INTEGRATED Services of Kalamazoo
Community • Independence • Empowerment

Jeffrey W. Patton
Chief Executive Officer
www.iskzoo.org
(269) 553-8000
Administrative Services
610 South Burdick Street
Kalamazoo, MI 49007

24-HOUR CRISIS HOTLINE or NON-EMERGENCY CLINICAL SERVICES: (269) 373-6000

AGENDA

April 27, 2026

Name: INTEGRATED Services of Kalamazoo Board of Directors
Location: 610 South Burdick Street/Kalamazoo, MI., 2nd Floor
ISK Boardroom #220
Commencement Time: *4:30PM*

I. CALL TO ORDER – CITY & COUNTY DECLARATION
II. AGENDA

V. CONSENT CALENDAR/VERBAL MOTION
Given the importance and time-sensitive nature of this matter, the Chair recommends moving this item earlier on the agenda.

a. Minutes *March 23, 2026*
b. Board Committee Principles (11.05)(Policy)
c. Chairperson's Role (II.04)(Policy)
d. Net Position Management (VI.05)(Policy)
e. Annual Leave Reserve (VI.01) (Policy & Report)
f. Treatment of Persons Served w/Substantiated Complaints (Report)
g. Customer Services (Report)

VII. FINANCIAL REPORTS
Given the importance and time-sensitive nature of this matter, the Chair recommends moving this item earlier on the agenda.

a. Financial Condition Report
b. Utilization Report
c. Investment Report
d. March 2026 Disbursement/MOTION

III. CITIZEN TIME

IV. RECIPIENT RIGHTS
a. Recipient Rights Monthly Report

V. CONSENT CALENDAR/VERBAL MOTION- MOVED UP ON THE AGENDA
a. Minutes *March 23, 2026*
b. Board Committee Principles (11.05)(Policy)
c. Chairperson's Role (II.04)(Policy)
d. Net Position Management (VI.05)(Policy)
e. Annual Leave Reserve (VI.01) (Policy & Report)
f. Treatment of Persons Served w/Substantiated Complaints (Report)
g. Customer Services (Report)

VI. MONITORING REPORTS
a. Year-End Report & Ends (ALL POPULATIONS) Warwick Barlow
b. Compliance & Risk: BOARD TRAINING (Report)
c. Compliance & Risk: STATUS (Report)

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VII. FINANCIAL REPORTS - MOVED UP ON THE AGENDA
- a. Financial Condition Report
- b. Utilization Report
- c. Investment Report
- d. March 2026 Disbursement/MOTION

VIII. CHIEF EXECUTIVE OFFICER VERBAL REPORT
- a. CLOSED SESSION – Personnel Evaluation/ROLL CALL MOTION
- b. Approval to combine the Annual & Budget Public Hearings in September 2026.

IX. CITIZEN TIME

X. ACKNOWLEDGEMENT of MERITORIOUS STATUS
- a. *Mr. Charles Thomas*, Retired from ISK after 26 years of service!
- b. *Mr. James "Jim" Jump*, Retired from ISK after 14 years of service!

XI. BOARD MEMBER TIME
- a. Appointment of Nominating Committee for ISK Board Officers/Karen Longanecker
- b. SWMBH (Southwest Michigan Behavioral Health) Updates/Michael Seals

XII. ADJOURNMENT

IV.a.

Office of Recipient Rights
Report to the Mental Health Board
On Complaints/Allegations
Closed in: March 2026

Office of Recipient Rights Report to the Mental Health Board
Complaints/Allegations Closed in March 2026

	March 2026	FY 25-26	March 2025	FY 24-25
Total # of Complaints Closed	**46**	**241**	**32**	**201**
Total # of Allegations Closed	**65**	**323**	**47**	**329**
Total # of Allegations Substantiated	**24**	**127**	**13**	**99**

The data below represents the total number of closed allegations and 4substantiations for the following categories: **Consumer Safety, Dignity/Respect of Consumer, Treatment Issues, and Abuse/Neglect.**

ALLEGATIONS	**March 2026**		**March 2025**	
Category	**TOTAL**	**SUBSTANTIATED**	**TOTAL**	**SUBSTANTIATED**
Consumer Safety	1	0	1	1
Dignity/Respect of Consumer	13	8	9	2
Treatment Issues/Suitable Services (Including Person Centered Planning)	21	2	8	2
Abuse I	0	0	0	0
Abuse II	6	2	0	0
Abuse III	6	2	5	2
Neglect I	0	0	0	0
Neglect II	3	3	0	0
Neglect III	7	4	6	4
	57	**21**	**29**	**11**

APPEALS	**March 2026**	**FY 25-26**	**March 2025**	**FY 24-25**
Uphold Investigative Findings & Plan of Action	2	4	0	1
Return Investigation to ORR; Reopen or Reinvestigate	0	0	0	1
Uphold Investigative Findings but Recommend Respondent Take Additional or Different Action to Remedy the Violation	0	0	0	1
Request an External Investigation by the State ORR	0	0	0	0

ABUSE AND NEGLECT DEFINITIONS – SUMMARIZED

Abuse Class I means serious injury to the recipient by staff. Also, sexual contact between a staff and a recipient.
Abuse Class II means non-serious injury or exploitation to the recipient by staff and includes using unreasonable force, even if no injury results.
Abuse Class III means communication by staff to a recipient that is threatening or degrading. (such as; putting down, making fun of, insulting)
Neglect Class I means a serious injury occurred because a staff person DID NOT do something he or she should have done (an omission). It also includes failure to report apparent or suspected abuse I or neglect I of a recipient.
Neglect Class II means a non-serious injury occurred to a recipient because a staff person DID NOT do something he or she should have done (an omission). It also includes failure to report apparent or suspected abuse II or neglect II of a recipient
Neglect Class III means a recipient was put at risk of physical harm or sexual abuse because a staff person DID NOT do something he or she should have done per rule or guideline. It also includes failure to report apparent or suspected abuse III or neglect III of a recipient.

ORR ADDENDUM TO MH BOARD REPORT
April 2026

Re: March 2026 Abuse/Neglect Violations

March

Abuse Violations

- There were two substantiated Abuse II violations in March 2026.
    - The remedial actions for these violations were Contract Action (1), Written Reprimand (1), and Training (1).
- There were two substantiated Abuse III violations in March 2026.
    - The remedial actions for these violations were Employment Termination (1), Written Reprimand (1), and Training (1).

Neglect Violations

- There were three substantiated Neglect II violations in March 2026. Two of the violations were Neglect II, Failure to Report violations.
    - The remedial actions for these violations were Employment Termination (2), Written Reprimand (3), and Training (2). There were 2 staff involved in 2 of the violations.

      Two of the 3 violations occurred at the same agency and program site. One of which was a Failure to Report violation.
- There were four substantiated Neglect III violations in March 2026.
    - The remedial actions for these violations were Employee left agency (1), Written Reprimand (3), Training (3), and Policy/Revision Development (1).

      The 4 violations occurred at the different agencies.

All of the ORR case information is forwarded to the ISK Population Directors on a monthly basis for any tracking/trending of the RR information in their areas of authority. *(Agencies can include ISK).

INTEGRATED Services of Kalamazoo

Community • Independence • Empowerment

INTEGRATED Services of Kalamazoo (*ISK*) Board of Director's Meeting

INTEGRATED Services of Kalamazoo
610 South Burdick Street
Kalamazoo MI 49007

March 23, 2026 V.a.

ISK Board Member	Board Members PRESENT	Declaration of Location City/County	Board Members ABSENT
Karen Longanecker, *CHAIR*	X	Kalamazoo/Kalamazoo	
Michael Seals, *VICE CHAIR*	X	Kalamazoo/Kalamazoo	
Nkenge Bergan	X	Kalamazoo/Kalamazoo	
Catherine Huynh			X
Patrick Dolly			X
Pat Guenther	X	Kalamazoo/Kalamazoo	
Ramona Lumpkin	X	Kalamazoo/Kalamazoo	
Michael Raphelson	X	Kalamazoo/Kalamazoo	
Melissa Woosley	X	Kalamazoo/Kalamazoo	
Abigail Wheeler, *COMMISSIONER*	X	Kalamazoo/Kalamazoo	

ISK - Staff Present:
Jeff Patton, *CEO*
Beth Ann Meints
Sheila Hibbs
Charlotte Bowser
Wanda Brown
Chantel Graham
Nancy McDonald
Amy Rottman
Dianne Shaffer
Ed Sova
Michael Schlack, *Corporate Counsel*
Alecia Pollard
Demeta Wallace, *Board Liaison*

Guests Present:
Jodi Best
Sarah (Spears) Huff
Shenetta Coleman, CEO/ROI
Sean Harris, CEO/Recovery Institute
Diane Marquess, CEO/FCS
Fiorella Spalvieri, CEO/CLO

Call to Order

The Board of Directors (Integrated Services of Kalamazoo) held their meeting on *Monday, March 23, 2026*. It began @ 4:30PM and was presided over by the Chair, *Karen Longanecker.*

Resolution Honoring the Service, Life & Legacy of *Ms. Sharon Marie Spears*
This resolution was adopted without restriction and with full support from the ISK Board of Directors. It was then presented to Ms. Spears' two daughters (*Jodi Best & Sarah (Spears) Huff*), who were in attendance.

