INTEGRATED
Services of Kalamazoo

Community • Independence • Empowerment

QUALITY IMPROVEMENT PROGRAM & PLAN

PERFORMANCE MEASUREMENT AND MANAGEMENT PLAN

FISCAL YEAR 2024/25

VII.a.

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 (QAPIP) which meets the specified standards in the contract with MDHHS. In addition to the QAPIP, 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 2024/25. Aside from this QIP, ISK participates in and contributes to the QAPIP 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

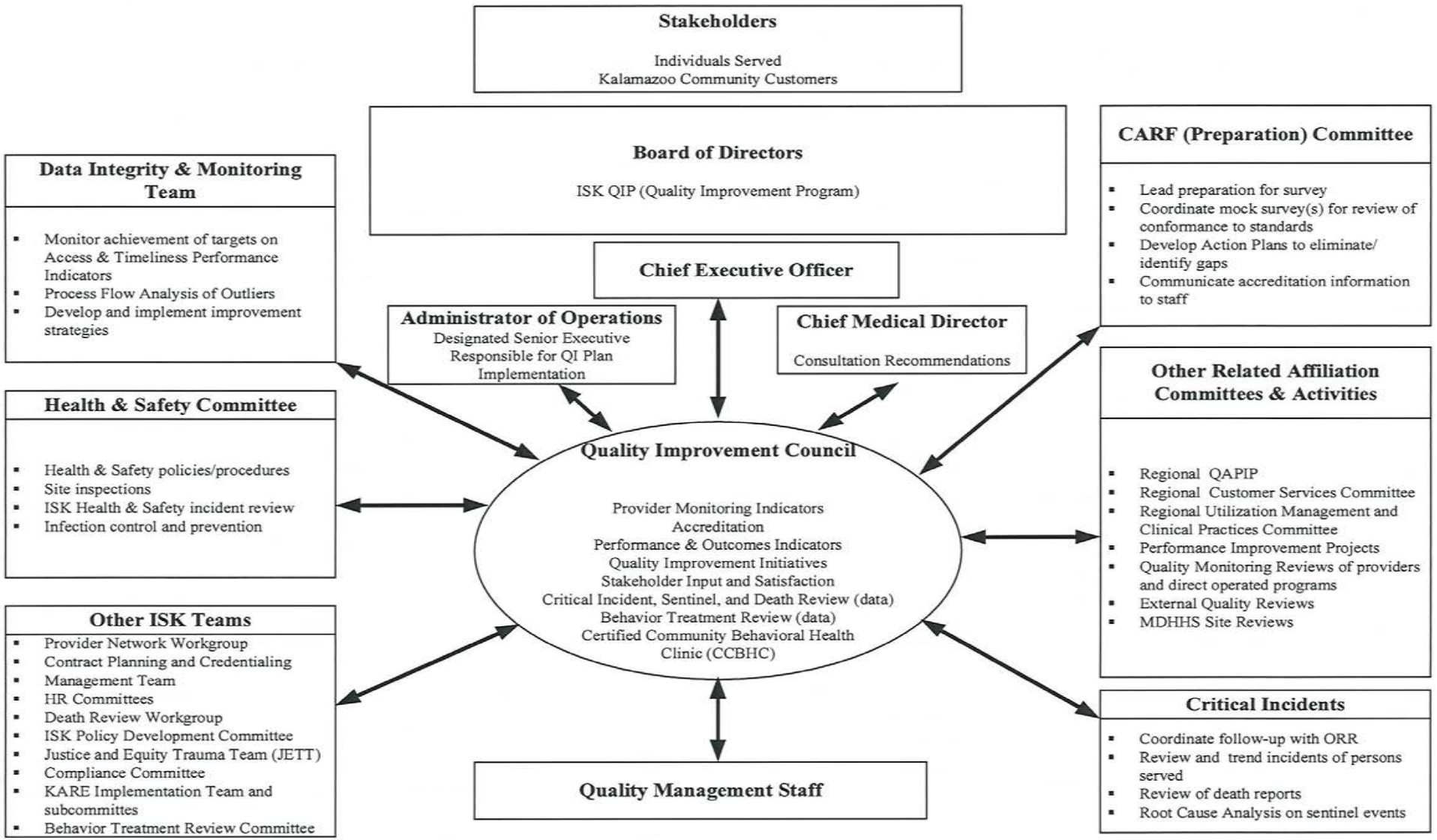
Values

- 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 Director 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, standing committees throughout the organization include the voice of individuals served through Peer Support Specialist representation. Peer Support Specialists play a key role to inform ISK committee goals and initiatives in the in the 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 the 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 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 Health 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), Habilitative Support Waiver (HSW), 1915i State Plan Amendment (iSPA) and others who receive services funded by these programs from CMHSPs as required. 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. Additional monitoring and review with applicable service programs will occur throughout the year at identified frequencies in accordance with specific measures. Plan will be updated as necessary.

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 2024/25

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 2024/25:

#	GOALS	OBJECTIVES / ACTION STEPS	Attachment A MEASURES/TIMETABLE
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. Encounters status c. BH TEDS d. SWMBH Board Metrics 2. Monitoring and outcome reports are shared with program staff, committees and leadership for Performance Measurement Plan status and progress. 3. Ensure knowledge of current accreditation standards and changes within the CARF manual. 