and overall personal effectiveness and well-being.
5) Train the ISK network on principals of successful transition practices.
6) Improve services for youth as they transition into adulthood through developing a bridge between Youth and Adult services at ISK.

ISK was awarded a 3-year federal SAMHSA grant to focus on the National Strategy for Suicide Prevention. ISK is partnering with Gryphon Place and the Suicide Prevention Action Network. This

project will utilize the Zero Suicide model as a foundational framework and will incorporate recommended best practices for the implementation of required activities. This project seeks to reduce the number of suicide deaths and non-fatal suicide attempts by individuals aged 25 and older through the application of these strategies:

1) implement a community wide suicide prevention plan
2) train clinical staff working with individuals involved in the behavioral health system presenting with ideation
3) implement effective follow-up and care transition protocols for populations with the highest rate of suicide is our three-pronged strategy proposed to address local needs

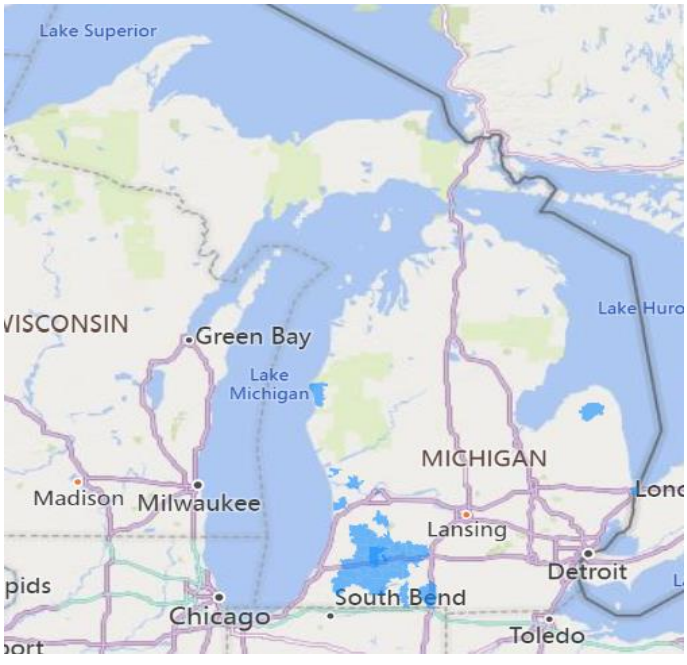
ISK was also awarded a 5-year federal SAMHSA grant to transform ISK's approach to suicide prevention and treatment consistent with the goals and objectives of the 2012 National Strategy for Suicide Prevention and incorporating the core elements of the Zero Suicide framework. The primary goals of this grant are to:

1) Create a leadership-driven, safety-oriented culture committed to reducing suicide within ISK health system.
2) Provide effective, evidence-based treatment and services for those at risk of suicide.
3) Develop quality Suicide Care Management Plans for every individual identified at risk of suicide. This grant ended in August 2023.

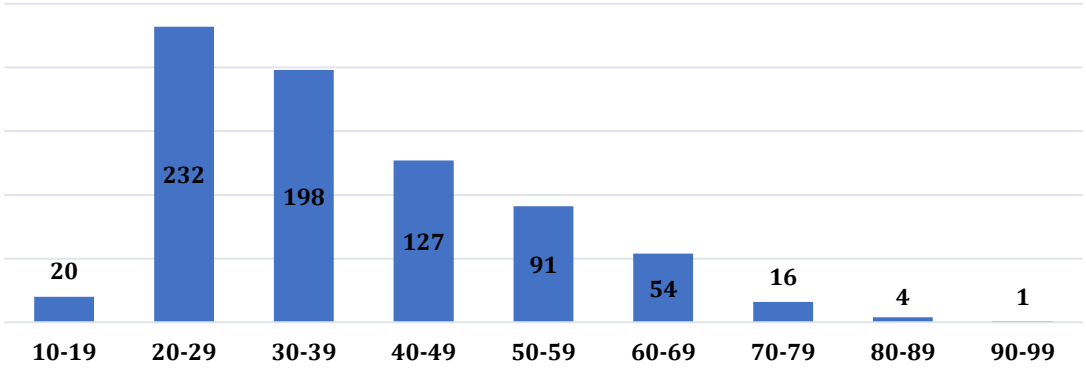
III. CCBHC DEMONSTRATION

The CCBHC state demonstration and continued SAMHSA expansion grants have allowed ISK to continue growth and to provide easier access to needed behavioral health and substance use services, not only to our community but to all that seek and are determined eligible for services. ISK has further expanded integrated care and provides evidence-based treatment models as a needed resource for the community. Through our CCBHC demonstration and grants, ISK has increased access to crisis services and routine requests to care through opening our new Behavioral Health Urgent Care Access Center. Opening this center in July 2023 with extended hours of Monday through Friday 8am-8pm routine access hours and open 24 hours for crisis and emergency intervention. The data below represents the services provided to 743 individuals through the UCAC during FY23 since opening on July 10, 2023-September 30, 2023.

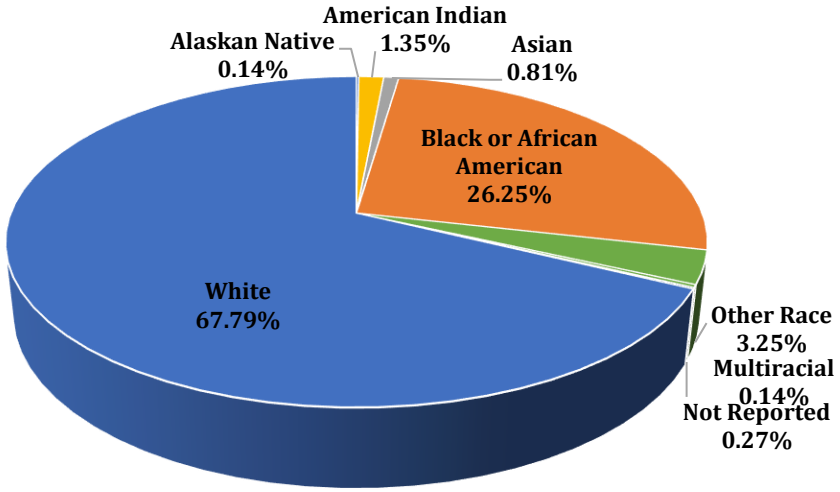
Reported residence location of persons served through the ISK Behavioral Health Urgent Care and Access Center 07/10/2023 - 09/30/2023 as demonstrated in the darker blue coloring:



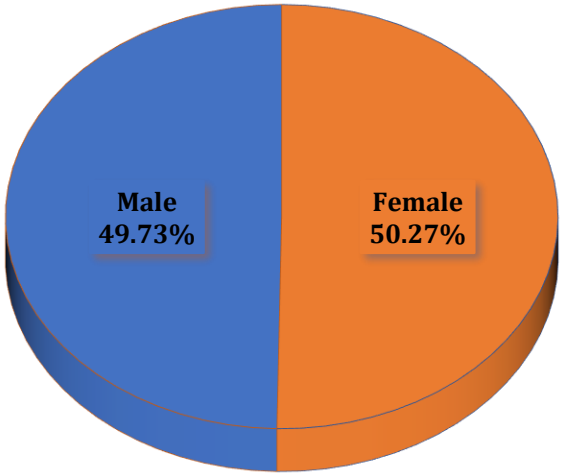
CLIENTS SERVED BY AGE GROUP
ISK BEHAVIORAL HEALTH URGENT CARE AND ACCESS CENTER
7/10/2023 - 9/30/2023



CLIENTS SERVED BY RACE
ISK BEHAVIORAL HEALTH URGENT CARE AND ACCESS CENTER
7/10/2023 - 9/30/2023



CLIENTS SERVED BY SEX
ISK BEHAVIORAL HEALTH URGENT CARE AND ACCESS CENTER
7/10/2023 - 9/30/2023



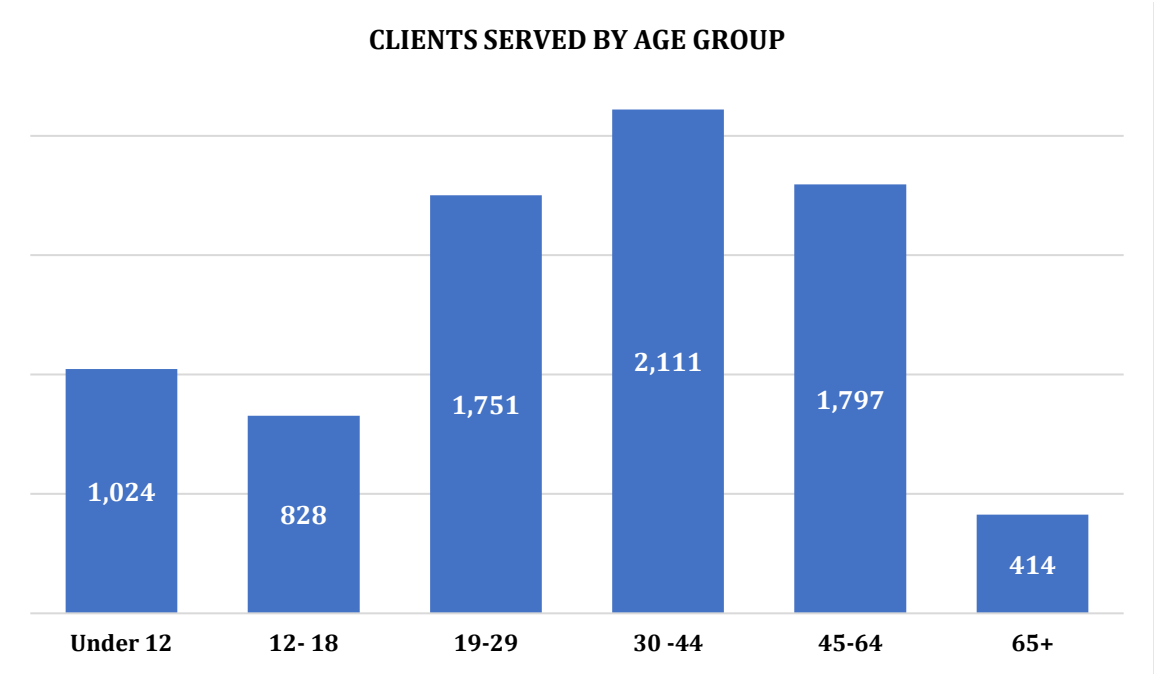
IV. DEMOGRAPHICS

During FY 2022/22 (October 1, 2022 to September 30, 2023), ISK provided services to a total of 7,925 persons (unduplicated count). These individuals were served directly by the ISK service programs and by a network of provider agencies that work in partnership with ISK on a contractual basis. Services were provided through a variety of programs and supports designed to meet the specific needs of the individuals served. Services are reported as per MDHHS designated population groups,

ISK directly served 7,767 individuals through programs such as Psychiatric Services, Emergency Mental Health (EMH), Targeted Case Management, Outpatient therapy and Access/Intake. 158 individuals were served through our network of external providers only. A total of 1,778 individuals received services from both ISK direct operations and an external provider.

There were 1,900 individuals who were new to the network this fiscal year (never previously served).

Of the total served, below is a demonstration of the age groups that were served:

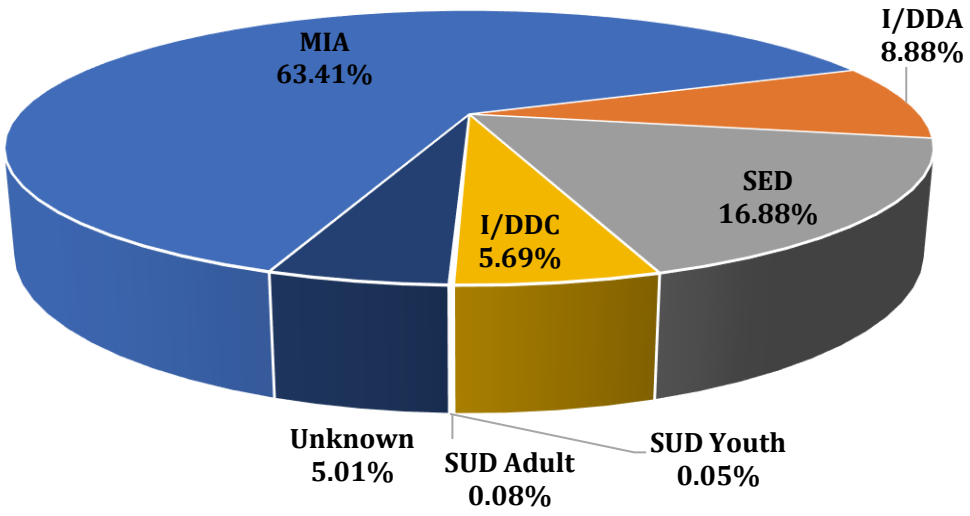


Following is a series of tables and charts, which provide a demographic breakdown of the persons served by ISK during FY 2022/23. The following tables demonstrate data that is sourced from completed MDHHS Treatment Episode Data Set (BH TEDS) and other demographic data sources. The total number of individuals who completed a BH TEDS during the fiscal year was 7,379.