Resolution Honoring the Life and Service of ISK Board of Directors

Ms. Sharon Marie Spears

WHEREAS, the Board of Directors of Integrated Services of Kalamazoo has learned with profound sadness of the passing of Ms. Sharon Marie Spears, a valued member of this Board; and

WHEREAS, Sharon served faithfully as a board member from (February 6, 2007-February 1, 2026), contributing time, wisdom, and leadership with her extensive knowledge on the care necessary for the Intellectual/Developmental Disabilities population and valuing the mission, vision, and guiding values of Integrated Services of Kalamazoo; and

WHEREAS, Sharon demonstrated unwavering commitment, integrity, and compassion, and was instrumental in advancing the organization's work on behalf of our persons-served; and

WHEREAS, Sharon's service and counsel strengthened the Board and the mental health community and her impact on this community and organization will be lasting upon staff, persons-served, politics and advocacy.

BE IT FURTHER RESOLVED, that the Board extends its heartfelt sympathy and condolences to Sharon's family, friends, and loved ones during this time of loss; and

BE IT FURTHER RESOLVED, that this resolution be entered into the permanent records of the organization and that a copy be shared with the family as a testament to the Board's respect, appreciation, and remembrance of Ms. Sharon Marie Spears.

Adopted this 23rd day of March 2026, by the Integrated Services of Kalamazoo Board of Directors.

Karen Longanecker
Karen Longanecker
ISK Board Chair

INTEGRATED Services of Kalamazoo
Community • Independence • Empowerment

Jeffrey M. Patton
Jeffrey M. Patton
ISK Chief Executive Officer

Financial Statement and Single Audit Act Compliance/YEAR ENDING September 30, 2025,
MOTION/ *Joshua Laramy*/CPA/BDO

Summary of Request:

- The independent audit of fiscal year 2025 was completed by BDO.
- The independent audit report is unmodified, or "clean".
- There are no reported material weaknesses in internal controls.
- No findings related to the financial statements which are required to be reported.
- No findings or questioned costs for federal awards which are required to be reported.
- Net position changed from $46.5 million in FY 2024 to $54.1 million in 2025.

Vice Chair Seals, "I MOVE TO ACCEPT AND FILE THE FY2025 FINANCIAL STATEMENTS AND SINGLE AUDIT ACT COMPLIANCE REPORT." Supported by Member Raphelson.

MOTION PASSED.

Agenda
MOTION
Vice Chair Seals,
"I move to approve the agenda by having the following items placed at the start of the agenda due to their time sensitivity, decision-making priority, or strategic importance." Supported by Member Bergan and carried without dissent.

- Consent Calendar Reports
- Financial Reports

CONSENT CALENDAR
VERBAL MOTION
Chair Longanecker, "Is there anything that is on the Consent Calendar that anyone wants pulled out?"
No materials were requested to be removed.

a. Minutes *February 23, 2026 & February 26, 2026*
b. Board Compensation (II.07)(Policy)
c. Board Members Code of Conduct (II.09)(Policy)
d. Conflict of Interest (II.11)(Policy)
e. Utilization Management (Report)

Member Raphelson, "I MOVE TO ACCEPT THE CONSENT AGENDA [CALENDAR] AS PRESENTED." Supported by Member Bergan.

MOTION PASSED.

Financial Reports/Financial Condition Reports
Amy Rottman, ISK, Chief Financial Officer, presented the Financial Condition Reports for February 28, 2026.

To review the financial reports, please use the following link: https://iskzoo.org/about-us/board/

Utilization Reports
Charlotte Bowser, ISK, Director of Finance, presented the Utilization Report for the period ending February 28, 2026.

- Autism Services is at (60) clients and is favorable at $1,082,264.
- Youth Community Inpatient Services is at (60) days and is favorable at $42,654.
- MI Adult Community Inpatient Services is at (62) days and is favorable at $198,742. Community Living Supports, Personal Care, and Crisis Residential are favorable at $865,059.

Citizen Time No citizens came forth.

Recipient Rights
Lisa Smith ISK, Director of ORR, presented the complaints/allegations closed in February 2026.

Abuse Violations

- There was one substantiated Abuse II violation in February 2026.
    - The remedial actions for this violation were Written Counseling (1), and Training (1).

Neglect Violations

- There were nine substantiated Neglect III violations in February 2026. One of the nine was a Failure to Report.
    - The remedial actions for these violations were Written Counseling (3), Written Reprimand (5), Training (4), and Pending (2).

Two of the 9 violations occurred at the same agency but different program sites.
Three of the 9 violations occurred at the same agency, but different program sites.
One of those 3 violations was a Failure to Report.
The 4 other violations occurred at different agencies.

All of the ORR case information is sent to the ISK Population Directors on a monthly basis for any tracking/trending of the RR information in their areas of authority. *(Agencies can include ISK).

Recipient Rights Advisory Committee Appointments

MOTION

Member Guenther, "I MOVE TO APPOINT THE FOLLOWING INDIVIDUAL TO THE RECIPIENT RIGHTS APPEALS COMMITTEE (RRAC): ELIZABETH SCHLOTT AND JENNIFER LEIGH FOR A TWO-YEAR TERM (BEGINNING MARCH 2026 – MARCH 2028)."
Supported by Member Raphelson.

MOTION PASSED.

Program Service Report

Nancy McDonald, Senior Executive – Adult Community Services, gave a presentation on the "Engagement Team".

The Engagement Team is one of the newest programs at ISK. This program was developed to help improve our ability to engage individuals into services AND also to help ensure people quickly and successfully engage in their first service after they complete an assessment at our front door.
Staff consist of:

- current supervisor, who was determined to have capacity to take on extra duties
- 2 peer support specialists (we are in the process of hiring a 3rd peer staff)
- 1 BSW social worker

The program is part of the Adult MIA Department, but serves all populations. To date, the program has primarily served adults seeking MIA services, but has served youth and adults referred to the IDD department as well.
Referrals come from staff who are attempting to link individuals into services: Care Coordinators, Justice Department Staff, Hospital Liaison staff, Housing Staff.

Referrals also come from the front door staff at the UCAC. The engagement team will take any referral; key indicators we've suggested staff look for include: adults on an AOT, individuals who have been closed from services in the last year due to non engagement and have returned seeking services, people/families with multiple social determinants of health, and those who are unhoused.

Staff follow up with clients until they are succesfully engaged in their service, or we have been unsuccessful after multiple outreach attempts.

Staff are expected to look for individuals in the community; this is not an office based/telephonic program. However, staff do make lots of phone call reminders and check ins. One member of the team is located at the UCAC every day to immediately engage with new referrals and discuss the program.

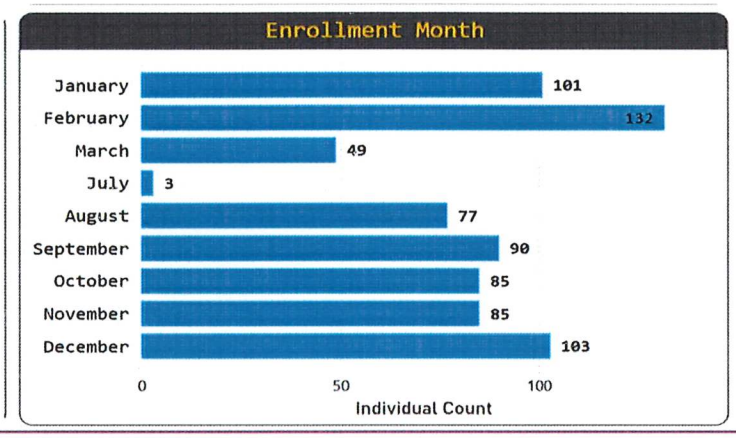
Staff are currently working hours that are the busiest at the UCAC and have been determined to be most succesful in locating clients: Monday through Friday: 9-7.