4. Continue efforts to increase the percentage of new persons starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment. The goal is to reach the MDHHS set benchmark of 72.9%.	1. Number of improvement efforts and/or projects related to performance measure data review a. Number of improvement efforts resulting from audit results and outcomes 2. Performance Measurement Plan is reviewed at the identified measure frequency and plan status report is presented at least every 6 months. 3. Annual CARF manual is reviewed for changes with evidence of revised processes and/or policies are demonstrated to conform with current standards by 9/30/2025. 4. ISK will meet the benchmark of 72.9% for performance indicator 3 by 9/30/2025.
2.	Ensure effective implementation of Certified Community Behavioral Health Clinic (CCBHC) state demonstration	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.	1. Report and review QBP metrics during IQIC committee meeting. Trending and analysis of QBP metrics completed within CCBHC subgroups. a. QBP metrics meet established standards by 12/31/2025. 2. Increase the number of individuals receiving CCBHC services that have not been in CMH service in the last 3 years.
3.	Further promote cultural competency, equity, inclusion, and trauma informed approaches to respond to the needs of individuals served, workforce and the community	As facilitated, monitored, and implemented through the JETT FY25 workplan: 1. Using data and an equity lens, analyze the work of ISK to identify actionable recommendations for the agency. 2. Enhance training for staff and provider network to include and expand on concepts of trauma (including trauma informed and responsive care as well as historical and racial trauma),	JETT representative will provide status update to IQIC on progress and barriers to the FY25 JETT Workplan at least every 6 months. FY25 Workplan will be successfully implemented through the ISK JETT committee as demonstrated by achieving goals and related measures by 9/30/2025.