A. Population Served by Client

	FY 21/22 = 8,173		FY 22/23 = 7,925	
MIA	4,924	60.25%	5025	63.41%
I/DDA	745	9.12%	704	8.88%
SED	2,005	24.53%	1,338	16.88%
I/DDC	419	5.13%	451	5.69%
SUD Adult	80	0.98%	6	0.08%
SUD Youth			4	0.05%
Undetermined			397	5.01%

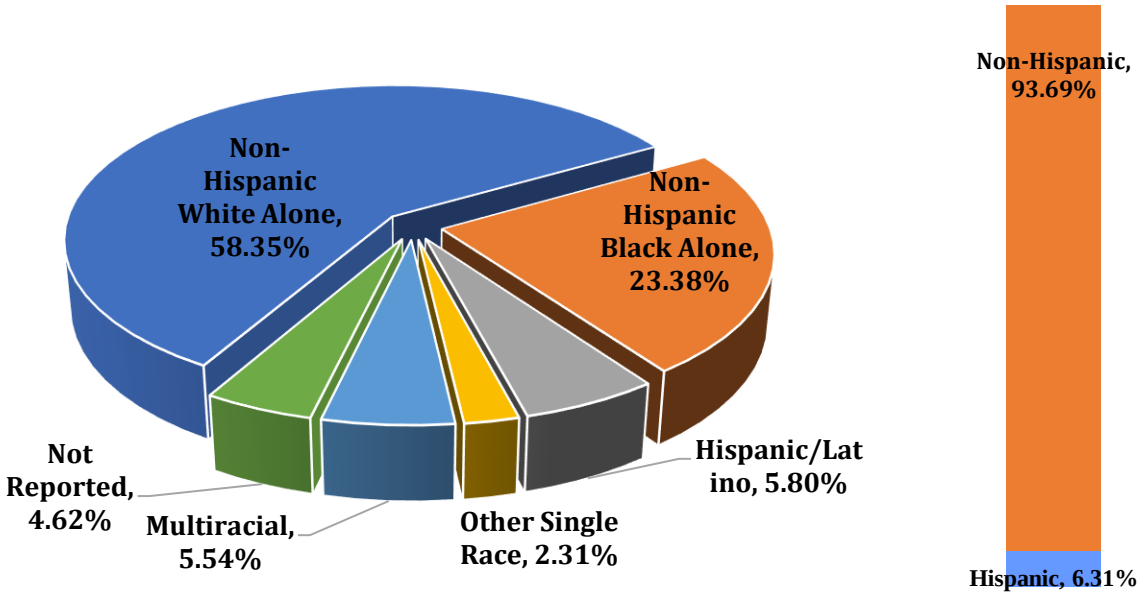
POPULATION SERVED BY POPULATION



B. Population Served by Race/Ethnicity

	FY 21/22 = 8,173		FY 22/23 = 7925	
Non-Hispanic White alone	4,429	54.19%	4,624	58.35%
Non-Hispanic Black/AA alone	1,879	22.99%	1,853	23.38%
Hispanic/ Latino	426	5.21%	460	5.80%
Other single race	75	0.92%	183	2.31%
Multiracial	546	6.68%	439	5.54%
Not reported	818	10.01%	366	4.62%

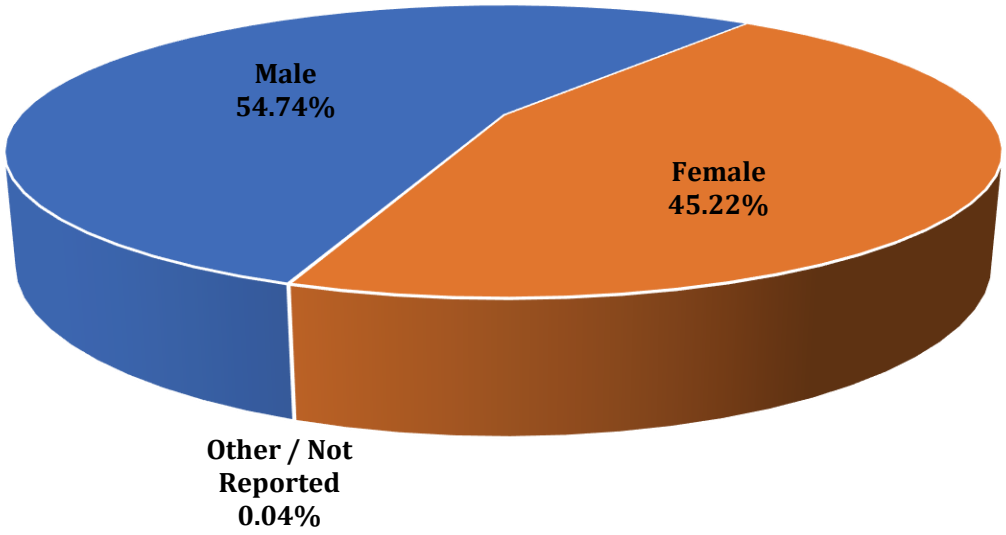
POPULATION SERVED BY RACE/ETHNICITY



C. Population Served by Sex

	FY 21/22 = 8,173		FY 22/23 = 7925	
Male	4,287	52.45%	4,338	54.74%
Female	3,571	43.69%	3,584	45.22%
Other / Not Reported	315	3.85%	3	0.04%

POPULATION SERVED BY SEX



D. Special Populations Served

	Count of Persons Served	% of Total Population
Medicaid recipients	7,122	89.87%
Medicare recipients	1,819	22.95%
Uninsured individuals	447	5.64%
Criminal Justice system involved	732	9.24%
Homelessness self-reported	854	10.78%
LGBTQ+ identity	778	9.82%
Veteran/active military	187	2.36%
Total service population	**7,925**	

V. POPULATION HEALTH

A. Mental/Behavioral Health Diagnoses

A summary of the prevalence of the most common mental/behavioral health and developmental/cognitive diagnoses. The tables below are duplicated counts, counting all primary and secondary diagnoses endorsed any time during the year for each individual.

MI / SUD Adults	Count of Persons Served	% of Total Population
Major Depressive Disorders	1,887	41.08%
Substance Use Disorders	1,780	38.75%
PTSD and trauma	1,419	30.89%
Anxiety Disorders	1,225	26.67%
Bipolar Disorder	1,137	24.76%
Schizophrenia/Psychotic dis.	1,114	24.25%
Total service population	**4,593**	

SED Youth	Count of Persons Served	% of Total Population
PTSD and trauma	575	52.01%
ADHD	406	36.78%
Major Depressive Disorders	379	34.33%
Anxiety Disorders	271	24.55%
Substance Use Disorders	53	4.80%
Autism / Pervasive Development Disorder	43	3.89%
Bipolar Disorder	19	1.72%
Total service population	**1,104**	

IDD Adults	Count of Persons Served	% of Total Population
Mild Intellectual disability	337	48.00%
Moderate ID	202	28.77%
Autism / Pervasive Development Disorder	193	27.49%
Anxiety Disorders	151	21.51%
Major Depressive Disorder	112	15.96%
ADHD	109	15.53%
Severe/profound ID	92	13.11%
Schizophrenia/Psychotic dis.	67	9.54%
PTSD and trauma	62	8.83%
Bipolar Disorder	54	7.69%
Chromosomal abnormality	51	7.26%
Cerebral palsy	48	6.84%
Sleep Disorders	22	3.13%
Total service population	**702**	

IDD Youth	Count of Persons Served	% of Total Population
Autism / Pervasive Development Disorder	226	50.22%
ADHD	80	17.78%
Mild Intellectual disability	53	11.78%
PTSD and trauma	39	8.67%
Anxiety Disorders	26	4.44%

IDD Youth	Count of Persons Served	% of Total Population
Major Depressive Disorder	17	3.77%
Moderate ID	14	3.11%
Severe/profound ID	8	1.78%
Total service population	**450**	

B. Health Indicators

Various health data points are tracked for some individuals served by ISK, depending on program enrollment and other eligibility factors. Some health data tracking has been implemented with the CCBHC. The below data tables represent the reporting and screening of tobacco and alcohol use based on data at time of assessment.

