YEAR-END SUMMARY

October 1, 2023 - September 30, 2024

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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.

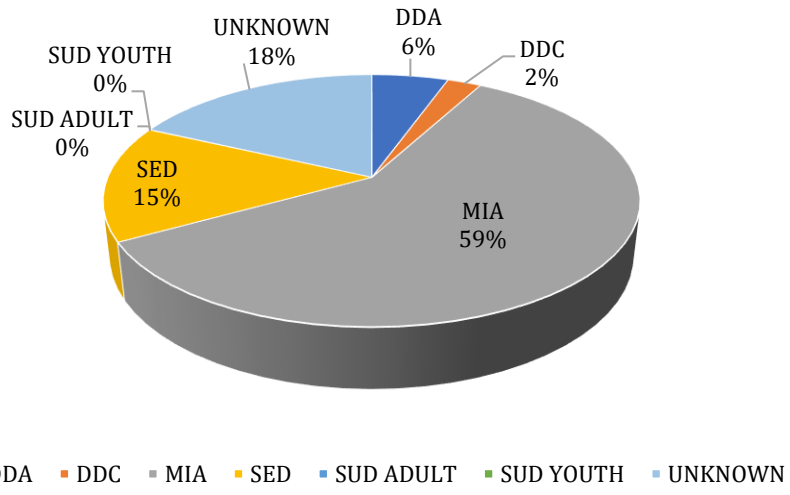
The **Guiding Values** of ISK are community, competence, diversity, effectiveness, integrity, leadership, recovery and self-determination, respect, responsibility, teamwork and trust.

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.

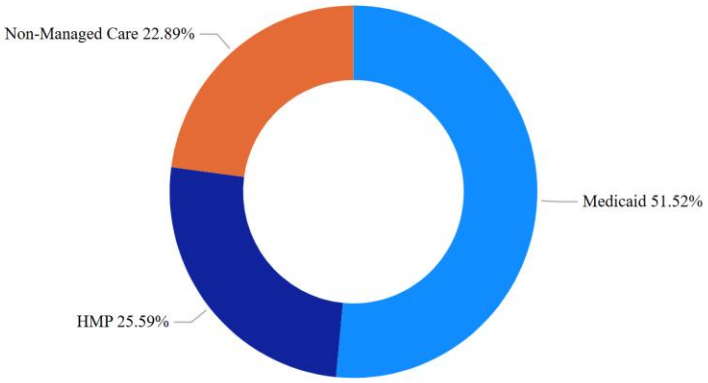
II. CCBHC DEMONSTRATION

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. 8,401 distinct individuals were provided with CCBHC services during FY24.