#	GOALS	OBJECTIVES / ACTION STEPS	Attachment A MEASURES/TIMETABLE
		resilience-oriented principles, and equity principles. 3. Increase and enhance organization's ability to prevent, identify and appropriately respond to workforce concerns/stressors (burnout, secondary traumatic stress, compassion fatigue) utilizing Trauma Informed Principles and an Equity Lens 4. Evaluate methods by which diverse communities can access services including ways in which ISK actively provides outreach to these communities to create safety and trust.	
4.	Strive to build sustainable financial operations to support the delivery of CCBHC and specialty CMH supports and services	1. Define and develop plan for organizational financial sustainability, including but not limited to: a. Diversification of funding b. Department and staff level tracking of billable service	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.
5.	Achieve the ISK Strategic Plan goal to be active listeners to our diverse community needs	1. Stakeholder satisfaction will be collected through established methods (kiosks, surveys, etc.) and reviewed by the ISK Survey Team at least quarterly. 2. Improvement opportunities will be identified and implemented as appropriate. 3. Community Health Needs Assessment priority areas are addressed in response to stakeholder feedback on community and service needs.	1. Summary of feedback results will be reviewed by IQIC at least twice per year. 2. Feedback is addressed and action is taken to improve satisfaction. 3. Information about prioritized agency needs, improvement projects and changes in performance is shared with staff and stakeholders in an accessible manner.
6.	ISK shall meet MDHHS requirements regarding reviewing and addressing events per contractual requirements and the MDHHS CCBHC Handbook	1. Required reportable events and the steps taken to prevent re-occurrence will be reviewed for the following areas at a minimum of quarterly: a. CCBHC individuals served suicide deaths or suicide attempts. b. Fatal and non-fatal overdoses c. All cause mortality among people receiving CCBHC services. d. CCBHC individuals served 30-day hospital readmissions for psychiatric or substance use reasons.	1. Reportable events are submitted to SWMBH monthly as required. 2. Trends and analysis of events are reviewed at each IQIC meeting, including improvement efforts to address any negative findings. 3. Trending of death review data will be presented to IQIC at least annually.

#	GOALS	OBJECTIVES / ACTION STEPS	MEASURES/TIMETABLE
		e. Critical, Sentinel, and Risk events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of the ISK QI plan. f. Critical, Sentinel, and Risk events per MDHHS requirements 2. ISK Death review committee will meet every three months to review assess for improvement related to preventative measures and availability of data to inform clinical processes.	

Attachment B

INTEGRATED SERVICES OF KALAMAZOO QUALITY IMPROVEMENT COUNCIL
TEAM CHARTER
2024/2025

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
      - ~ Dashboard reports
      - ~ Stakeholder Survey Reports (i.e., persons served, 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 Rottman, Chief Financial Officer	arottman@iskzoo.org	Finance	R	ongoing
Angela Thompson, Program Coordinator	athompson@iskzoo.org	Quality Management	A	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
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

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)
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
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, Clinical Director of Justice Services	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, Clinical Director of Outpatient Services	tkelly@iskzoo.org	Clinical / Outpatient Services	R	ongoing
Tracy Free, Facilities Coordinator	tfree@iskzoo.org	Facility Management	R	ongoing
Wanda Brown, Senior Executive	wbrown@iskzoo.org	Psychiatric Services	A	ongoing

PROCESS

A. ROLES

Role	Assigned Team Member	Responsibilities
Team Leader/Chair	Administrator of Operations	Agenda creation, monitoring of performance and activities directed by the committee, meeting facilitation and scheduling.
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.

Integrated Services of Kalamazoo
Performance Measurement and Management Plan
Fiscal Year 2024/2025

ISK CARF Accredited Programs						
Assertive Community Treatment (ACT)	**Intensive Family Based Services**	**Job Development and Employment**	**Case Management**	**Crisis Intervention**	**Home Health**	**Outpatient Therapy (OPT)**
• ACT Team 3* • ACT Team 5* ***Evidence Based Practice Fidelity (EBP)**	• Intensive Care Coordination with Wraparound • Homebased • Healthy Transitions* • Multi-systemic Therapy (MST) ***Evidence Based Practice Fidelity (EBP)**	• Supported Employment* ***Evidence Based Practice Fidelity (EBP)**	• Adults with Mental Illness (MIA) • Adults with Intellectual Developmental Disabilities (I/DDA) • Youth with Serious Emotional Disturbances (SED) • Youth with Intellectual Developmental Disabilities (I/DDC)	• Youth Crisis Intervention • Mobile Crisis Response (MCR) • Intensive Crisis Stabilization • Emergency Mental Health/ Adult Crisis	• Whole Health Initiative (WHI)	• Dialectical Behavior Treatment (DBT) • Navigate • Youth - Mental Health • Youth - Substance Use Disorders (SUD) • Adult – Mental Health • Adult – Substance Use Disorders (SUD) • Substance Abuse Management Model (SAMM)