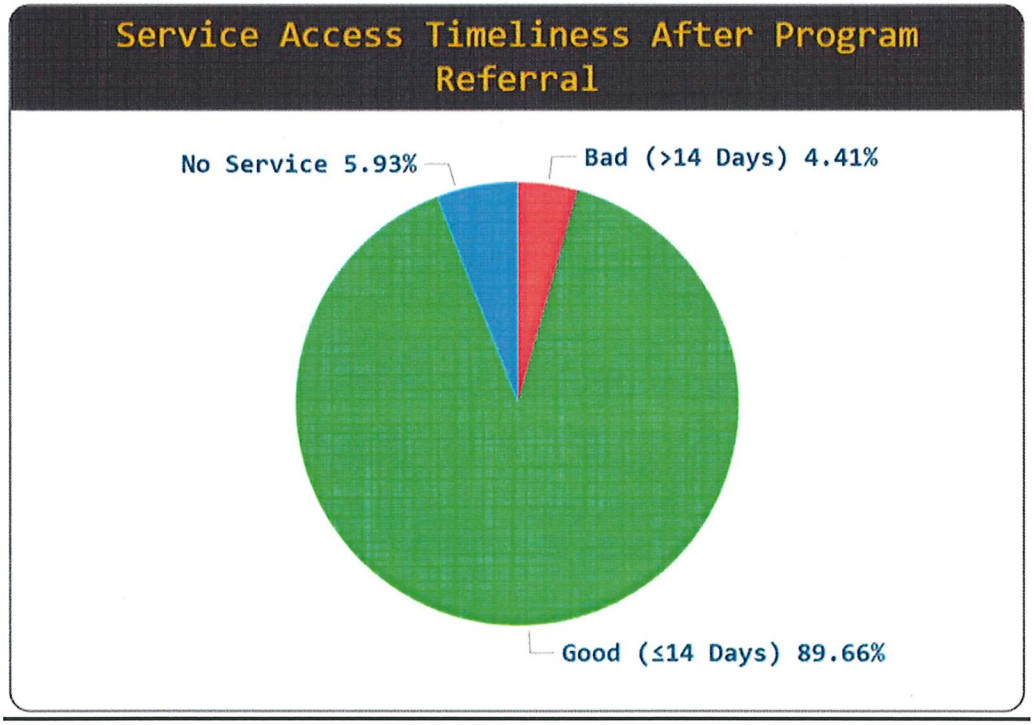
On average, staff receive 6 new referrals per day; busiest day this month involved 13 new referrals. As of 3/12/26, we have 114 open referrals.

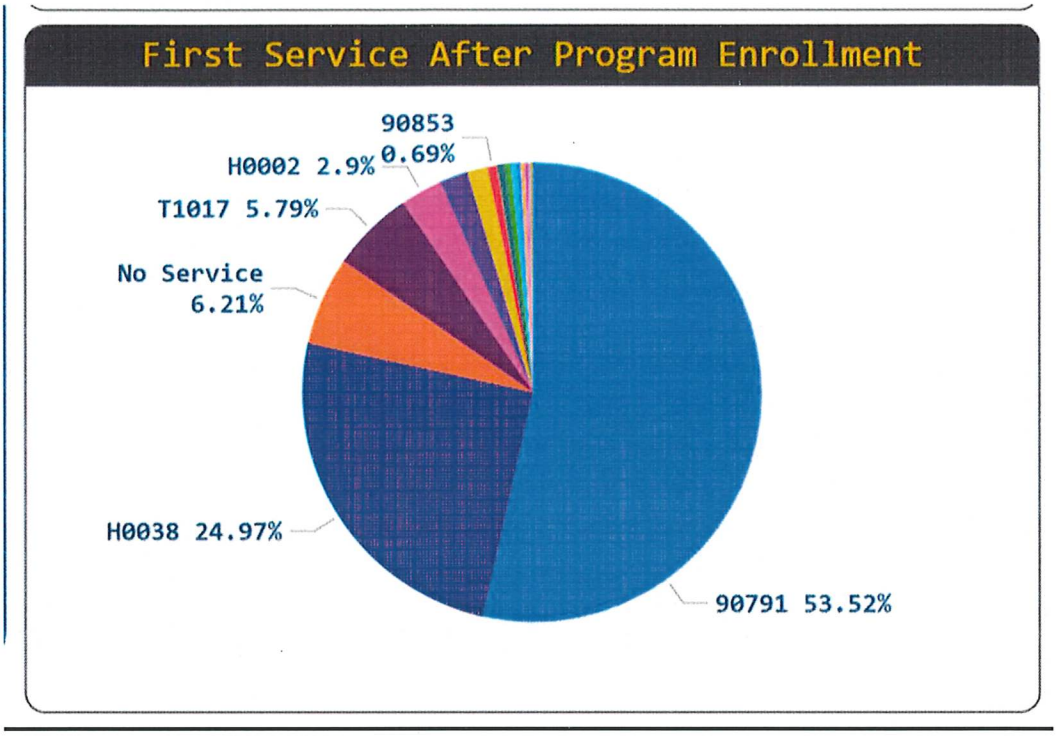
Engagement Program Dashboard

Report ID: C1.09 Refreshed Date: 03/10/2026

725	636	636	89
Referrals	Received 90791	Had Follow Up Service After 90791	Did not Receive 90791







Beth Ann Meints, Administrator of Clinical Services, CCBHC Report

During the past month, ISK has submitted the CCBHC Cost Report that will be establishing our new Perspective Payment for FY26. The cost report is currently showing that ISK will have a reduction within our perspective payment, but our financial department has already expected this reduction within the FY26 financial reports.

Michigan Department of Health and Human Services has received a grant from the National Council and the Balmer Group along with the State of Kansas and Illinois. This grant will allow the state of Michigan to focus on Technical Assistance that will support the growth and change provided under the CCBHC. ISK has a small group of staff that are active in the development of this technical assistance.

That concludes my report.

Chief Executive Officer Report

On Monday, April 13, 2026, Michael Schlack and I will be attending the hearing in the Court of Claims, where MDHHS will be asking the Judge to dismiss the procurement lawsuit without prejudice.

We received an invitation from Kristen Morningstar, Specialty Behavioral Health Services Director Michigan Department of Health and Human Services, to take part in a discussion about Michigan's Behavioral Health System. We did attend and offered our thoughts on the Behavioral Health System.

Welcome, Commissioner Abigail Wheeler, to the ISK Board of Directors!

That concludes my report.

Citizen Time No citizens came forth.

SWMBH (Southwest Michigan Behavioral Health) Updates/Michael Seals
The concerns that the ISK Board of Directors had about the SWMBH Ownership Survey were shared with the SWMBH Board of Directors during our last meeting.

Mila Todd accepted the position as the Chief Executive Officer for Southwest Michigan Behavioral Health. Ms. Todd has done an excellent job being the interim CEO and we all have high expectations and hope that she will do even greater things as the permanent CEO.
That concludes my report.

Meeting adjourned by voice vote at 6:05PM.
MOTION PASSED

Demeta J. Wallace
Administrative Coordinator & Board Liaison
Office of the CEO
Integrated Services of Kalamazoo Board of Directors

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY II.05

AREA:	Governance		
SECTION:	Board Governance Process	PAGE:	1 of 2
SUBJECT:	**BOARD COMMITTEE PRINCIPLES**	SUPERSEDES:	04/25/2011
		REVISED:	04/23/2018

PURPOSE/EXPLANATION

To define the principles of established Board committees and applies only to committees that are formed by Board action, whether or not the committees include non-Board members, but does not apply to committees formed under the authority of the Chief Executive Officer (CEO).

POLICY

Board committees, when used, will be assigned so as to reinforce the wholeness of the Board's job so as never to interfere with delegation from Board to CEO. Committees may be used sparingly and ordinarily in an *ad hoc* capacity.

A. Board action is required to establish a committee of the Board. The Board will state the purposes for which the committee is formed and the tasks the committee is expected to complete. Membership will be appointed by the Board and may include persons who are not Board members. Unless otherwise stated by the Board, a committee ceases to exist as soon as its purpose and/or task(s) are complete.

B. Board committees will assist the Board by preparing policy alternatives and implications for Board deliberation. Board committees will normally not have direct dealings with current staff operations.

C. Board committees may not speak or act for the Board, except when formally given such authority for specific and time-limited purposes. Exceptions and authority will be carefully stated in order not to conflict with authority delegated to the CEO.

D. The Board recognizes that a Board member may also be a member of a committee that was not established by the Board however such committees will not be considered to be a Board committee.

E. The Board Finance and Compliance Committee has been established by the Board to be a standing committee that ordinarily meets monthly.

CHIEF EXECUTIVE OFFICER

Jeff Patton
Chief Executive Officer

APPROVED

Erik Krogh
Board Chair

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY II.04

AREA:	Governance		
SECTION:	Board Governance Process	PAGE:	1 of 2
SUBJECT:	**CHAIRPERSON'S ROLE**	SUPERSEDES:	03/28/2011
		REVISED:	07/24/2023

PURPOSE/EXPLANATION

To define the role of the Board Chairperson.

POLICY

A. The Chairperson assures the integrity of the Board's process and, secondarily, occasionally represents the Board to outside parties. The Chairperson is the only Board member authorized to speak for the Board (beyond reporting Board decisions) other than in specifically authorized instances.

B. The responsibility of the Chairperson is to ensure that the Board's behavior consistently follows its own rules and those legitimately imposed upon it from outside the organization.

1. Meeting discussion content will only be those issues which, according to Board policy, clearly belong to the Board to decide, not the Chief Executive Officer (CEO).
2. Deliberation will be fair, open and thorough, but also efficient, timely, orderly and kept to the point.

The authority of the Chairperson consists in making decisions that fall within the topics covered by Board policies on Governance Process and Board/CEO Relationship, except where the Board specifically delegates portions of this authority to others. The Chairperson is authorized to use any reasonable interpretation of the provisions in these policies.

The Chairperson:

1. Is empowered to chair Board meetings with all the commonly accepted power of that position (i.e., ruling, recognizing).
2. Has no authority to make decisions about policies created by the Board within Ends and Executive Limitations policy areas. Therefore, the Chairperson has no authority to supervise or direct the CEO.
3. May represent the Board to outside parties in announcing Board-stated positions and in stating Chair decisions and interpretations within the area delegated to them.
4. May delegate this authority but remains accountable for its use.