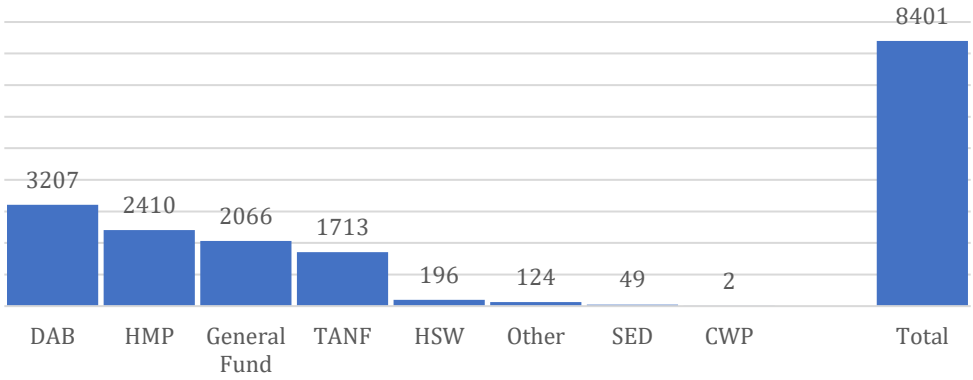
CCBHC SERVED BY POPULATION



Distinct CCBHC Persons Served by Funding Source

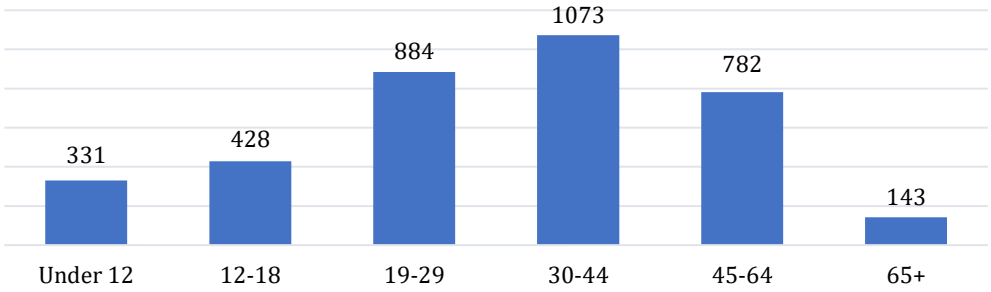


Distinct CCBHC Persons Served by EQI Population

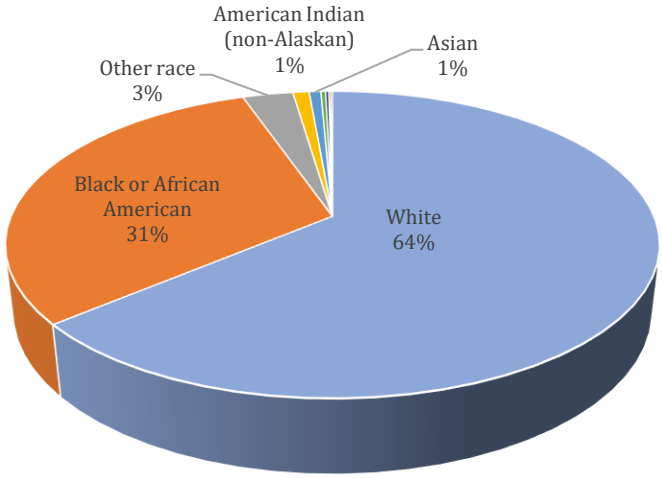


Through our CCBHC demonstration and grants, ISK has increased access to crisis services and routine requests to care through opening the Behavioral Health Urgent Care and Access Center. The Behavioral Health Urgent Care and Access Center maintains extended hours of Monday through Friday 8am-8pm, Saturday 9am-2pm for routine access hours and open 24 hours for crisis and emergency intervention. The data below represents the services provided to 3,641 individuals through the UCAC during FY24 October 1, 2023-September 30, 2024.

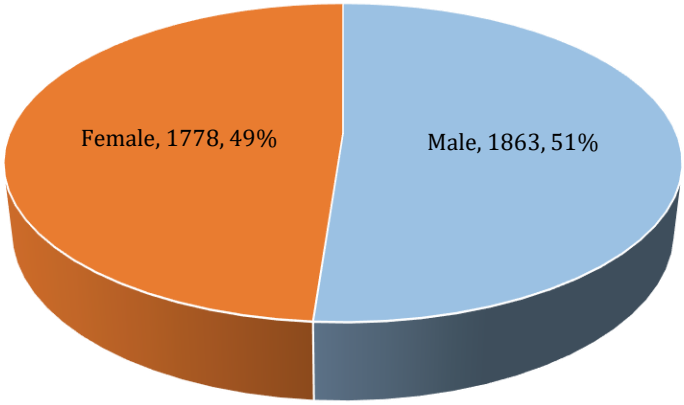
PERSONS SERVED BY AGE GROUP
ISK BEHAVIORAL HEALTH URGENT CARE AND ACCESS CENTER
10/01/2023 - 9/30/2024



PERSONS SERVED BY RACE
ISK BEHAVIORAL HEALTH URGENT CARE AND ACCESS CENTER
10/01/2023 - 9/30/2024



PERSONS SERVED BY SEX
ISK BEHAVIORAL HEALTH URGENT CARE AND ACCESS CENTER
10/01/2023 - 9/30/2024



III. DEMOGRAPHICS

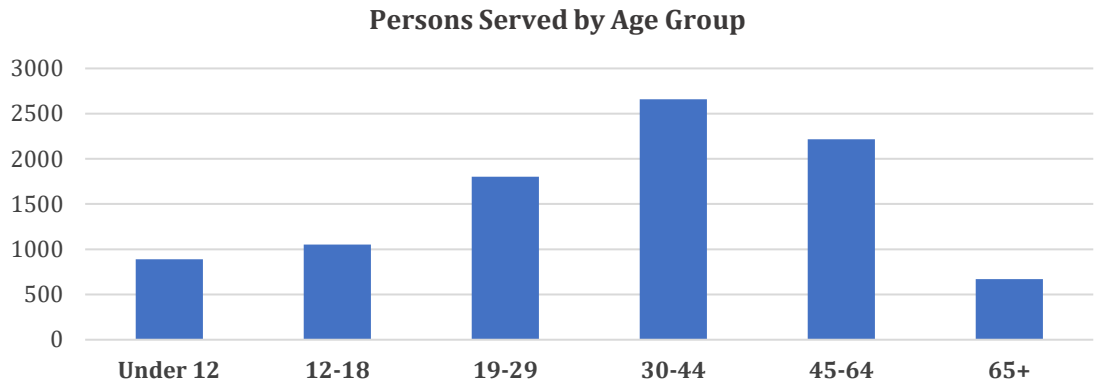
During FY 2023/24 (October 1, 2023 to September 30, 2024), ISK provided services to a total of 9,295 persons (unduplicated count), which is an increase compared to 7,925 individuals during FY 2022/23. These individuals were served directly by the ISK service programs and by a network of provider agencies 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 6,285 individuals through programs such as Psychiatric Services, Emergency Mental Health (EMH), Targeted Case Management, Outpatient therapy and Access/Intake. 172

individuals were served through our network of external providers only. A total of 2,838 individuals received services from both ISK direct operations and an external provider.

There were 3,346 individuals who were new to the network this fiscal year (never previously served) compared to 1,900 individuals who were new to the network during the previous fiscal year.

