QUALITY IMPROVEMENT PROGRAM & PLAN

PERFORMANCE MEASUREMENT AND MANAGEMENT PLAN

FISCAL YEAR 2025/26

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 2025/26. 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

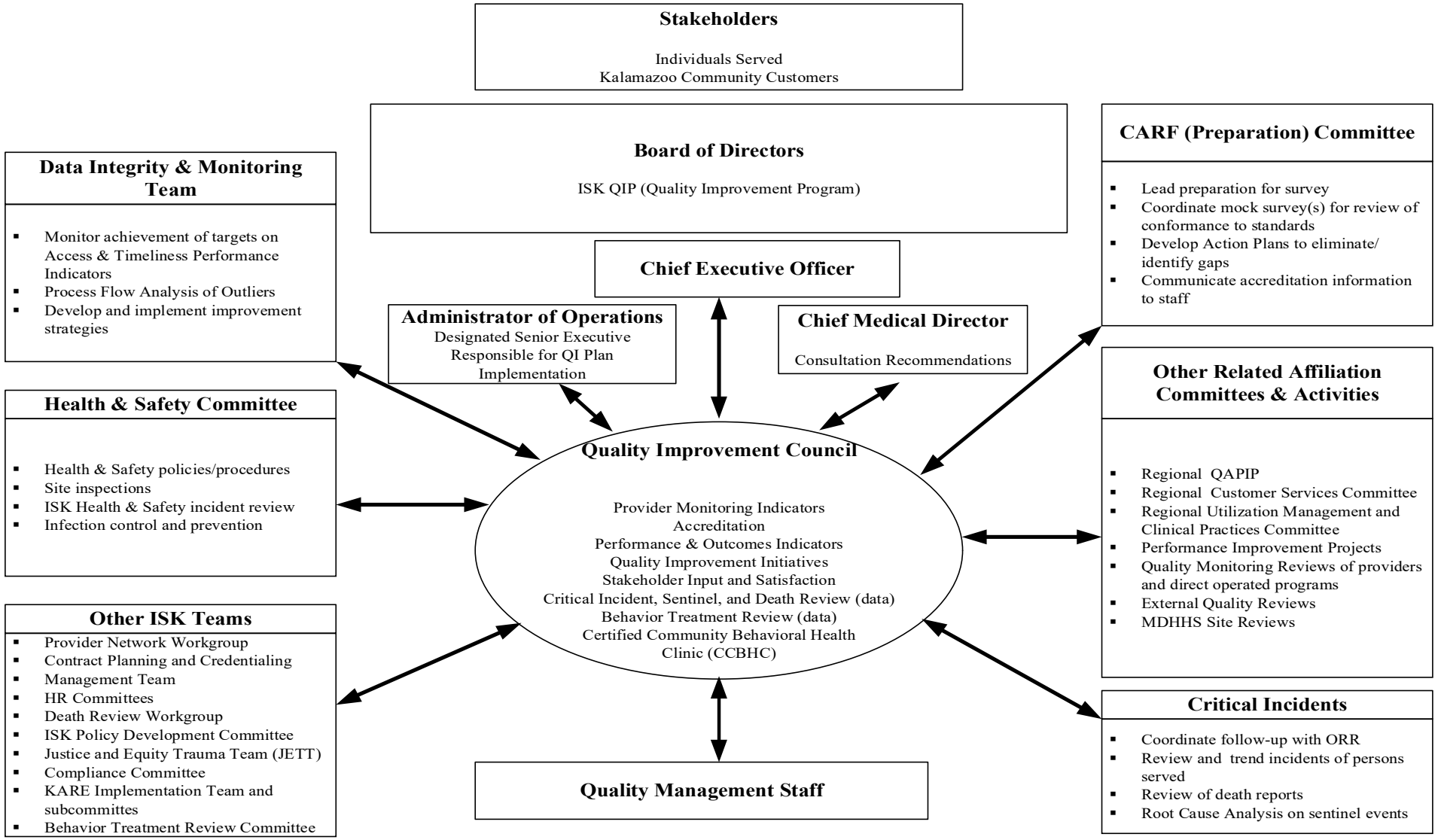
Values

- 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 member of ISK executive leadership 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 Equity 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.

In accordance with the MDHHS CCBHC Handbook, ISK must collect, report, and track outcome and quality data, including but not limited to data capturing:

- CCBHC recipient characteristics
- Staffing
- Access to Services
- Use of Services
- Screening, prevention, and treatment
- Care coordination
- Sentinel Events
- Sentinel Event Mortality Reviews
- Other processes of care
- Costs
- CCBHC recipient outcomes
- Financial reporting requirements (i.e. Financial Status Reports, the Encounter Quality Initiative, and Standard Cost Allocation) will follow MDHHS guidance released by the accounting and actuarial areas.