5. Will ensure, in coordination with ISK's Board Liaison and the Kalamazoo County Administrator's Office, the recruitment of Board members to fill openings. Will serve as liaison between the Board and the CEO.
6. Will ensure the completion of the annual performance review of the CEO.

CHIEF EXECUTIVE OFFICER

Jeff Patton
Chief Executive Officer

APPROVED

Karen Longanecker
Board Chair

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY VI.05

AREA:	Governance		
SECTION:	System Governance	PAGE:	1 of 2
SUBJECT:	**NET POSITION MANAGEMENT**	SUPERSEDES:	04/25/2016
		REVISED:	04/21/2025

PURPOSE/EXPLANATION

To establish policies regarding an appropriate level of Kalamazoo County Community Mental Health Authority d/b/a Integrated Services of Kalamazoo (ISK) Net Position.

DEFINITIONS

Southwest Michigan Behavioral Health (SWMBH) Financial Risk
Annual operating revenue and expenses for Medicaid and Healthy Michigan capitation are financial risk of SWMBH. ISK cost settles its expenditures so revenue and expense match exactly, having no impact on Net Position of ISK.

ISK Financial Risk
The annual operating revenue and expenses for State General Fund, the Certified Community Behavioral Health Clinic, grants and earned contracts, and local funding from Kalamazoo County is under the financial management and financial risk of ISK. Operational surpluses in these areas result in increases in Net Position and operational deficits would require the use of Net Position.

Cash Flow/Liquidity
Cash flow is the net amount of ISK incoming cash receipts and outgoing cash payments over a period of time. Unrestricted Net Assets may provide Liquidity when cash flow is negative.

Unrestricted Net Assets
Excess funds available for spending during a fiscal year and/or to be available for future fiscal year expenditures.

Annual Operating Expenses
The projected and budgeted annual expenditure total approved by the Board.

Unrestricted Net Assets % for Operations
A percent computed by dividing the sum of unrestricted net assets by the total operating expenses.

POLICY

I. In order to ensure appropriate risk management funding, provide liquidity, and to ensure smooth continuity of operations, ISK shall maintain a minimum unrestricted Net Position % for operations as follows:

A. 5% of the portion of ISK annual operating expenses that are under SWMBH Financial Risk

B. 20% of the portion of ISK annual operating expenses that are under ISK Financial Risk

II. An Annual Finance Report to the Board shall include a report of the current Net Position Percent.

III. At the discretion of the Board, Unrestricted Net Position can be dedicated towards projects that would result in a fund balance % below the prescribed percentages.

CHIEF EXECUTIVE OFFICER

Jeff Patton
Chief Executive Officer

BOARD CHAIR

Karen Longanecker
Board Chair

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY VI.01

AREA:	Governance		
SECTION:	System Governance	PAGE:	1 of 1
SUBJECT:	**ANNUAL LEAVE RESERVE**	SUPERSEDES:	01/24/2011
		REVISED:	01/26/2015

PURPOSE/EXPLANATION

To formally document an Annual Leave Reserve policy that will provide a uniform and systematic process of maintaining an annual leave reserve to fund the liability for each staff member's vested annual leave and sick leave cost as determined at the end of each fiscal year.

The establishment of the annual leave reserve fund improves efficiencies and provides method of funding a significant liability in a manner that is not disruptive to the service delivery system and which provides a mechanism for ensuring that funds are available to cover the vested benefits of staff.

The Annual Leave Reserve policy applies to all programs and activities operated under the auspices of the Integrated Services of Kalamazoo (ISK) Board which are eligible for such reimbursement. The Chief Executive Officer (CEO) will annually report to the Board the status of the liability account.

POLICY

It is the policy of the ISK Board to establish and fund a reserve for vested staff members' annual and sick leave in accordance with generally accepted accounting principles and consistent with the appropriate government accounting standards and board.

CHIEF EXECUTIVE OFFICER

Jeff Patton
Chief Executive Officer

APPROVED

Erik Krogh
Board Chair

ISK Board Report
Board Policy VI.01
Annual Leave Reserve Status

ISK maintains an Annual Leave Reserve as a reserve within the equity section of the balance sheet for employee accrued leave. Annually, the finance staff calculate the amount required to be reserved per board policy. The change is reflected in the current year expenditures. Below is a historical review of the changes to that reserve account balance.

Historical Sick and Annual Reserve Changes
615 Liability Account

Fiscal Year	Beginning Balance	Additions/ (Usage)	Ending Balance
	623,828		
99/00		(68,849)	554,979
00/01	554,979	(34,270)	520,709
01/02 *	520,709	102,222	622,931
02/03 *	622,931	20,766	643,697
03/04 **	643,697	(191,044)	452,653
04/05	452,653	78,677	531,330
05/06	531,330	31,186	562,516
06/07	562,516	25,592	588,108
07/08	588,108	67,725	655,833
08/09	655,833	32,903	688,736
09/10	688,736	25,606	714,342
10/11	714,342	83,062	797,404
11/12	797,404	76,871	874,275
12/13	874,275	106,564	980,839
13/14	980,839	(128,714)	852,125
14/15	852,125	87,345	939,470
15/16	939,470	74,445	1,013,915
16/17	1,013,915	55,020	1,068,935
17/18	1,068,935	4,910	1,073,845
18/19	1,073,845	89,901	1,163,746
19/20	1,163,746	213,620	1,377,366
20/21	1,377,366	14,952	1,392,318
21/22	1,392,318	246,850	1,639,168
22/23	1,639,168	133,482	1,772,650
23/24	1,772,650	333,540	2,106,190
24/25	2,106,190	(29,059)	2,077,131

* Note: Change in policy regarding use of reserve, allowed bonus payout of accrued leave on anniversary date. Also payouts for employees terminated @ 9/30/03

** Note: Adjusted for reversing JE to 615, error in posting.

INTEGRATED
Services of Kalamazoo

Community • Independence • Empowerment

TREATMENT OF PERSONS SERVED

April 2026

FY26 Data October 1, 2025 – March 31, 2026

Integrated Services of Kalamazoo
Treatment of Persons Served Report
April 2026

EXECUTIVE LIMITATION POLICY:

"With respect to interactions with persons served, or individuals applying to receive services, the Chief Executive Officer shall not cause or allow conditions, procedures, or decisions which are unsafe, disrespectful, unduly undignified, unnecessarily intrusive, or which fail to provide appropriate confidentiality and privacy."

ACCORDINGLY, THE CHIEF EXECUTIVE OFFICER MAY NOT:

A. **Use application forms or procedures that elicit information for which there is no clear necessity.**

Response:
Forms (paper and electronic) are based on the Michigan Department of Health and Human Services requirements and accreditation standards. Each element of the clinical record has been cross referenced with external requirements/standards to help ensure that Integrated Services of Kalamazoo (ISK) expectations are set on necessity.

Integrated Services of Kalamazoo (ISK) is compliant with this requirement.

B. **Use methods of collecting, reviewing, or storing information on persons served that fails to protect against improper access to the information elicited.**

Response:
All information of persons served is managed by provider contract, business associate agreements, and policy boundaries; these include recipient rights, compliance, information technology, and quality management policies. Information on persons served is safeguarded and limited only to those with a need to access the information. ISK has processes in place to monitor appropriate access to protected health information of persons served in the electronic health record. ISK also holds a Breach Notification policy that outlines expectations and processes to follow in the occurrence of a potential or actual breach.

ISK is compliant with this requirement.

C. **Maintain facilities that fail to provide a reasonable level of privacy, both audio and visual.**

Response:
All business conducted with persons served is done in private areas or in places determined by the individual. If complaints occur in this area, the

Office of Recipient Rights and/or the Privacy Officer will investigate and recommend corrective action(s) as needed.

ISK is compliant with this requirement.

D. **Fail to provide procedural safeguards for the transmission of information.**

Response:
Recipient Rights, Compliance, Privacy, and Information Management policies are in place in order to protect the confidentiality of persons served. All clinicians working out in the community have been supplied with computers that have safeguards against security breaches. ISK Compliance and Information Management takes steps to ensure the HIPAA compliant platforms are utilized for telehealth appointments. Other devices that have access to confidential information of persons served are encrypted for security and protection. ISK also holds a Breach Notification policy that outlines expectations and processes to follow in the occurrence of a potential or actual breach. ISK enforces two-factor authentication to safeguard against outside threats and access into the ISK system. ISK staff receive training and ongoing reminders related to external threats, including phishing attempts, and protection of protected health information of persons served.

ISK is compliant with this requirement.

E. **Fail to inform persons served of their options, choices and conditions.**

Response:
Intake admission procedures, recipient rights policies and person-centered planning, all work toward informing the individual of their options and choices.

ISK is compliant with this requirement.

F. **Fail to establish with persons served, a clear contract of what may be expected and what may not be expected from the services offered.**

Response:
When starting services, individuals are given the Customer Services Handbook, which provides extensive information on services and expectations. Individuals are provided information on services, the person-centered planning process, and program expectations. The signature of each person served and/or their appointed guardian is obtained on relevant documents to help ensure that all required information is clearly and adequately provided to each individual.