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

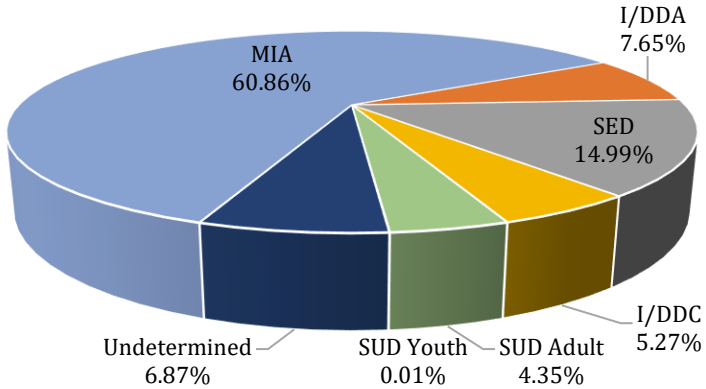


Following is a series of tables and charts, which provide a demographic breakdown of the persons served by ISK during FY 2023/24. The following tables demonstrate data that is sourced from completed MDHHS Treatment Episode Data Set (BH TEDS) and other demographic data sources. The total number of individuals who completed a BH TEDS during the fiscal year was 9,029.

A. Population Served by Persons Served

	FY 22/23 = 7,925		FY 23/24 = 9,295	
MIA	5025	63.41%	5657	60.86%
I/DDA	704	8.88%	711	7.65%
SED	1,338	16.88%	1393	14.99%
I/DDC	451	5.69%	490	5.27%
SUD Adult	6	0.08%	404	4.35%
SUD Youth	4	0.05%	1	0.01%
Undetermined	397	5.01%	639	6.87%

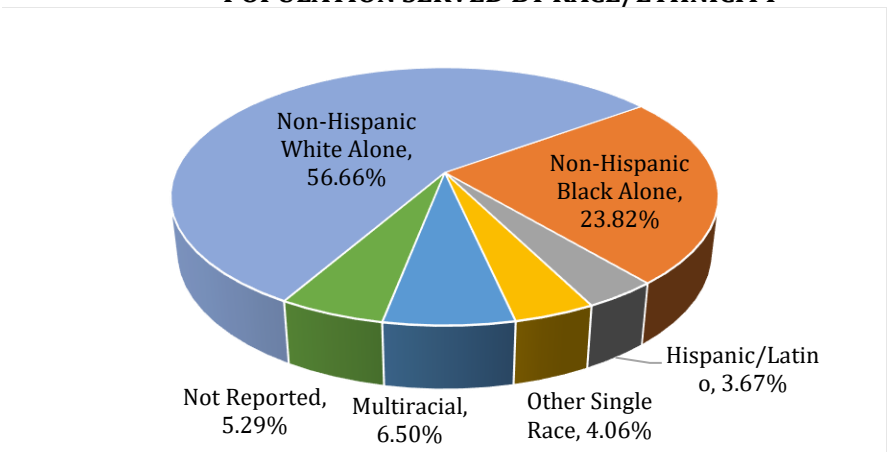
PERSONS SERVED BY POPULATION



B. Population Served by Race/Ethnicity

	FY 22/23 = 7,925		FY 23/24 = 9,295	
Non-Hispanic White alone	4,624	58.35%	5267	56.66%
Non-Hispanic Black/AA alone	1,853	23.38%	2214	23.83%
Hispanic/ Latino	460	5.80%	341	3.67%
Other single race	183	2.31%	377	4.06%
Multiracial	439	5.54%	604	6.50%
Not reported	366	4.62%	492	5.29%

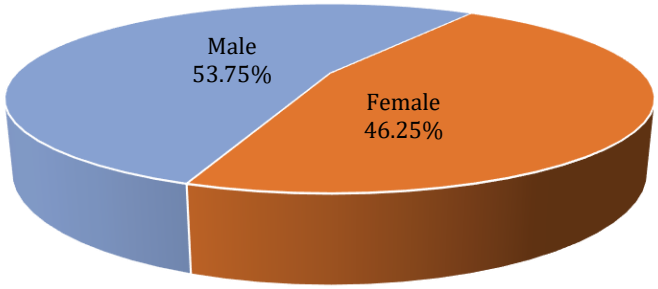
POPULATION SERVED BY RACE/ETHNICITY



C. Population Served by Sex

	FY 22/23 = 7,925		FY 23/24 = 9,295	
Male	4,338	54.74%	4,996	53.72%
Female	3,584	45.22%	4,299	46.28%
Other / Not Reported	3	0.04%	0	0%

POPULATION SERVED BY SEX



D. Special Populations Served

	Count of Persons Served	% of Total Population
Medicaid recipients	7,788	83.79%
Medicare recipients	1,907	20.51%
Uninsured individuals	1,005	10.81%
Criminal Justice system involved	821	8.83%
Homelessness self-reported	1,455	15.65%

	Count of Persons Served	% of Total Population
LGBTQ+ identity	823	8.85%
Veteran/active military	177	1.90%
Total service population	**9,295**	

IV. 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	2,369	39.09%
Substance Use Disorders	1,750	28.87%
PTSD and trauma	1,716	28.31%
Anxiety Disorders	1,423	23.48%
Bipolar Disorder	1,183	19.52%
Schizophrenia/Psychotic dis.	1,255	20.71%
Total service population	**6,061**	

SED Youth	Count of Persons Served	% of Total Population
PTSD and trauma	587	42.14%
ADHD	469	33.67%
Major Depressive Disorders	461	33.09%
Anxiety Disorders	318	22.83%
Substance Use Disorders	63	4.52%
Autism / Pervasive Development Disorder	35	2.51%
Bipolar Disorder	21	1.51%
Total service population	**1,393**	