Self-Reported Tobacco Use	Count of Persons Served	% of Total Population
MI Adults with tobacco screen	3,814	
Positive tobacco use indicated	1,914	50.18%
DD Adults with tobacco screen	528	
Positive tobacco use indicated	38	7.20%
Youth with tobacco screen	974	
Positive tobacco use indicated	75	7.70%

Self-Reported Alcohol Use	Count of Clients	% of Total Population
Adults with alcohol screen	4,019	
Positive alcohol use indicated	1,065	26.50%
Youth with alcohol screen	1,346	
Positive alcohol use indicated	20	1.49%

VI. STAKEHOLDER INPUT

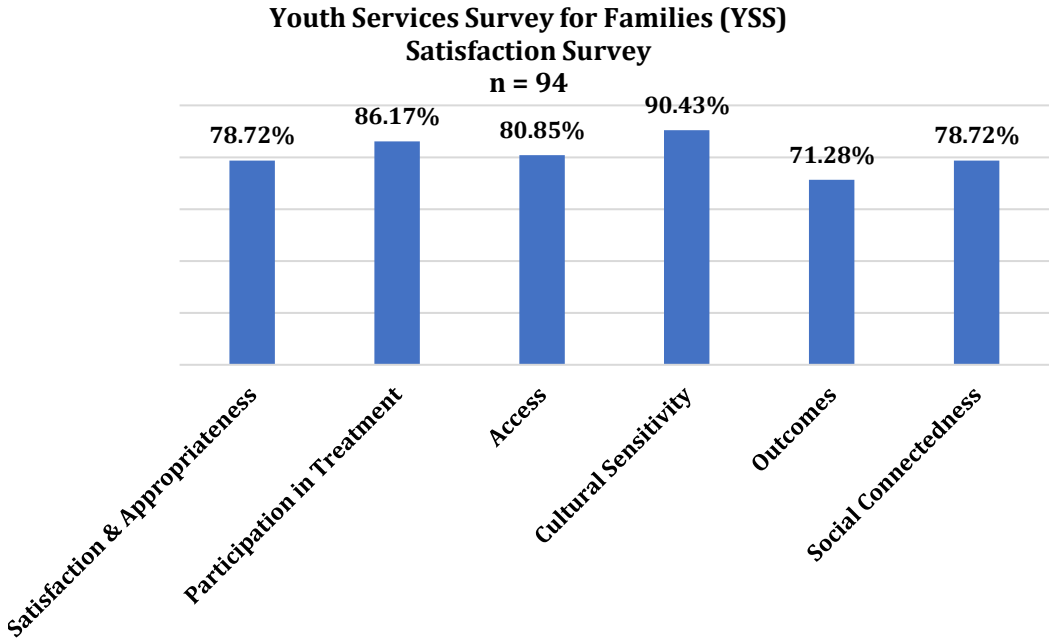
A. Person-Served Survey

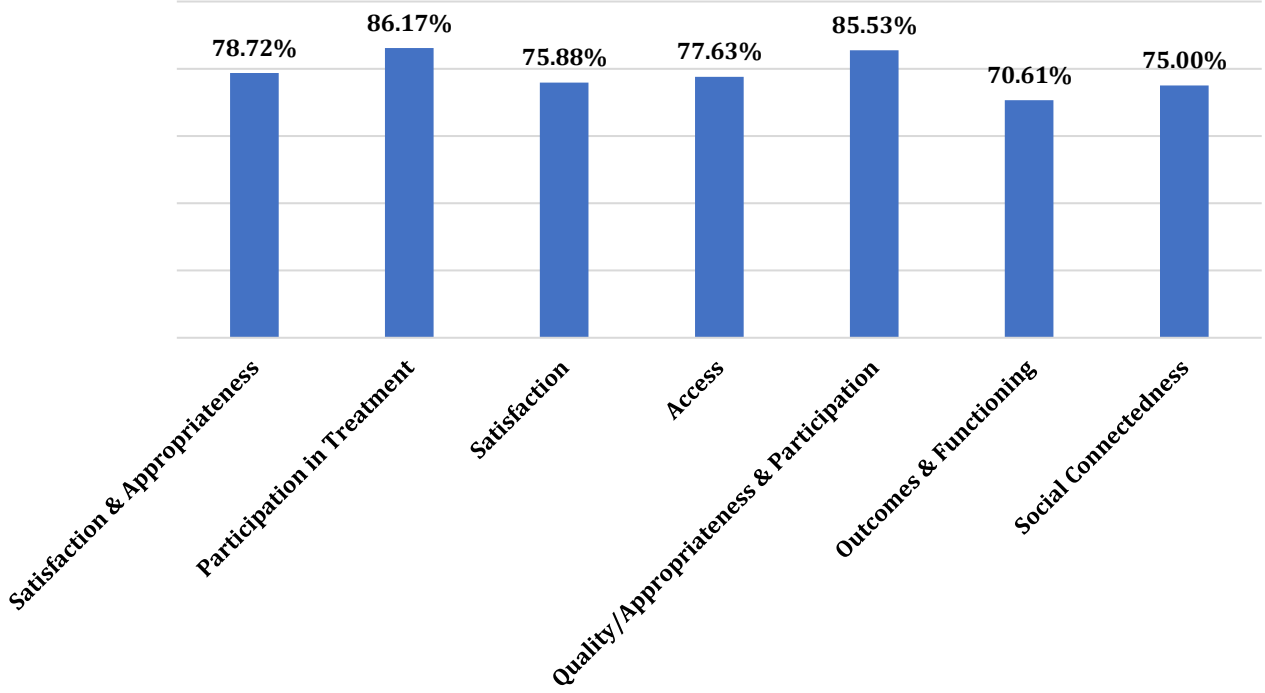
A nationally adopted, standardized tool designed to assess service recipients' perception of care across behavioral health services was facilitated through SWMBH for the eight-county region. This same survey tool was utilized to gather feedback from ISK CCBHC persons served. This survey assesses the experience of service recipients across the public behavioral health system, regardless of whether the person is receiving services from one or more programs or organizations. Standardized adult (36 items, entitled the Mental Health Statistics Improvement Program or MHSIP) and youth (26 items, entitled the Youth Satisfaction Survey or YSS) versions of the tool exist with minor differences in question wording and constructs measured by each version. Constructs related to service

experience are measured by grouping items from one or both of the tools into the following domains:

1. General Satisfaction with Services (MHSIP only)
2. Improved Functioning (MHSIP only)
3. Cultural Sensitivity (YSS only)
4. Access to Services (both versions)
5. Appropriateness of Care (both versions)
6. Level of Participation in Treatment (both versions)
7. Treatment Outcomes (both versions)
8. Social Connectedness (both versions)

The likert scale for each tool ranges from 1 (Strongly Disagree) to 4 (Strongly Agree), the higher the score, the more positive the service experience of the respondent. A total of 322 survey interviews were completed (children under age 18 and adults). The following graphs display the "percentage in agreement" by survey and domain:





The data collected through these surveys is in the process of being discussed and analyzed by the regional Quality Management Committee.