ISK is compliant with this requirement.

G. **Fail to provide persons served with grievance processes which they understand and feel free to use without fear of direct or indirect, intended or unintended retaliation or retribution when they believe that they have not been accorded a reasonable interpretation of their rights under this policy.**

Response
Each person served of mental health services is informed of their rights under the Michigan Mental Health Code, as well as their right to access the grievance and appeal process. The Office of Recipient Rights notifies the recipient/complainant of their right to appeal the findings of each Recipient Rights investigation. ISK policy and the Mental Health Code include provisions that forbid retaliation/harassment in conjunction with rights activity.

ISK is compliant with these requirements.

H. **Fail to provide a state-certified recipient rights system.**

Response
The Michigan Department of Health and Human Services Office of Recipient Rights found ISK to be in full compliance with recipient rights systems standards in January 2025. ISK is certified through 2027.

ISK is compliant with this requirement.

I. **Fail to acknowledge that competent persons served, or their surrogates have the right to decline any and all forms of medical intervention, including lifesaving or life-prolonging treatment...**

Response
General information about Advance Directives is included in the Customer Handbook, which is given to each individual at the time of starting ISK funded services. Advance Directives information is again offered to person served, as appropriate, whenever an individual plan of service is completed.

ISK is compliant with these requirements.

J. **Fail to administer a Person-centered Process for persons receiving mental health services**
K. **Fail to include families in the planning and delivery of services.**

Response
ISK operates under the Person/family-centered Planning Process Policy for all mental health. The ISK Quality Monitoring Review process and internal ISK Quarterly Record Reviews continually reviews a sampling of plans to ensure that plans are follow the applicable policies and guidelines.

ISK is compliant with these requirements.

OFFICE OF RECIPIENT RIGHTS
SUBSTANTIATED COMPLAINTS - DATA
October 1, 2026-March 31, 2026

TOTAL FOR ALL CATEGORIES: 100

CATEGORY:	#	CATEGORY	#
Abuse/Neglect		**Personal Property**	
Abuse I	0	Possession and Use	2
Abuse II	5	Limitations	0
Abuse III	8		
Neglect I	0		
Neglect II	6		
Neglect III	28		
Sexual Abuse	0		
Admission/Discharge		Photographs, Fingerprints,	0
Second Opinion/denial of	0	Audiotapes, One-Way Glass	0
Hospitalization		Prior Consent	0
Communications/Visits		**Rights Protection System**	
Access to Phone	0	Access to Rights System	0
Visitation	0	Comp. Investigation Process	0
Uncensored mail	0	Failure to Report	0
		Retaliation/harassment	0
Confidentiality		**Suitable Services**	
Disclosure of Confidential Info.	3	MH Services Suited to Condition	8
Withholding of Information	0	Informed Consent	0
Privileged Communication	0	Services of MH Professional	0
Correction of Record	0		
Complete Record	1		
Family Rights	1	**Treatment Environment**	
		Safe Environment/Sanitary/Humane Environment	6
		Dignity/Respect	31
		Assessment of Needs	0
Financial		**Treatment Planning**	
Safeguarding money	0	Person-Centered Planning	0
Ability to use or spend as desired	0	Timely Development of Plan	0
		Treatment Planning: Other	0
Labor and Compensation	0		
Easy Access to Money in Account	0		
Freedom of Movement	1	**Civil Rights**	
Seclusion	0	Religion Practice	0
Restrictions/Limitations	0	Discrimination	0
Restraint	0		
Least Restrictive Setting	0		

All substantiated complaints result in remedial action, per the Michigan Mental Health Code.

Integrated Services of Kalamazoo (ISK) V.g.

Customer Services department - Report to the Board for Fiscal Year 2025-2026

Activity Summary: October 1, 2025 through March 31, 2026

Customer Services Duties/Assignments:
CARF Accreditation Preparation: Our survey was conducted September 17-19, 2025 The Quality Improvement Plan we submitted to address their Recommendations was accepted by CARF. We have implemented the corrective action steps.
Root Cause Analyses for Sentinel Events: For the first two quarters of this fiscal year, we have identified 9 unfortunate sentinel events (SE). Significant this year, we have lost 4 individuals to suicide so far. Our Zero Suicide Grant Coordinator continues to participate in our Root Cause Analysis meetings to help our teams identify any improvement activities we can engage in as they relate to suicide. The requirements for reporting SE's to MDHHS have changed this year. Reports will be sent for SE to both our PIHP and the state CCBHC office – depending on which types of services the individual was receiving. We are modifying our reporting processes.
ISK Endowment Fund: For this fiscal year, we awarded 12 full-year awards for a total of $56,000. Based on spending in recent years, our team has determined that any contingent awards that are presented for approval will need to be focused on maintaining housing or another true emergency.
Suicide Prevention Planning Team: CS Manager continues membership on the planning committee. So far this fiscal year, CS Manager co-facilitated 1 safeTALK and 7 Mental Health First Aid classes.
Supporting Customer Grievances and Appeals: Please see the attached data reports. Grievances and Appeals are tracked in year-to-date/cumulative summary reports. Customer Service Office Interventions/Inquiries are reported per quarter based on volume.
Qualitative/Quarterly Record Review: We have started our 3rd year these reviews with Customer Services and Medical Records coordinating the process for our CARF accredited programs. At the conclusion of each review, our team meets with the supervisor(s) of the programs reviewed to share our immediate feedback. We are planning on transitioning our data collection to the Audit Module within our medical record/KARE system during this fiscal year. Overall agency data and trends are shared with the Quality Improvement Council.
Customer Satisfaction: They consistent survey processes we are maintaining are: • "Environmental Scan" survey available at each of our lobby sites and available to anyone served to share feedback about their appointment that day (or overall) services. • Discharge Survey. We send a letter to everyone closed to services to invite them to participate. They can use QR code, telephone or ask for a paper copy. • We plan to continue to work with SWMBH this year to secure survey data for our CCBHC population - utilizing the data collection methods of previous years. That survey typically runs from April to September each year. Our Survey Committee reviews data quarterly to identify and address improvements that are identified.

SWMBH-wide Meetings/Committees and Activities
• Customer Services Committee • Quality Improvement Committee • Quarterly reporting of Grievance/Appeal and Authorization Denial data • Annual coordination of customer survey process and delegation review materials for scope of responsibility. This year, the SWMBH delegation review was in April. Score for Customer Services was 100% and Grievances/Appeals was 96.9%.

State-wide Meetings/Committees and Activities
• Continued participation in meetings and peer collaboration. • Advocating for enhancements to PCE electronic health record system through state-wide work group.

Questions about this report can be sent to Teresa Lewis, LBSW at 553-7000 or tlewis@iskzoo.org.

4/16/26>TL

Integrated Services of Kalamazoo

Appeals

Report Criteria:

Date Range: 10/01/2025 - 03/31/2026. FY 2025-2026. Q1 and Q2. **6 new Appeals were filed in Q2.**

Appeal Date	Service(s)	Type	Status	CCBHC/PIHP	Reason	Local Outcome	State Outcome	Decision Date	Decision Date
3/18/2026	CLS in own home 24-7 Health/Safety monitor	Local	Closed	PIHP	Service Termination	Approved	N/A	04/15/2026	N/A
3/5/2026	CLS in Licensed setting	Local	Closed	PIHP	Service Termination	Denied	N/A	04/01/2026	N/A
2/16/2026	ABA	Local	Closed	CCBHC	Service Suspension	Approved	N/A	03/17/2026	N/A
2/4/2026	CLS/PC in Residential	Local	Closed	PIHP	Service Termination	Approved	N/A	03/02/2026	N/A
1/29/2026	WrapAround	Local	Closed	CCBHC	Service Termination	Denied	N/A	02/23/2026	N/A
1/21/2026	CLS/PC in Residential	Local	Closed	PIHP	Service Denial	Denied	N/A	02/17/2026	N/A
11/18/2025	SAMM (OPT/CM) Peer Supported Employment	Local	Closed	CCBHC/PIHP	Service Termination	Denied	N/A	12/03/2025	N/A
10/30/2025	CLS - hours determination	State	Closed	PIHP	Service Partial Denial	N/A	Supported	N/A	01/21/2026
10/30/2025	WrapAround / Psychiatric	Local	Closed	CCBHC	Service Termination	Approved	N/A	11/26/2025	N/A
10/14/2025	CLS/PC in Residential	Local	Closed	PIHP	Service Denial	Denied	N/A	11/05/2025	N/A
10/6/2025	CLS/PC in Residential	Local	Closed	PIHP	Service Denial	Denied	N/A	10/27/2025	N/A

Green = Medicaid Appeal

Red = Non-Medicaid

Purple = State-level Hearing

Reported in Q3 to PIHP/MDHHS

Integrated Services of Kalamazoo

Grievances

Report Criteria:

Date Range: 10/01/2025 - 03/31/2026. FY 2025-2026. Q1 and Q2

Inquiry Date	Medicaid	CCBHC/PIHP	Provider	Category	Resolution	Date Closed
12/8/2025	YES	PIHP	Specialized Residential Case Management	Level of Care Review	Resolved	1/29/2026

Integrated Services of Kalamazoo

Customer Service Inquiries

Report Criteria:

Date Range: 01/01/2026 - 03/31/2026. FY 2025-2026. Q2.