IDD Adults	Count of Persons Served	% of Total Population
Mild Intellectual disability	320	45.01%
Moderate ID	206	28.97%
Autism / Pervasive Development Disorder	170	23.91%
Anxiety Disorders	108	15.19%
Major Depressive Disorder	86	12.10%
ADHD	55	7.74%
Severe/profound ID	88	12.38%
Schizophrenia/Psychotic dis.	53	7.45%
PTSD and trauma	30	4.22%
Bipolar Disorder	37	5.20%

IDD Adults	Count of Persons Served	% of Total Population
Chromosomal abnormality	43	6.05%
Cerebral palsy	39	5.49%
Sleep Disorders	1	0.14%
Total service population	**711**	

IDD Youth	Count of Persons Served	% of Total Population
Autism / Pervasive Development Disorder	307	62.65%
ADHD	76	15.51%
Mild Intellectual disability	57	11.63%
PTSD and trauma	51	10.41%
Anxiety Disorders	22	4.49%
Major Depressive Disorder	11	2.24%
Moderate ID	16	3.27%
Severe/profound ID	8	1.63%
Total service population	**490**	

B. CCBHC Clinic-Reported Quality Performance Measures

Unlike traditional service organizations that operate differently in each state or community, CCBHCs are required to meet established and standardized criteria related to care coordination, crisis response and service delivery, and to be evaluated by a common set of quality measures. CCBHCs must collect and report on CCBHC-reported performance metrics identified in the MDHHS CCBHC Handbook Section 7.A.1 CCBHC Reported Measures annually. CCBHCs must meet the minimum numerator and denominator requirements (N=5, D=30) for the calculation of a Quality Bonus Payment (QBP) measure for it to be included in the determination and eligible for the award. If performance benchmarks are met, MDHHS will provide the QBP payment to the PIHP for distribution to the awarded CCBHC(s). CCBHCs are eligible to receive 5% of the clinic's annual Medicaid costs (defined as the reported Medicaid daily visits x demonstration year PPS rate). Each measure is weighted, and the portion of the QBP awarded for each measure is listed in Appendix F of the CCBHC Handbook. For measures with sub-measures, CCBHCs must meet the benchmark for each sub-measure in order to receive payment related to the overall measure. If a CCBHC does not meet benchmarks for QBP measures, the potential distribution amount will be added to a redistribution pool.

CCBHC Reported Measures (FY24)

Measure Name and Designated Abbreviation	Steward	Required Measure or State Added
Time to Services (I-SERV)*	SAMHSA	Required
Depression Remission at Six Months (DEP-REM-6) *	MN Community Measurement	Required
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	NCQA	Required
Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)	CMS	Required
Screening for Social Drivers of Health (SDOH)	CMS	Required
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	NCQA	State Added

Adult Major Depressive Disorder: Suicide Risk Assessment (SRA-A) *	Mathematica	State Added
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-C) *	Mathematica	State Added
Patient Experience of Care Survey	SAMHSA	Required
Youth/Family Experience of Care Survey	SAMHSA	Required

*Denotes a measure that is also a quality bonus payment measure

CCBHC State Reported Measures (FY24)

Measure Name and Designated Abbreviation	Steward	Required Measure or State Added
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	CMS	Required
Follow-Up After Hospitalization for Mental Illness, (FUH-CH) (FUH-AD)*	NCQA	Required
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)*	NCQA	Required
Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD)	NCQA	Required
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)	NCQA	Required
Plan All-Cause Readmissions Rate (PCR-AD)*	NCQA	Required
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)	NCQA	Required
Antidepressant Medication Management (AMM-BH)	NCQA	Required
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	CMS	Required
Glycemic Status Assessment for Patients with Diabetes (GSD-AD)*	NCQA	Required
Child and Adolescent Well-Care Visits (WCV-CH)	NCQA	State Added

*Denotes a measure that is also a quality bonus payment measure

FY24 Quality Bonus Payment Performance Results

Measure	Numerator	Denominator	Rate	Benchmark	Benchmark Met
FUH-30AD	320	456	0.70	**0.58**	TRUE
FUH-30CH	58	67	0.87	**0.7**	TRUE
IET14-TOT	215	515	0.42	**0.25**	TRUE
SAA-AD	170	323	0.53	**0.585**	FALSE
SRA-BH-C	1171	1502	0.78	**0.239**	TRUE
SRA-A	1111	1385	0.80	**0.125**	TRUE

V. 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 629 survey interviews were completed (children under age 18 and adults). The following graphs display the "percentage in agreement" by survey and domain for survey respondents from October 1, 2023-September 30, 2024:

Mental Health Statistics Improvement Plan (MHSIP)
Satisfaction Survey
n = 531 (421 completed, 110 partial completion)

Satisfaction

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Does not apply	Responses
I like the services that I received here. Count Row %	304 66.7%	88 19.3%	30 6.6%	23 5.0%	11 2.4%	456
Totals Total Responses						456

Satisfaction and Access

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Does not apply	Responses
If I had other choices, I would still get services from this agency. Count Row %	287 62.0%	105 22.7%	21 4.5%	37 8.0%	13 2.8%	463
I would recommend this agency to a friend or family member. Count Row %	314 67.8%	92 19.9%	21 4.5%	29 6.3%	7 1.5%	463
Staff were willing to see me as often as my treatment plan stated. Count Row %	330 71.3%	68 14.7%	25 5.4%	15 3.2%	25 5.4%	463
Staff returned my calls within 1 business day. Count Row %	251 54.2%	98 21.2%	36 7.8%	39 8.4%	39 8.4%	463
I was able to get urgent support within 3 hours. Count Row %	165 35.6%	78 16.8%	30 6.5%	39 8.4%	151 32.6%	463
Totals Total Responses						463