Information will be used as input for planning, designing, modifying and improving services provided to individuals. The results of these surveys are made available to Stakeholders through the ISK portal and public website, as appropriate.

B. CCBHC Patient Care Experience and Youth / Family Experience Survey

In accordance with the MDHHS CCBHC Handbook, ISK completed an annual Patient Care Experience Survey. As demonstrated in the data above, the MHSIP and YSS survey tools were utilized to complete these surveys with a goal of distributing 300 surveys to adults through the MHSIP and 300 surveys to parents/youth or guardians through the YSS. Respondents of the Patient Care Experience survey must have had a CCBHC service during the demonstration year.

VII. ASSESSMENT OF QUALITY & COMPLIANCE

A. Quality Monitoring Review (QMR)

The QMR process provides a systematic and comprehensive approach to verify that provider and internal ISK direct run services are compliant with contract and regulatory requirements as well as with specific standards for quality of services provided. The QMR system is designed to support compliance with applicable standards and brings about continuous quality improvement of the practices and services provided to persons receiving ISK services.

The Quality Management Department coordinates the QMR schedule for direct operated services with the Qualitative Quarterly Record Review (QRR) schedule so as not to add unnecessary administrative burden. QRR is referenced below in section VI. C.

1. Claims Verification / Clinical Record Review (CVCRR) – Mental Health and Substance Use Disorder Services

   The CVCRR tool encompasses elements for claims verification and quality of clinical record documentation.

   The CVCRR elements address the entire spectrum from service to payment. Multiple elements such as, but not limited to, service delivery, supporting documentation, claims submission and claims payments were audited. The CVCRR elements also address clinical documentation compliance with MDHHS requirements of the Michigan Mental Health Code and the Michigan Medicaid Provider Manual and the CCBHC Handbook when applicable. CVCRR elements also include monitoring of CARF standards conformance for internal ISK accredited programs.

   The FY 2022/23 QMR scores demonstrated improvement in many areas across organizations and service delivery. Although there continues to be areas of improvement, the ISK Provider Network and Direct Operated services demonstrate overall compliance with clinical documentation and accurate claims verification.

   The total number of records reviewed in FY 2022/23 is 545. If a provider received an overall score of 95% or higher on the previous year's full CVCRR, they may have been given a "follow-up" review during FY 22/23 which included a reduction in items that were reviewed within the clinical record, primarily focusing on claims verification and follow-up from the previous year's Plan for Improvement.

2. Organizational Practices Review (OPR)

   The OPR assesses an organization in the areas of Administrative Oversight, Quality Improvement, Person Served Involvement and satisfaction, Customer Services / Access to Care, Facility & Maintenance, Medication Management, Emergency Response, Training and Credentialing, and HCBS requirements monitoring for applicable sites.

Depending on the provider program, if a provider received an overall score of 90% or higher on the full OPR, they were given a "follow-up" review. This involves a reduction of items reviewed along with a follow-up on the previous year's Plan for Improvement.

Multiple collaboration efforts were conducted by the Quality Management Department as part of an ongoing education and training initiatives on QMR process improvement. Consultation continues to be provided during the site reviews. The Quality Management and Customer Services provide in-service and/or other technical assistance upon specific request from provider. Quality Department Office Hours were offered and held quarterly to allow opportunity for an open QMR consultation for providers throughout the year.

QMR trainings were provided by service area for the ISK Provider Network and direct run services. QMR trainings are conducted annually via virtual and onsite training, and it covers multiple training requirements. These include Claims Verification and Clinical Records Review, Corporate Compliance, Organizational Practices Review, Customer Services, Grievance & Appeals and Person-Centered Planning. For FY 2022/23, there were 117 participants in the QMR training of which 11 is from Autism Behavioral Service provider, 31 from Specialized Residential Services, 25 from Ancillary Services and 56 from Primary service providers.

B. Utilization Management

Utilization reviews are conducted by appropriately qualified Quality Management, Utilization Management, Program Services and Care Coordinator staff to ensure appropriateness of the types and levels of services provided to persons served in accordance with the ISK Utilization Management Plan. Utilization Reviews assess needs of an individual served and then those needs are matched with the levels and types of services currently being authorized and provided, in order to establish proper correlation. Utilization Reviews are also completed as a result of an individual locally appealing a notice to reduce, suspend, increase, add or terminate an ISK authorized service in accordance with the ISK Grievance and Appeals policy. The Utilization Management review is utilized in this capacity to assist with making the most appropriate disposition for the individual's level of care based on medical necessity and service appropriateness as outlined in the Michigan Medicaid Manual. ISK Utilization Management performs utilization review and monitoring activities which include outlier management methodologies. The outlier management process and subsequent reports to manage it, including over and under-utilization and uniformity of benefit, are based on accurate and timely assessment information, level of care and service determination criteria.

C. Direct Operated Qualitative Quarterly Record Review (QRR) & Peer Record Review

A Qualitative Quarterly Record Review (QRR) is conducted on a relative sample of open and closed ISK direct operated service cases.

With recent restructuring of administrative functions, ISK has combined the oversight of the Contracts Management, Medical Records, Compliance and Customer Services under the Department of Network Compliance. To enhance efficiencies and minimize administrative workload for clinical teams, the completion of the QRR process is now managed by the Department of Network Compliance. The Integrated Psychiatric Behavioral Health Clinic continues to conduct a measure of clinical peer review/case consultation to enhance the services provided to individual patients. Record reviews that

were formerly part of that peer review process has been absorbed into the QRR in the fiscal year.

These reviews evaluate and provide feedback to determine the level of compliance with required documentation standards, utilization patterns and appropriateness of clinical service within a case record.

ISK Psychiatric Behavioral Health Clinic continues to conduct a measure of clinical peer review/case consultation to enhance the services provided to individual patients. Record reviews that were formerly a part of the peer review process has been absorbed into the QRR.