4 Inquires from Q1 closed in Q2. **36 new Inquireies received in Q2.** 4 remain open to start Q3.

Inquiry Date	Inquiry Category	Resolution/Disposition/Assistance Provided	Date Closed
3/30/2026	Services / Supports		
3/27/2026	Services / Supports	Materials/Information provided about Re-Connect.	4/16/2026
3/18/2026	Services / Supports	LOC completed. Change in primary service	4/16/2026
3/5/2026	Services / Supports		
3/4/2026	Services / Supports		
3/3/2026	Other	update address for closed case as requested.	4/16/2026
3/2/2026	Services / Supports		
3/12/2026	Services / Supports	Resolved w/ Customer Service; Assistance with appointments	4/7/2026
3/11/2026	Services / Supports	Listen/Support; Materials/Information Provided	4/1/2026
3/9/2026	Services / Supports	No response to Customer Outreach to discuss	4/1/2026
3/3/2026	Services / Supports	Materials/Information Provided	3/3/2026
3/2/2026	Policies/Procedures/Pra	Materials/Information Provided	3/26/2026
2/23/2026	Services / Supports	Listen/Support; Materials/Information Provided; Referral to Acce	4/16/2026
2/19/2026	Services / Supports	Listen/Support; Resolved w/ Customer Service	3/26/2026
2/18/2026	Services / Supports	Listen/Support; Resolved w/ Customer Service	3/19/2026
2/17/2026	Services / Supports	Listen/Support; Materials/Information Provided; Referral to Acce	4/16/2026
2/17/2026	Services / Supports	Listen/Support; Materials/Information Provided; Referral to Acce	4/16/2026
2/17/2026	Services / Supports	Resolved w/ Customer Service	3/19/2026
2/16/2026	Services / Supports	Referral to Access; assistance with phone calls	3/5/2026
2/13/2026	Services / Supports	Resolved w/ Customer Service; Assistance with phone calls	3/5/2026
2/6/2026	Services / Supports	Materials/Information Provided; Referral to Access	3/12/2026
2/5/2026	Services / Supports	Materials/Information Provided; Resolved w/ Customer Service	2/20/2026
2/4/2026	Services / Supports	Resolved w/ Customer Service: Assistance with making appointr	3/26/2026
2/4/2026	Services / Supports	Resolved w/ Customer Service: Assistance with making appointr	4/7/2026
2/3/2026	Services / Supports	Resolved w/ Customer Service: Assistance with making appointr	2/10/2026
2/2/2026	Services / Supports	Materials/Information Provided; Referral to Access	2/12/2026
2/2/2026	Services / Supports	Resolved w/ Customer Service' assist with phone calls	2/12/2026
1/29/2026	Services / Supports	Appeal initiated	1/30/2026
1/28/2026	Services / Supports	Listen/Support; Materials/Information Provided	2/10/2026
1/23/2026	Services / Supports	Resolved w/ Customer Service/Case transfer	2/10/2026
1/22/2026	Services / Supports	Listen/Support; Materials/Information Provided; Referral to Com	2/26/2026
1/16/2026	Services / Supports	Listen/Support; Resolved w/ Customer Service: Assistance with	1/30/2026
1/7/2026	Services / Supports	Resolved w/ Customer Service	2/6/2026

1/7/2026	Services / Supports	Resolved w/ Customer Service	2/6/2026
1/7/2026	Services / Supports	Listen/Support; Referral to Access; Rights Complaint	2/19/2026
1/6/2026	Services / Supports	Resolved w/ Customer Service: Assistance with making appointr	1/8/2026

INTEGRATED
Services of Kalamazoo

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YEAR-END SUMMARY

October 1, 2024 - September 30, 2025

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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.

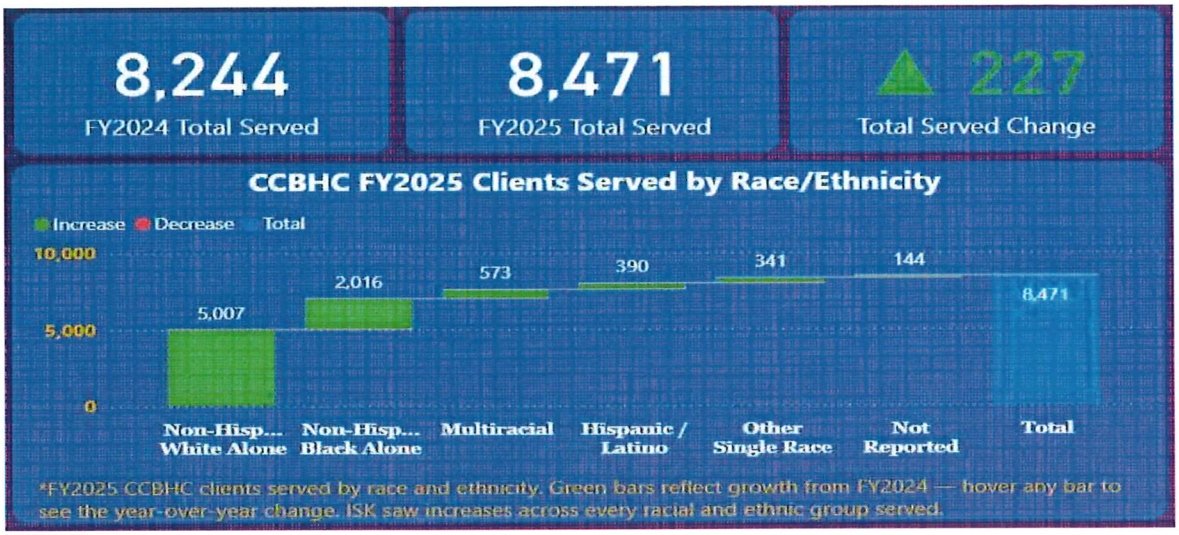
Mission – Integrated Services of Kalamazoo promotes and provides mental health, intellectual and development disability and substance use disorder supports and services that empower people to succeed.

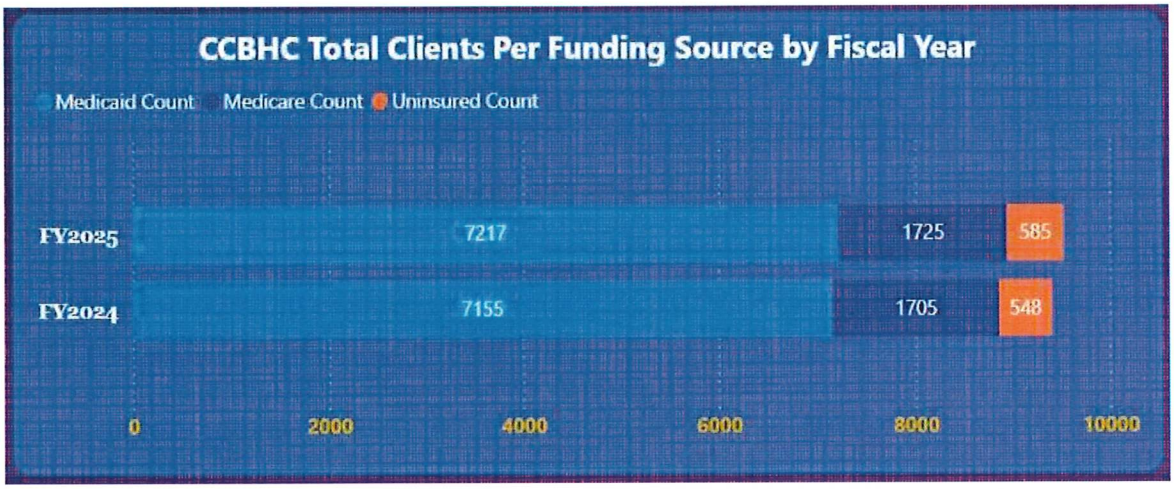
The **Guiding Values** of ISK are community, competence, diversity, effectiveness, integrity, leadership, recovery and self-determination, respect, responsibility, teamwork and trust.