Access and Quality Appropriateness & Participation

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Does not apply	Responses
Services were available at times that were good for me. Count Row %	304 65.7%	91 19.7%	38 8.2%	18 3.9%	12 2.6%	463
I was able to get every service that my provider and I decided I should get. Count Row %	278 60.0%	94 20.3%	34 7.3%	32 6.9%	25 5.4%	463
I was not afraid to ask questions about my treatment and medication. Count Row %	359 77.5%	55 11.9%	20 4.3%	15 3.2%	14 3.0%	463
I was given information about my rights. Count Row %	378 81.6%	60 13.0%	5 1.1%	9 1.9%	11 2.4%	463
Staff encouraged me to take responsibility for how I live my life. Count Row %	291 62.9%	88 19.0%	21 4.5%	14 3.0%	49 10.6%	463
Totals Total Responses						463

Quality-Appropritateness & Participation and Outcomes & Functioning

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Does not apply	Responses
Staff respected my wishes about who should or should not be given information about my treatment. Count Row %	376 81.2%	45 9.7%	6 1.3%	10 2.2%	26 5.6%	463
I, not staff, decided my treatment goals. Count Row %	298 64.4%	98 21.2%	22 4.8%	21 4.5%	24 5.2%	463
Staff were sensitive to my cultural background (race, religion, language, etc.) Count Row %	318 68.7%	54 11.7%	13 2.8%	10 2.2%	68 14.7%	463
Staff helped me get the information I needed (programs, side effects, etc.) so that I could take charge of managing my illness. Count Row %	287 62.0%	99 21.4%	25 5.4%	24 5.2%	28 6.0%	463
Because of the help I received, I can better handle my daily problems. Count Row %	259 55.9%	119 25.7%	25 5.4%	33 7.1%	27 5.8%	463
Totals Total Responses						463

Outcomes & Functioning

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Does not apply	Responses
Because of the help I received, I do better in social situations. Count Row %	220 47.5%	129 27.9%	43 9.3%	37 8.0%	34 7.3%	463
Because of the help I received, I do better in school and/or work. Count Row %	174 37.6%	99 21.4%	35 7.6%	39 8.4%	116 25.1%	463
Because of the help I received, my symptoms are not bothering me as much. Count Row %	176 38.0%	160 34.6%	52 11.2%	43 9.3%	32 6.9%	463
Because of the help I received, I am better able to take care of my needs. Count Row %	220 47.5%	145 31.3%	30 6.5%	36 7.8%	32 6.9%	463
Because of the help I received, I am better able to handle things when they go wrong. Count Row %	209 45.1%	141 30.5%	40 8.6%	42 9.1%	31 6.7%	463
Because of the help I received, I am better able to do things that I want to do. Count Row %	212 45.8%	150 32.4%	40 8.6%	37 8.0%	24 5.2%	463
Totals Total Responses						463

Social Connectedness

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Does not apply	Responses
I have people with whom I can do enjoyable things. Count Row %	273 59.0%	122 26.3%	26 5.6%	31 6.7%	11 2.4%	463
I have the support I need from family or friends. Count Row %	246 53.1%	138 29.8%	36 7.8%	35 7.6%	8 1.7%	463
Totals Total Responses						463

Youth Services Survey for Families (YSS)
Satisfaction Survey
n = 189 (160 completed, 29 partial completion)

Satisfaction & Appropriateness

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Not applicable	Responses
Overall, I am satisfied with the services my child received. Count Row %	95 55.9%	49 28.8%	12 7.1%	10 5.9%	4 2.4%	170
Totals Total Responses						170

Satisfaction & Appropriateness and Participation in Treatment

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Does not apply	Responses
The people helping my child stuck with us no matter what. Count Row %	104 61.2%	34 20.0%	10 5.9%	11 6.5%	11 6.5%	170
I felt my child had someone to talk with when they were troubled. Count Row %	75 44.1%	41 24.1%	12 7.1%	9 5.3%	33 19.4%	170
The services my child and/or family received were right for us. Count Row %	89 52.4%	49 28.8%	15 8.8%	12 7.1%	5 2.9%	170
My family got as much help as we needed for my child. Count Row %	71 41.8%	59 34.7%	18 10.6%	17 10.0%	5 2.9%	170
I helped to choose my child's services. Count Row %	97 57.1%	45 26.5%	13 7.6%	7 4.1%	8 4.7%	170
Totals Total Responses						170

Participation in Treatment and Access

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Does not apply	Responses
I helped to choose my child's treatment goals. Count Row %	113 66.5%	35 20.6%	6 3.5%	6 3.5%	10 5.9%	170
I participated in my child's treatment. Count Row %	129 75.9%	27 15.9%	2 1.2%	2 1.2%	10 5.9%	170
Staff were willing to see my child as often as their treatment plan stated. Count Row %	109 64.1%	30 17.6%	11 6.5%	5 2.9%	15 8.8%	170
Staff returned our calls within 1 business day. Count Row %	98 57.6%	36 21.2%	7 4.1%	12 7.1%	17 10.0%	170
Services were available at times that were good for us. Count Row %	94 55.3%	47 27.6%	13 7.6%	6 3.5%	10 5.9%	170
Totals Total Responses						170