ISK will specifically review and addresses the following as part of the Quality Improvement Plan process:

1. CCBHC individuals sentinel events, including suicide deaths or suicide attempts
2. Fatal and non-fatal overdoses
3. All cause mortality among people receiving CCBHC services, including sentinel event mortality reviews.
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.

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, The Michigan Department of Health and Human Services (MDHHS) requires CCBHC Demonstration sites to report, review, investigate, and act upon sentinel events for persons receiving CCBHC services. For CCBHC reporting purposes, a sentinel event is defined by any unexpected occurrence involving death of a person served. These event types are classified as follows, non-suicide death, death of unknown cause, suicide, natural causes, overdose death, homicide and accidental. If applicable to the event the CCBHC should also provide the Death Determination: suspected suicide/overdose or death determination-best judgement.

CCBHC sites will submit semi-annual aggregate data to the CCBHC mailbox by event type for number of sentinel events and plans of action or interventions which occurred during the 6-month period. Please see

the chart below for the reporting date periods and due dates. MDHHS will review all sentinel event reports to determine if any quality improvement needs to take place.

As a CCBHC, ISK must develop and maintain mortality review processes for the review and follow-up of sentinel events for CCBHC persons served. These processes must be made available to MDHHS upon request.

1. At a minimum, sentinel events must be reviewed and acted upon as appropriate, with root cause analyses to commence within two business days of knowledge of the sentinel event.
2. Staff involved in reviewing and analyzing the sentinel event must have the appropriate credentials to review the scope of care (e.g. a physician or nurse).
3. Documentation of the mortality review process, findings, and recommendations must be maintained.
4. Use of mortality information to address quality of care must occur through the CCBHC Quality Improvement Committee's Continuous Quality Improvement (CQI) Plan.
5. Aggregation of mortality data over time to identify possible trends must be maintained.
6. Mortality review documentation must be available to MDHHS upon request.

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. The Plan will be updated as necessary. The analysis of service delivery performance will address service delivery indicators for each program/service seeking accreditation, including results achieved for the individuals served, and is used to identify areas needing performance improvement, developing an action plan(s) to address the improvements needed, implementing the action plan(s), and determining whether the actions taken accomplished the intended results.

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 2025/26

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

The following pages outline the specific quality improvement goals/objectives for 2025/26:

#	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. CCBHC Quality Measures c. Encounters status d. BH TEDS 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.	1. Completion of performance review as evidenced by IQIC meeting minutes. 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 9/30/2026.
2.	Ensure effective implementation of Certified Community Behavioral Health Clinic (CCBHC) state demonstration, inclusive of the transition of CCBHC Direct Payment methodology with MDHHS.	2. Meet MDHHS incentive thresholds for all Quality Bonus Payment (QBP) metrics 3. Ensure that CCBHC implementation, outreach and engagement efforts are effectively expanding access to services.	1. Report and review QBP metrics during IQIC committee meeting at least annually. Trending and analysis of QBP metrics completed within CCBHC subgroups. a. QBP metrics meet established standards each reporting period. 2. Continue to analyze and 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 FY26 workplan strategies: 1. Excellent and transparent communicators, both internally and externally, providing timely, proactive, and transparent communication. 2. Hospitable – Supporting persons served and our staff in honorable spaces (trauma informed and welcoming spaces) 3. Invested in growth (capacity and trainings) and development of our workforce and leaders	JETT representative will provide status update to IQIC on progress and barriers to the FY26 JETT Workplan at least every 6 months. FY26 Workplan will be successfully implemented through the ISK JETT committee as demonstrated by achieving goals and related measures by 9/30/2026.
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	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.

#	GOALS	OBJECTIVES / ACTION STEPS	Attachment A MEASURES/TIMETABLE
		b. Department and staff level tracking of billable service	2. Number of grants or amount of additional revenues obtained through grant awards per fiscal year.
5.	To be active listeners to our diverse community needs and responsive to stakeholder feedback for continuous quality improvement.	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. 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.	1. Reportable events are submitted to SWMBH monthly as required. 2. Reportable events are submitted to MDHHS CCBHC as required 3. Trends and analysis of events are reviewed at each IQIC meeting, including improvement efforts to address any negative findings. 4. Trending of death review data, including mortality review findings, will be presented to IQIC at least annually.