D. Monitoring of Incident Reports

All ISK staff, contract staff, volunteers and students who witness, discover or are notified of unusual incidents or events must complete an incident report in a timely manner in accordance with established standards and procedures. ISK has established a system to track, categorize and review incident reports. The intent is to analyze all incidents and data to ensure proper response, identify specific trends or patterns, and create mechanisms (based on trends) to prevent or minimize the negative impact of these incidents on the lives of individuals receiving services.

The following is a summary of the data reported by incident type:

Incident Type	2021/22	2022/23	Diff
Medication Issues	692	519	-173
Health & Safety Issues	1660	1710	+50
Behavioral / Social Issues	3728	4288	+560
Non-Violent Practices	305	184	-121
Deaths	70	283	+213
Other Issues	229	52	-177
TOTALS	**6684**	**7036**	**+352**

There was a 5.3% increase in the total number of incidents reported in FY 2022/23 compared to FY 2021/22. The largest increase was seen in the area of Behavioral/Social Issues and the largest decrease was noted in the area of Non-Violent Practices. Data related to Medication issues, along with all other incidents is reviewed by the ISK Office of Recipient Rights, the Quality Management Department and the ISK Quality Improvement Council (IQIC).

*A **Critical Incident** is "an event, occurrence or condition which represents actual or potential serious harm to CMH consumers and their families, visitors, volunteers or staff members (including medical emergencies)".*

*A **Sentinel Event** is a Critical Incident that is also "an unexpected occurrence involving the death or serious physical or psychological injury, or the risk thereof".*

Incidents that are more serious in nature and require closer review and follow-up are classified as Critical Incidents and Sentinel Events. A Root Cause Analysis (RCA) is completed on all Sentinel Events with treatment team members involved in the individual's care. Each RCA is reviewed by an established group of qualified staff to identify and implement improvement strategies that will prevent the reoccurrence, or reduce the risk of reoccurrence, of such an incident.

Below is a summary of the Critical Incidents (CI) and Sentinel Events (SE) that occurred in programs operated and/or funded by ISK during FY 21/22 and FY 22/23:

Nature of Incident	Critical Incidents 2021/22	Critical Incidents 2022/23	Sentinel Events 2021/22	Sentinel Events 2022/23
Medication Issues	0	0	0	0
Health & Safety Issues	44	41	0	0
Behavioral / Social Issues	20	14	0	0
Non-Violent Practices	77	29	0	0
Deaths	63	45	9	13
Other Issues	0	0	0	0
TOTALS	**204**	**129**	**9**	**13**

In accordance with ISK Incident, Event and Death Reporting policy, FY22/23 deaths of persons served that were classified as Sentinel Events demonstrated the following manner of death:

Manner of Death	FY 21/22	FY 22/23
Suicide	1	2
Homicide	0	1
Accidental / Unexpected	8	16
TOTALS	**9**	**20**

The Office of Recipient Rights completed reviews on all deaths to determine if services were appropriate based on individual need.

E. Credentialing

ISK ensures that services and supports are consistently provided by agencies and staff members (contracted or direct operated) who are properly and currently credentialed / licensed / qualified. The ISK Credentialing Committee met at least monthly (either face to face or through email correspondence) during FY 2022/23 to review and approve the credentialing of individuals and provider agencies.

F. Provider Monitoring Log & sanctions

The Provider Network Workgroup uses a Provider Monitoring Log to track significant compliance issues and sanctions with providers.

During FY 2022/23, 5 providers' issues were tracked and 2 were resolved. The issues involved were:

1. Additional monitoring being added due to on-going, numerous health and safety issues.
2. Contract violation / area of non-compliance
3. Failure to fully complete corrective action steps outlined the Plan for Improvement.
4. Failure to provide requested information
5. Unacceptable plan of correction / Failure to provide requested information for the Independent Financial audit for Fiscal Year 2021-2022.

G. Consumer Grievance & Appeals

Persons receiving mental health services have various avenues available to them to resolve disagreements or complaints.

Specific appeals and grievances are addressed by ISK Customer Services and coordinated with Southwest Michigan Behavioral Health (SWMBH) as appropriate. Appeals are complaints about an action to deny, suspend, reduce or terminate a mental health or substance use disorder service. Grievances are complaints about other aspects of care that are not actions and are not Recipient Rights complaints as identified by the State of Michigan.

During FY 2022/232, ISK Customer Services Office processed the following:

	Medicaid	**Non-Medicaid**
Local Appeals	5	0
Access 2nd Opinions	0	0
Hospital 2nd Opinions	1	0
Administrative Medicaid (Fair) Hearings	0	
MDHHS Alternative Dispute Resolution Process		0
Grievances	23	1
Totals	**29**	**1**

CMHSP Grievance and Appeals reports are reviewed on a quarterly basis by IQIC and SWMBH Customer Services. A report of Grievances and Appeals is provided to and reviewed with the ISK Board on a semi-annual basis.

VIII. PERFORMANCE MEASUREMENT

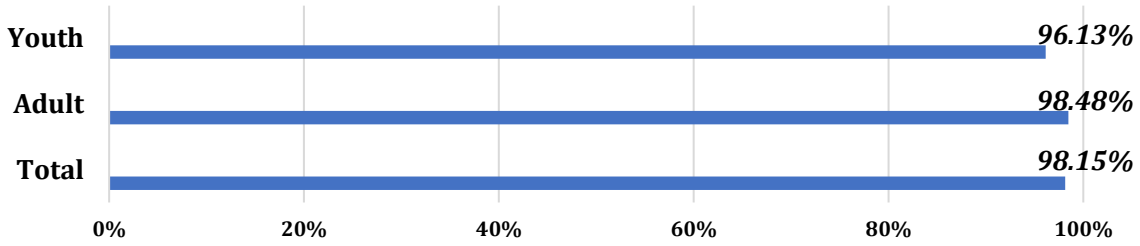
A. Performance Indicators

All CMHSPs are required to submit to SWMBH, MDHHS, and CCBHC specific information and data on the performance of its programs and services for each quarter. The information and data submitted is then evaluated according to specific benchmarks established by the Michigan Mission-Based Performance Indicator System (MMBPIS). This Performance Indicator System was developed by MDHHS based on the review of benchmarks used by various national organizations, input from consumers and advocates, and other interested parties.