Access and Cultural Sensitivity

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Does not apply	Responses
My child was able to get every type of service that their provider said they should. Count Row %	86 50.6%	45 26.5%	13 7.6%	11 6.5%	15 8.8%	170
My child was able to get urgent treatment as soon as they needed. Count Row %	64 37.6%	35 20.6%	10 5.9%	14 8.2%	47 27.6%	170
Staff were sensitive to my cultural/ethnic background. Count Row %	87 51.2%	20 11.8%	4 2.4%	6 3.5%	53 31.2%	170
Staff respected my family's religious/spiritual beliefs. Count Row %	91 53.5%	19 11.2%	3 1.8%	2 1.2%	55 32.4%	170
Staff spoke with me in a way that I understood. Count Row %	140 82.4%	23 13.5%	2 1.2%	1 0.6%	4 2.4%	170
Totals Total Responses						170

Outcomes

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Does not apply	Responses
Because of the help my child and/or family received, my child is better at handling daily life. Count Row %	75 44.1%	60 35.3%	10 5.9%	12 7.1%	13 7.6%	170
Because of the help my child and/or family received, my child gets along better with family members. Count Row %	61 36.1%	64 37.9%	11 6.5%	14 8.3%	19 11.2%	169
Because of the help my child and/or family received, my child is doing better in school or work. Count Row %	68 40.0%	57 33.5%	14 8.2%	11 6.5%	20 11.8%	170
Because of the help my child and/or family received, my child is better able to cope when things go wrong. Count Row %	51 30.0%	68 40.0%	22 12.9%	11 6.5%	18 10.6%	170
Because of the help my child and/or family received, my child is better able to do things they want to do. Count Row %	63 37.1%	69 40.6%	16 9.4%	8 4.7%	14 8.2%	170
Totals Total Responses						170

Parent Social Connectedness

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Does not apply	Responses
Because of the help my child and/or family received, I know people who will listen and understand me when I need to talk. Count Row %	79 46.5%	52 30.6%	14 8.2%	9 5.3%	16 9.4%	170
Because of the help my child and/or family received, I have people I am comfortable talking with about my child's problems. Count Row %	81 47.6%	51 30.0%	12 7.1%	8 4.7%	18 10.6%	170
Totals Total Responses						170

Feedback collected from these surveys are 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.

VI. 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. A total of 132 individual locations/sites were reviewed during FY24.

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 2023/24 QMR scores demonstrated improvement in 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 83 external provider and ISK programs were reviewed in FY24. 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 23/24 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.

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.

The completion of the QRR process is 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.

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.

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.

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.

*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".*

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 22/23 and FY 23/24:

Nature of Incident	Critical Incidents 2022/23	2023/24
Medication Issues	0	0
Health & Safety Issues	41	55
Behavioral / Social Issues	14	8
Non-Violent Practices	29	
Deaths	45	75
Other Issues	0	
TOTALS	**129**	**129**

In accordance with ISK Incident, Event and Death Reporting policy, FY23/24 deaths of persons served that were classified as Sentinel Events demonstrated the following manner of death:

Manner of Death	FY 22/23	FY 23/24
Suicide	2	2
Homicide	1	
Accidental / Unexpected	16	18
TOTALS	**20**	**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 as needed during FY 2023/24 to review and approve the credentialing of individuals and provider agencies.

F. 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 2023/24, ISK Customer Services Office processed the following:

	Medicaid	**Non-Medicaid**
Local Appeals	9	1
Access 2nd Opinions	0	0
Hospital 2nd Opinions	0	0
Administrative Medicaid (Fair) Hearings	2	
MDHHS Alternative Dispute Resolution Process		0
Grievances	10	2
Totals	**21**	**3**

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.

VII. PERFORMANCE MEASUREMENT

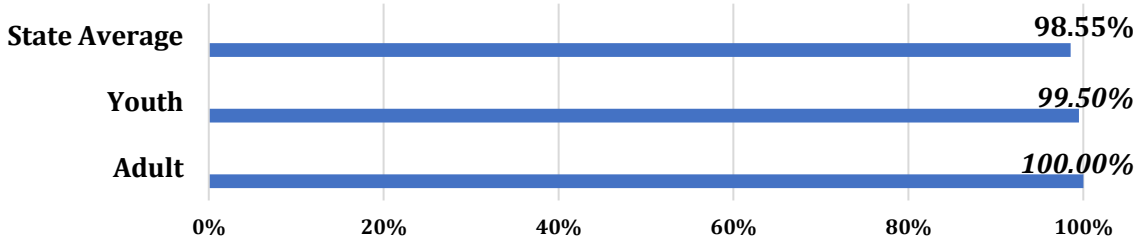
A. Performance Indicators

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.