OUTCOME	GOAL	SOURCE	PROGRAM REVIEWED
Effectiveness	Psychiatric hospitalization recidivism rate will be 15% or less	MMBPIS	All except Crisis Intervention
Effectiveness	Persons served will have an assessment, Individual Plan of Service (IPOS) and Periodic Reviews completed 90% on time within each reporting period.		All
Effectiveness	Persons served files will have a current Consent to Treat and Consent to Share Behavioral Health Information at least 90% within each reporting period		All except Crisis Intervention
Effectiveness	Less than 10% of the programs reviewed sample from the Quarterly Record Review (QRR) will be eligible for discharge		All except Crisis Intervention
Effectiveness	ACT- will discharge 10% or more persons served during the year to less intensive services	EBP Fidelity	ACT
Effectiveness	ACT- will discharge 10% or less of persons served during the year to a higher intensity service (i.e. hospitalization, jail/prison, nursing home, or specialized residential)	EBP Fidelity	ACT

Integrated Services of Kalamazoo
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Effectiveness	Healthy Transitions- All clinical staff are training in the 5-day TIP Model	EBP Fidelity	Healthy Transitions
Effectiveness	Healthy Transitions- Monthly coaching calls with State consultant including TIP model trainings	EBP Fidelity	Healthy Transitions
Effectiveness	Successful discharge- Planned discharges demonstrate at least one goal marked as "goal met" on discharge plan		Case Management Programs
Effectiveness	Percentage of persons served (12 years or older) with Major Depression or Dysthymia who reach Remission Six Months (+/- 60 days) after an Index Event Date.	CCBHC	All
Effectiveness	All Youth Programs (OPT, SED, DDC, Wraparound, Homebased, Healthy Transitions, MST) will complete annual 24-hour child specific training requirements	MDHHS	Youth Specific Programs
Effectiveness	Percentage of persons served aged 18 years and older who were screened for unhealthy alcohol use using a Systematic Screening Method at least once within the last 12 months	CCBHC	Adult programs
Effectiveness	Percentage of persons served aged 18 years and older who were identified as unhealthy alcohol users who received Brief Counseling	CCBHC	Youth Specific Programs
Effectiveness	Percentage of persons served aged 18+ screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow- up plan is documented on the date of the positive screen,	CCBHC	Adult programs
Effectiveness	The percentage of persons served aged 12-17 for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	CCBHC	Youth Specific Programs
Effectiveness	Percentage of persons served aged 18 years and older who were screened for Tobacco Use one or more times within the Measurement Year	CCBHC	Adult programs
Effectiveness	Percentage of persons served aged 18 years and older who were identified as a tobacco user during the Measurement Year in sub-measure 1 and who received a Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year	CCBHC	Adult programs
Effectiveness	73% of persons served aged 18 years and older with a diagnosis of Major Depressive Disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	CCBHC	Adult programs
Effectiveness	57% of persons served visits for those recipients aged 6 through 17 years with a diagnosis of Major Depressive Disorder (MDD) with an assessment for suicide risk.	CCBHC	Youth Specific Programs
Efficiency	Identified clinical teams will have their progress notes signed within 3 business days or less		All