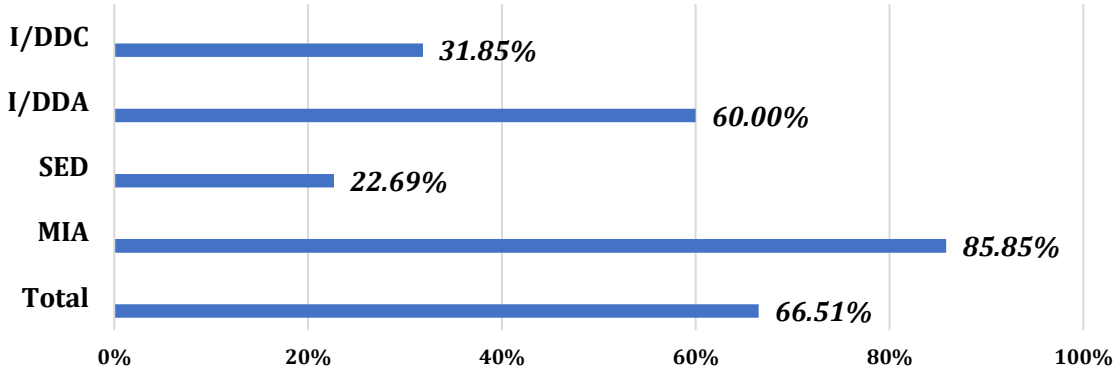
The Data Integrity Monitoring Team (DIMT) reviews the quality of the data obtained and reported. DIMT and IQIC review the results and trends of performance in the various service areas of the organization. The teams identify deficits in specific areas, determine trends and develop strategies for improvement. Performance indicator data and reports are shared with the ISK Board and stakeholders (individuals served, providers and external parties).

The following graphs display the results on the performance indicators in which MDHHS has established a goal:

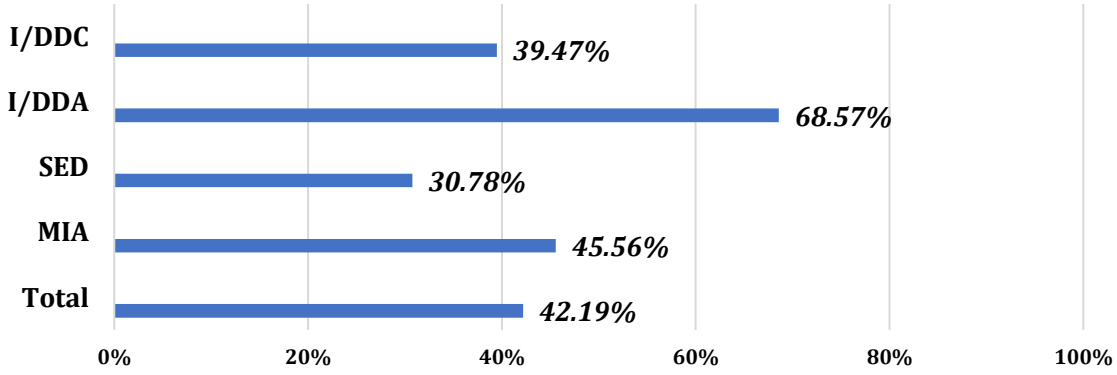
Persons receiving a Pre-Admission Screening for Psychiatriac Inpatient Care for whom the disposition was completed within 3 hours (Goal 95%)

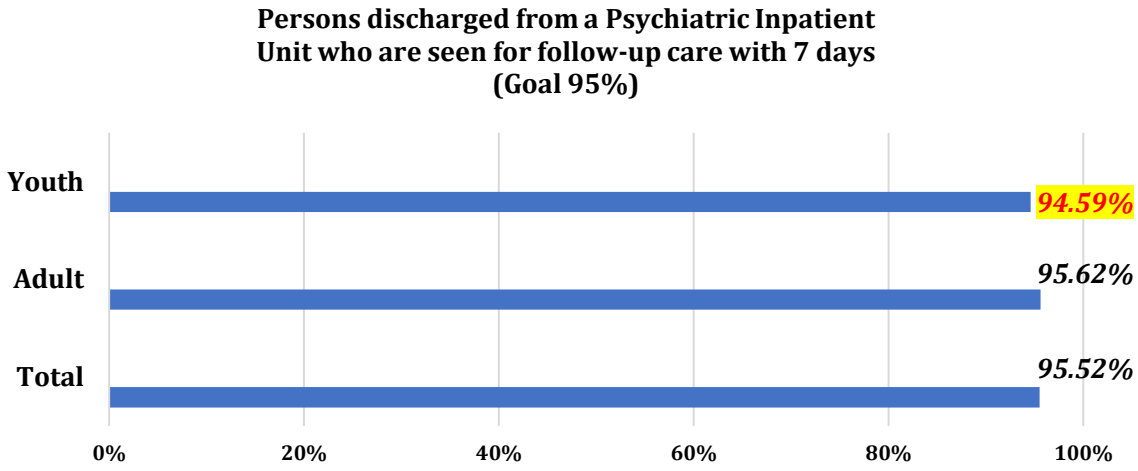


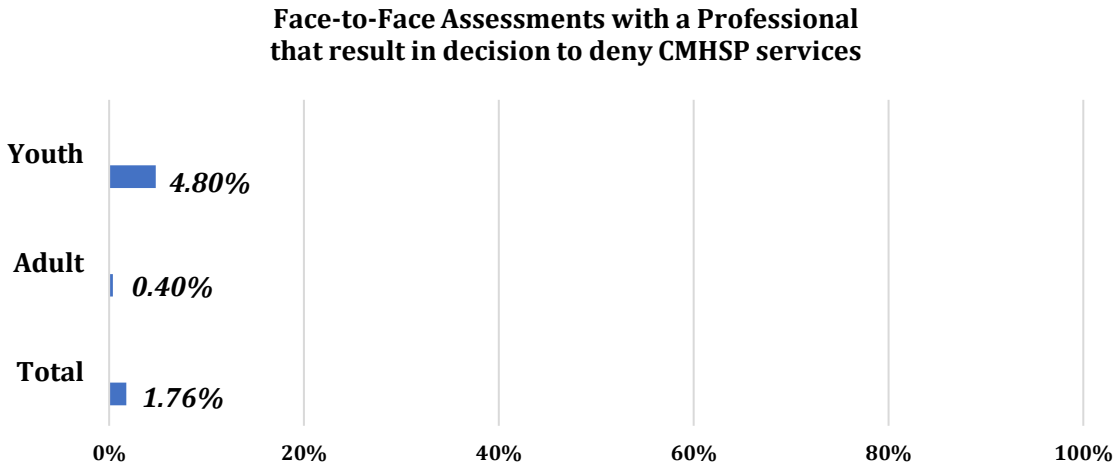
New persons receiving a completed Biopsychosocial Assessment within 14 calendar days of a non-emergency request for service