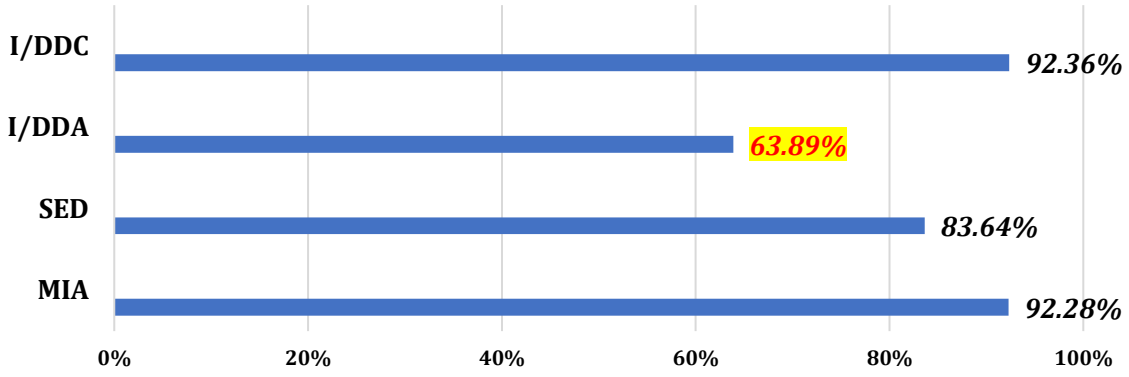
The Data Integrity Monitoring Team (DIMT) reviews the quality of the data obtained and reported. DIMT and IQIC review the results and trends of performance in the various service areas of the organization. The teams identify deficits in specific areas, determine trends and develop strategies for improvement. 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:

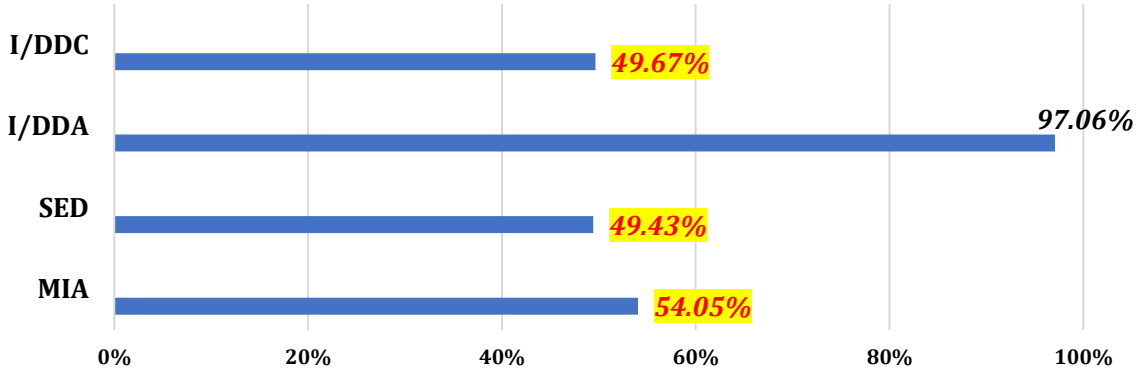
Persons receiving a Pre-Admission Screening for Psychiatriac Inpatient Care for whom the disposition was completed within 3 hours (Goal 95%)