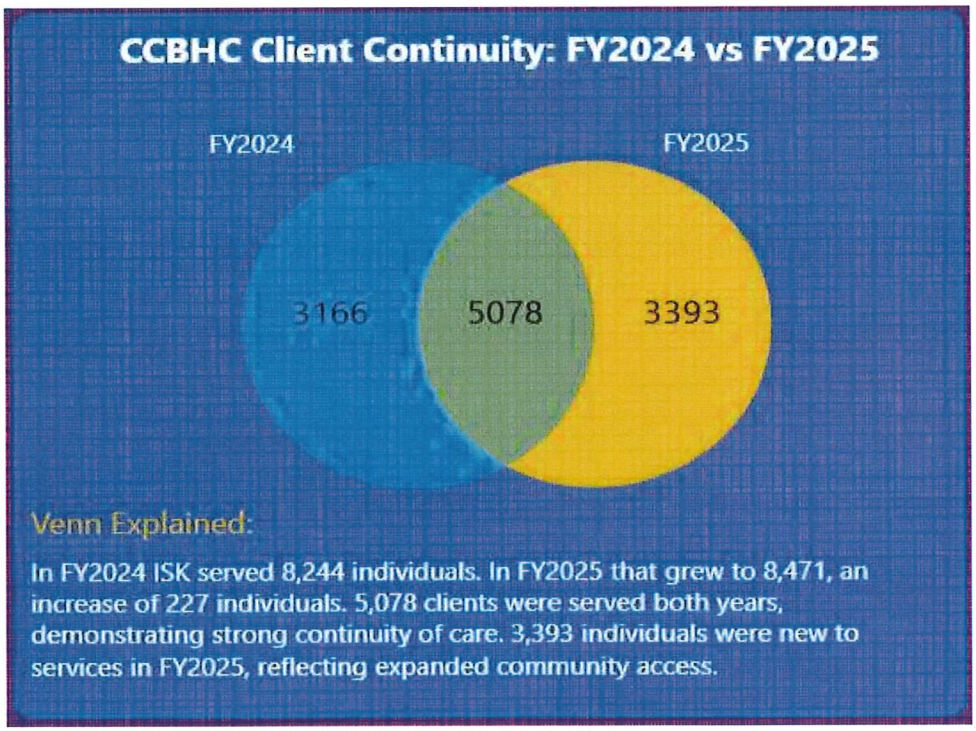
ISK provides a welcoming and diverse community partnership to share effective resources that support individuals and families to be successful through all phases of life. For more than 30 years, ISK has served youth, families and adults with mental health challenges, intellectual and developmental disabilities 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 unhoused 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. 8,471 distinct individuals were provided with CCBHC services during FY25. Compared to 8,244 from FY2024. Population totals and variance are illustrated below. Broken down by coverage by funding source and population:

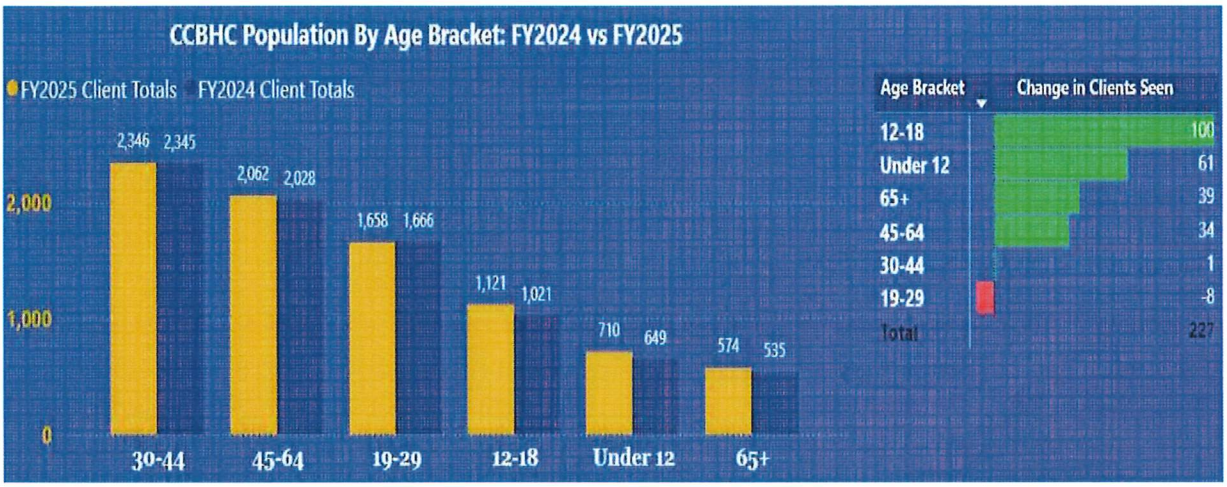

8,244
FY2024 Total Served
8,471
FY2025 Total Served
227
Total Served Change
CCBHC FY2025 Clients Served by Race/Ethnicity
Increase
Decrease
Total
10,000
5,000
0
5,007
2,016
573
390
341
144
8,471
Non-Hisp... White Alone
Non-Hisp... Black Alone
Multiracial
Hispanic / Latino
Other Single Race
Not Reported
Total
*FY2025 CCBHC clients served by race and ethnicity. Green bars reflect growth from FY2024 — hover any bar to see the year-over-year change. ISK saw increases across every racial and ethnic group served.


CCBHC Total Clients Per Funding Source by Fiscal Year
Medicaid Count
Medicare Count
Uninsured Count
FY2025
7217
1725
585
FY2024
7155
1705
548
0
2000
4000
6000
8000
10000


CCBHC Client Continuity: FY2024 vs FY2025
FY2024
FY2025
3166
5078
3393
Venn Explained:
In FY2024 ISK served 8,244 individuals. In FY2025 that grew to 8,471, an increase of 227 individuals. 5,078 clients were served both years, demonstrating strong continuity of care. 3,393 individuals were new to services in FY2025, reflecting expanded community access.

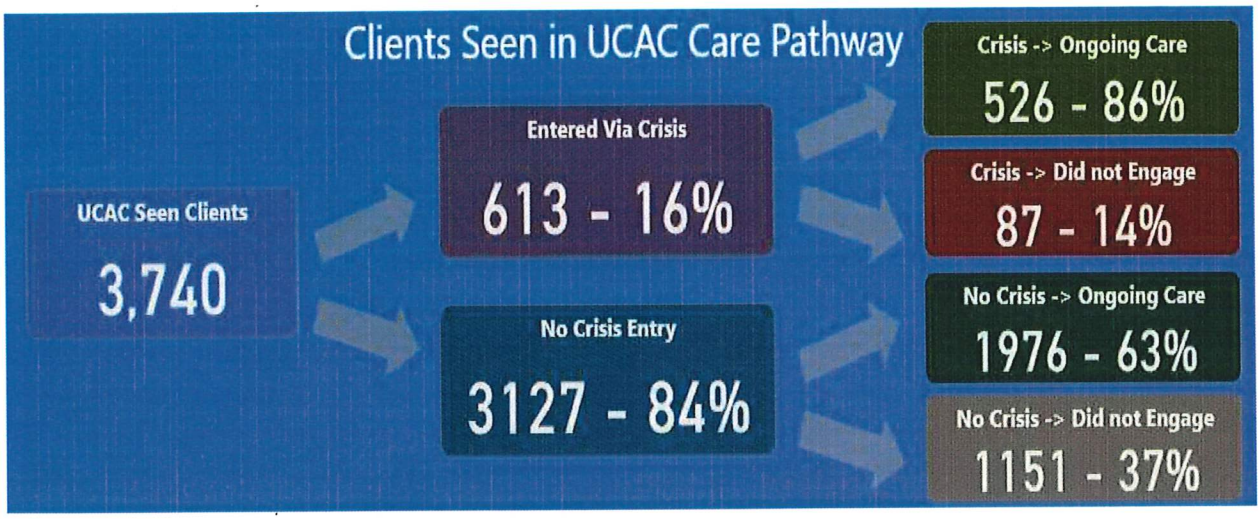
CCBHC Persons Served by Age Groups by Fiscal Year.

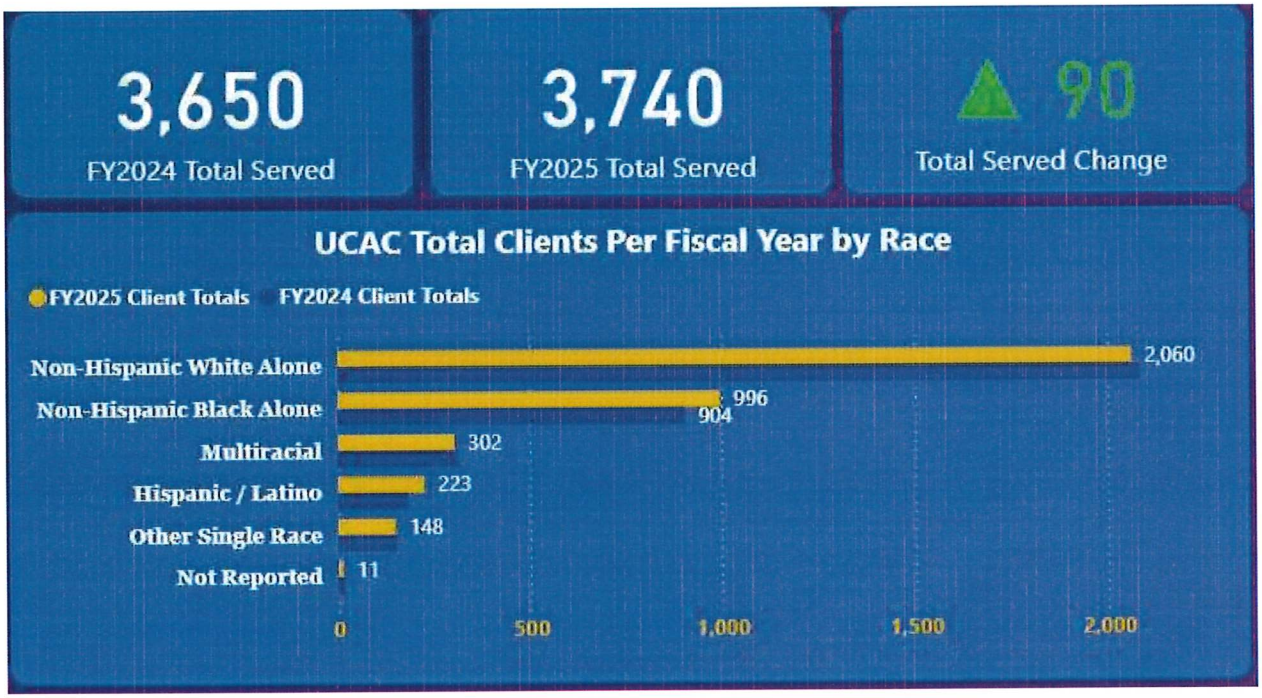
The chart below illustrates CCBHC persons served by age group across both fiscal years. FY2025 is represented in yellow and FY2024 is represented in blue. The accompanying table to the right quantifies the year-over-year variance by age bracket. The most significant growth was observed in the 12-18 bracket (+100), followed by Under 12 (+61) and 65+ (+39), reflecting meaningful expansion in youth and older adult access to CCBHC services. The 45-64 and 30-44 groups saw modest growth of +34 and +2 respectively, while 19-29 saw a slight decline of 9 individuals. The net result is a 227person increase in CCBHC individuals served, with youth populations driving the majority of that growth.