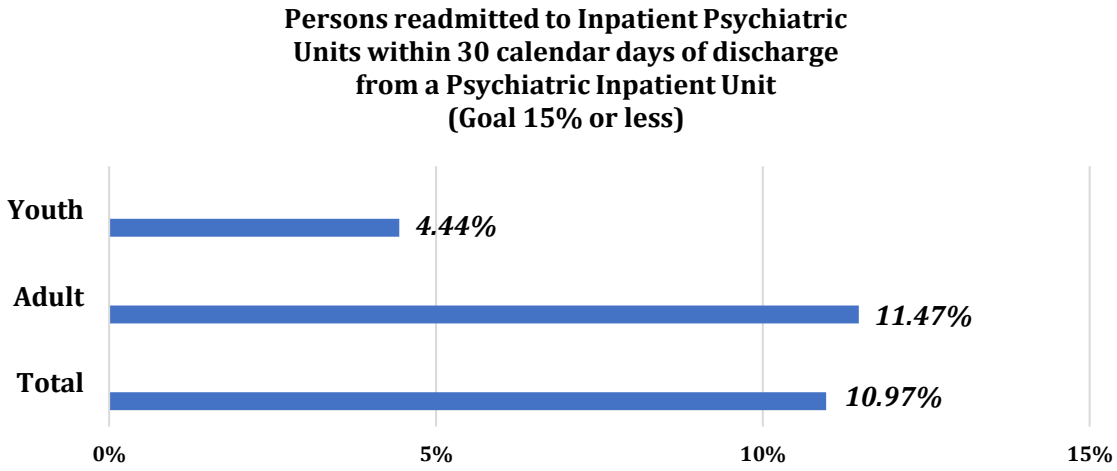


New persons starting any needed on-going service within 14 days of completing a non-emergent Biopsychosocial Assessment









B. Accreditation

CARF conducted an accreditation survey of ISK in April 2022. A three-year (3) accreditation (highest level) was received from CARF. Implementation of the Quality

Improvement Plan is overseen by the Administrator of Operations and the ISK Quality Improvement Council (IQIC).

CARF is recognized as one of the premier accreditation organizations as it develops and maintains "best practices" standards for behavioral health. Some of the benefits of CARF accreditation include:

1. The identification of an organization that has met internationally recognized standards.
2. Providing some assurances to stakeholders around the need for accountability in efficiency of the organization, effectiveness of services (consumer outcomes are being achieved) and stakeholder satisfaction with services.
3. Assisting programs in identifying their strengths and weaknesses through self-assessment activities in readiness for the survey.
4. Providing "best practices" and service improvement on-site consultation by peers within our field.
5. Achieving a "deemed status" as granted by MDHHS for accredited organizations.

IX. QUALITY IMPROVEMENT INITIATIVES

A. QI Ideas

In FY 2022/23 a new QI Idea application project was completed and released by the Information Technology Service Department, in collaboration with the Quality Management Department and ISK Quality Improvement Council (IQIC) committee. This is an improvement on the platform used by ISK in its intent to streamline the process of soliciting quality improvement ideas from ISK internal staff. IQIC discusses these submitted opportunities and compares them to a set of process improvement selection criteria. The overall goal is to empower staff to continuously seek ways to improve ISK services/business processes.

The following are examples of QI Ideas being reviewed by the IQIC:

- Improve care or services to our customers in order to enhance customer satisfaction
- Increase efficiency and eliminate waste within the organization (i.e., process improvement, reduce redundant paperwork, improve turn-around time, reduce expenses, etc.)
- Facilitate a systemic change (i.e., process improvement in how something works that increases quality of services, data integrity, etc.)
- Improve communication throughout the agency and its departments
- Improve our responsiveness and coordination to other stakeholders

For FY 2022/23, the IQIC Committee received a total of 49 QI Ideas submitted by ISK staff. Out of 49, 1 is still in process, 12 were denied and 36 were either addressed or approved / implemented as improvement projects and initiatives.

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B. Quality Management Goals & Objectives

Each year, as part of the Quality Management Plan, ISK develops quality management goals & objectives that include steps/actions. Following are the FY 2022/23 goals & objectives and the status achieved.

Goals	Objectives / Action Steps	Status
1. Remain informed and compliant with all performance indicators expected and maintain compliance with Accreditation and regulatory standards	1. Review at least one performance report per IQIC meeting, including but not limited to: a. MMBPIS b. Encounter status c. BH TEDS d. SWMBH Board Metrics	1. Reported during Jan IQIC meeting about working on establishing the measures, indicators and data points for the operationalizing of the Performance Measurement and Management Plan. 2. ISK Youth Department started their MMBPIS success team. 3. Quality continues to do quarterly spot checks to ensure outliers are accurate and/or if things need to be corrected prior to SWMBH submission.
	2. Ensure knowledge of current accreditation standards and changes within the CARF manual.	1. Policies updated as reported in IQIC May 2023 meeting. 2. Updated new hire orientation (to meet at least 2 recommendations). 3. Updated Health & Safety handbook (again to meet more than 1 recommendation). 4. Revised Program Measurement and Management Plan (met more than one recommendation). 5. Revised Orientation to Services. 6. Revised and updated Program Descriptions (for consistency across all programs).
2. Ensure effective implementation of Certified Community Behavioral Health Clinic (CCBHC) state demonstration	1. Meet MDHHS incentive thresholds for all Quality Bonus Payment (QMP) metrics (IET, SRA, FUH, SAA) 2. Ensure that CCBHC implementation, outreach and engagement efforts are effectively expanding access to services	1. CCBHC FY22 report reviewed on Jan 2023 IQIC meeting.
3. Further promote cultural competency, equity, inclusion,	As facilitated, monitored, and implemented through JETT: 1. Enhance staff training to include concepts of	1. Reports and updates provided during every IQIC meeting. 2. Four sessions of AFFIRM (support group for parents of youth in the

Goals	Objectives / Action Steps	Status
and trauma informed approaches to respond to the needs of persons served, workforce and the community.	historical/racial trauma and resilience-oriented principles. 2. Increase and enhance organization's ability to prevent, identify and appropriately respond to workforce concerns. 3. Educate ourselves on equity principles and apply those principles on the activities of training, hiring, and self-care.	LGBTQIA community) have occurred. 3. "How was your visit" questionnaires were placed in each ISK site to assist with individual satisfaction with services and our internal programs. 4. Continuous efforts are underway by staff including clinicians for staff to feel safe while working in the community, including agency steps needed to increase safety and safety awareness. 5. The JETT workgroup implemented an Equity Review on different processes/ policies our agency utilizes to ensure a trauma focused lens is being used. 6. JETT members presented at the National Council. 7. Coordination has occurred for ISK's participation in PRIDE event in June. 8. IQIC will provide support to JETT projects as needed, discussed in March 2023 meeting.
4. Ensure future financial sustainability.	1. Define and develop a plan for organizational financial sustainability, including but not limited to: a. Diversification of funding b. Department and staff level tracking of billable service	1. ISK Finance Department continues to report on and complete calculations monthly. 2. A Dashboard is in process of being developed to monitor. 3. ISK continues to evaluate and seek grants for new opportunities.
5. Ensure ISK staff are adequately trained to meet competency requirement	1. Improve onboarding training process for new staff in all departments. 2. Improve training opportunities provided to ISK leadership.	1. Orientation trainings wee updated as needed and the onboarding processes were evaluated for increased efficiencies and new hire experience. 2. Offered 3 Practicing Effective Management trainings by TBD Solutions. 3. Offered a 3-hour legal training Respect, Discrimination and Harassment/Hiring Procedures and Background Checks --- videos are assigned to new leadership staff along with mandatory Relias courses.