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Efficiency	% of staff appointments kept during the reporting period (breakdown to show no show, staff cancel, client cancel)		OPT
Efficiency	Meet 72.9% or more persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment by four subpopulations		All
Efficiency	ACT- at least 80% of contacts will occur in the community.	EBP Fidelity	ACT
Efficiency	ACT- 95% of ACT participants will be seen within 7 days of a psychiatric hospital discharge.	EBP Fidelity	ACT
Efficiency	At least 60% of contacts will occur in the community, including 40% of billable time scheduled.	EBP Fidelity	Supported Employment
Efficiency	Initial employment assessment and first face-to-face employer contact by the person served or the employment specialist about a competitive job occurs within 30 days after program entry.	EBP Fidelity	Supported Employment
Efficiency	Percentage of persons served (18 years of age or older) screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety	CCBHC	Adult programs
Access	Percentage of persons during the quarter receiving a prescreen for Inpatient Psychiatric admission, decision made within 3 hours of initial request	MMBPIS	All
Access	Percentage of new persons receiving a completed assessment within 14 calendar days of a non-emergent request and assigned to accredited program	MMBPIS	All
Access	Percentage of new persons starting continued services within 14 calendar days of a completed assessment for non-emergent services.	MMBPIS	All
Access	Percentage of discharges from psychiatric inpatient with follow up within 7 days	MMBPIS	All
Access	ACT- 95% of persons served referred to ACT will begin services within 14 days from referral	EBP Fidelity	ACT
Access	Average Number of Days until Initial Evaluation for New Clients	CCBHC	Same Day Access
Access	Average Number of Days until Initial Clinical Service for New Clients	CCBHC	Same Day Access
Access	Average Number of Hours until Provision of Crisis Services following a first Crisis Episode Contact.	CCBHC	EMH/Crisis Intervention Services
Access	Average Number of Hours until Provision of Crisis Services following a mobile Crisis Episode Contact.	CCBHC	EMH/Crisis Intervention Services
Access	Average Number of Hours until Provision of Crisis Services following an Urgent Care Crisis Episode Contact.	CCBHC	EMH/Crisis Intervention Services
Access	Average Number of Hours until Provision of Crisis Services following any other Crisis Episode Contacts	CCBHC	EMH/Crisis Intervention Services

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Business Function	Less than 5% of staff will click on Phishing emails		All
Business Function	85% of customer financial determinations will be completed		All
Business Function	Completion rate of BH/SUD TEDS will be 95% or higher		All
Business Function	Completion of emergency drills as required for each ISK site (per building)		All
Business Function	At least 90% compliance with monthly phishing training completion		All
Patient Satisfaction	Meet or exceed 80% satisfaction during the annual Mental Health Statistics Improvement Program (MHSIP)/Youth Services Survey (YSS) survey and CCBHC survey	CCBHC	All
Patient Satisfaction	95% of persons served who were satisfied with services received indicates "yes" on satisfaction during periodic review		All
Patient Satisfaction	95% of discharged persons served who responded with agree or strongly agree within ISK Discharge follow-up survey (excludes crisis)		All except Crisis Intervention
Patient Satisfaction	ACT- during 90% of ACT contacts, persons served will report satisfaction with services.	EBP Fidelity	ACT
Patient Satisfaction	Meet or exceed 80% satisfaction on the Recovery Self-Assessment (RSA-R) survey	CCBHC	SUD OPT
Stakeholder Satisfaction	Meet or exceed 80% agreeable satisfaction on QMR provider feedback survey	CCBHC	All
Stakeholder Satisfaction	Meet or exceed a score of 90% on the Annual Southwest Michigan Behavioral Health (SWMBH) delegation audit as it relates to the clinical review portion and as applicable by clinical programs selected by SWMBH.	CCBHC	All

Community • Independence • Empowerment

Integrated Services of Kalamazoo

MOTION

Subject:	ISK Quality Improvement Program Plan	
Meeting Date:	January 27, 2025	Approval Date:
Prepared by:	Sheila Hibbs	January 27, 2025

Recommended Motion:

"I MOVE APPROVAL OF THE ISK QUALITY IMPROVEMENT PROGRAM PLAN and ISK PERFORMANCE MEASUREMENT AND MANAGEMENT PLAN FOR FISCAL YEAR 2024/2025."

Summary of Request:

The Michigan Department of Health and Human Services (MDHHS) requires that each CMHSP is to have an annual Quality Improvement Program (QIP). CARF International requires an established Performance Measurement and Management Plan for each behavioral health organization accredited through CARF. The attached Quality Improvement Program and Plan and Performance Measurement and Management Plan meets the requirements for Integrated Services of Kalamazoo.

Budget:_____

Staff:_____

Date of Board Consideration: January 27, 2025