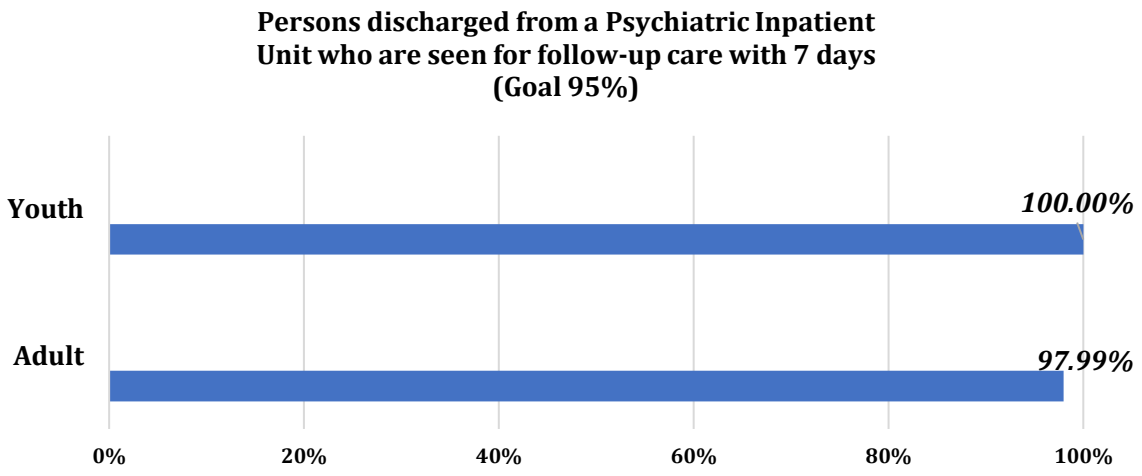


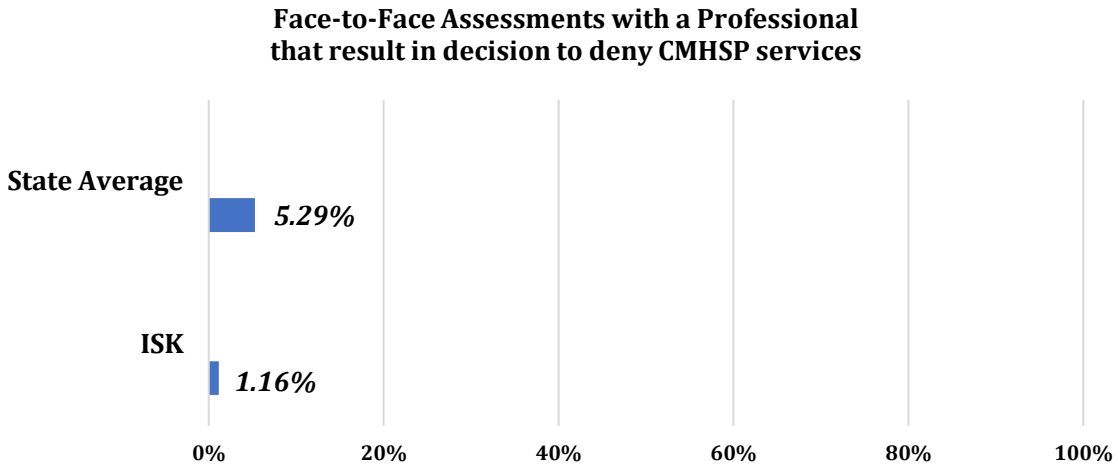
New persons receiving a completed Biopsychosocial Assessment within 14 calendar days of a non-emergency request for service

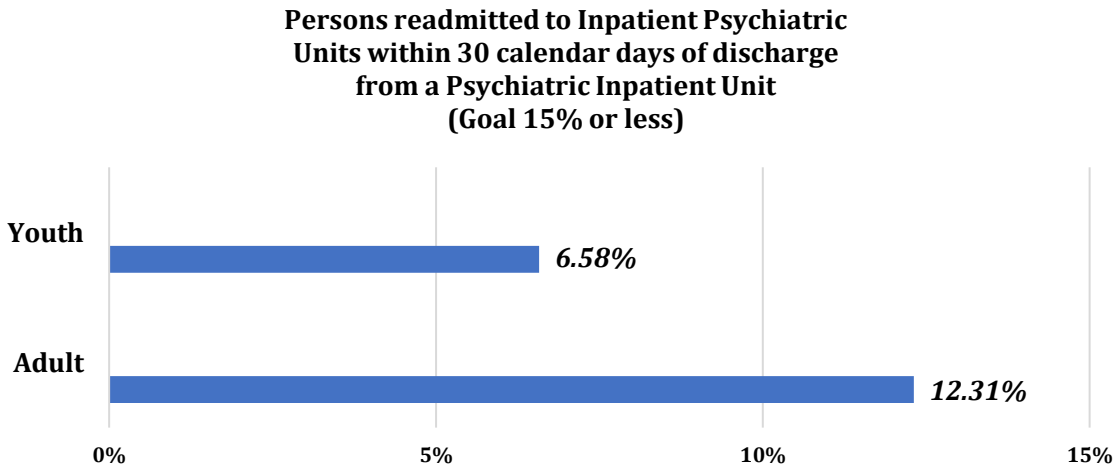


New persons starting any needed on-going service within 14 days of completing a non-emergent Biopsychosocial Assessment









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.

VIII. QUALITY IMPROVEMENT INITIATIVES

A. 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 2023/24 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 2. Ensure knowledge of current accreditation standards and changes within the CARF manual.	1. Completed 2. ISK CARF team has reviewed standards manual for 2024 that will be used for 2025 accreditation survey. Initial meeting have been held with Admin and Service/Program teams with noted standard changes. Updated show-proof worksheets are available to Admin and Service/Program teams for review and updating. ISK has confirmed few changes in the Services/Programs to be reviewed to reflect current programs within the agency. All improvement efforts from 2022 CARF accreditation survey have been implemented. Goal for ISK in 2025 survey: 1. No repeat recommendations 2. Fewer number of recommendations than the 28 received in 2022 survey.

Goals	Objectives / Action Steps	Status
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 updates are provided to the committee every 2 months. Quality Measures are reviewed quarterly and ISK continued to meet the adherence to antipsychotic medications but is meeting the remaining measures. 2. ISK received full certification for another three years.
3. Further promote cultural competency, equity, inclusion, and trauma informed approaches to respond to the needs of persons served, workforce and the community.	As facilitated, monitored, and implemented through JETT: 1. Enhance training for staff to include concepts of historical/racial trauma and resilience-oriented principles 2. Increase and enhance organization's ability to prevent, identify and appropriately respond to workforce concerns/ stressors 3. Educate ourselves on equity principles and apply those principles on the activities of training, hiring and self-care 4. Develop, adopt, and implement FY24 JETT Workplan which shall serve as the organization's Cultural Competency & Diversity Plan	1. Committee updates and projects are reported to the committee every 2 months. 2. Trauma Committee is reviewing trauma training requirements and working on organizational self-review tool for trauma • JETT members presented on Staff Wellbeing at the ISK All Staff meeting • JETT is continuing to offer equity reviews • The Infinity groups continue to host "function learns" • Training committee is working on developing a model for additional brief engaging trainings on equity topics • JETT is continuing to work thru and monitor FY 24 Plan • Equity Review Group lost a co-lead/member
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. A T1040 monitoring dashboard has been developed. It summarizes the CCBHC per diem by funding source and Mild/Moderate vs not. One can compare fiscal years, measure against goals. It shows monthly trends.

Attachments:
FY24 Board Ends Dashboard
FY24 Performance Measurement and Management Plan