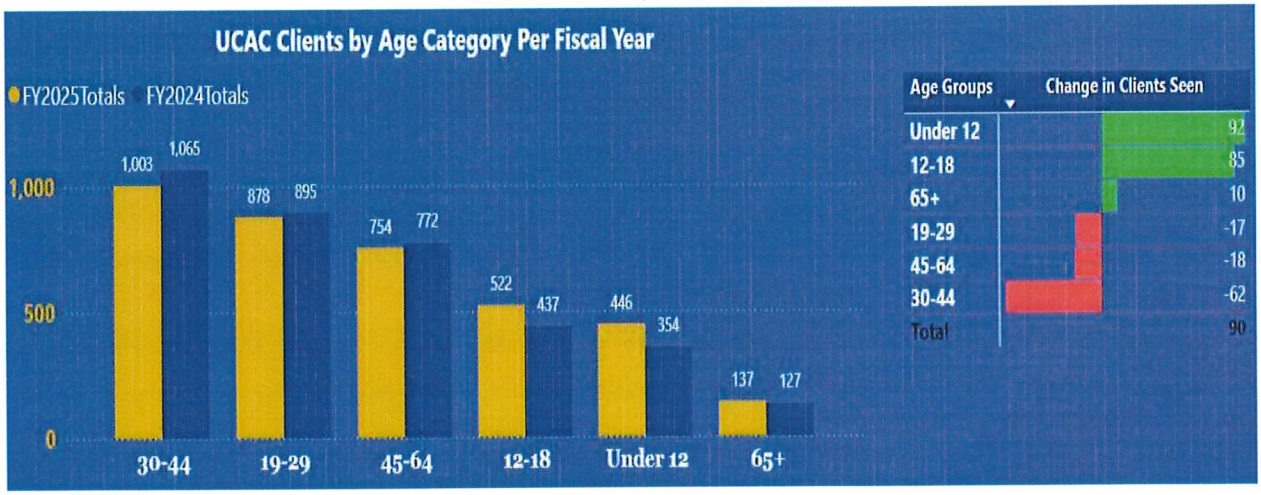


ISK Behavioral Health Urgent Care and Access Center (UCAC)

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 unique individuals seen by the UCAC per fiscal year and the total variance. 3,650 individuals were served at the UCAC in FY2024, growing to 3,740 in FY2025 which is an increase of 90 individuals. Notably, 3,189 of those served in FY2025 were new to UCAC services, demonstrating that ISK is successfully expanding access to new community members. The breakdown by fiscal year and age group is shown below.

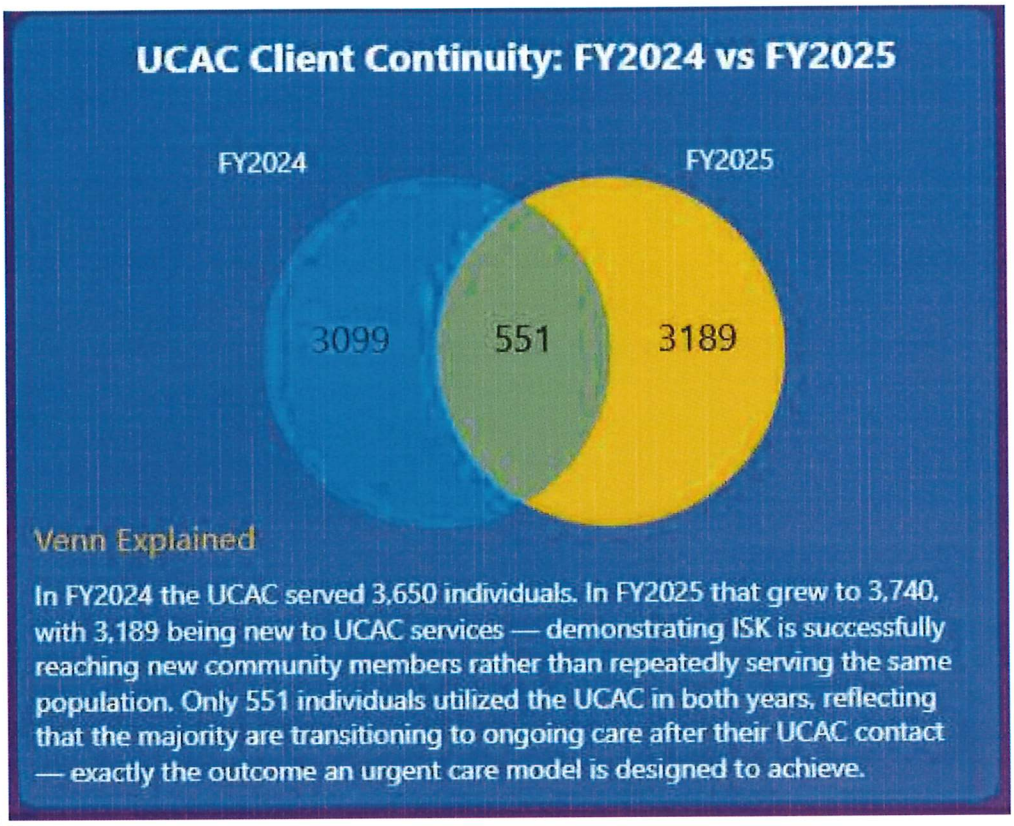




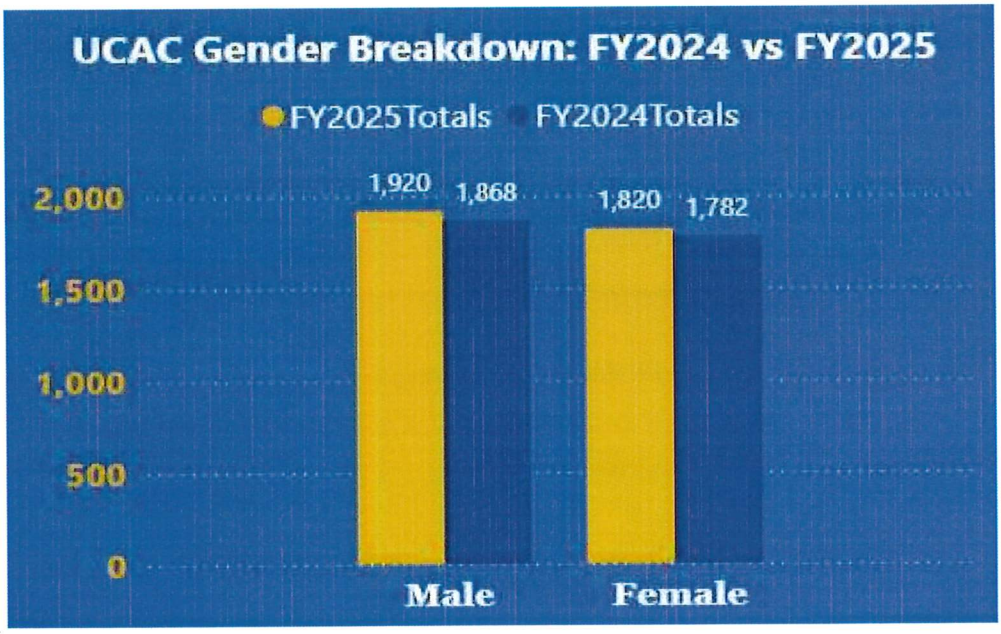


This visual provides a breakdown by fiscal year of UCAC individuals served, with variance illustrated by age group to the right. The largest increases were seen in Under 12 (+92) and 12-18 (+85). These age groups has been identified as underserved in

specific zip codes, making this uptick particularly meaningful. Decreases in age groups such as 30-44 (-62) and 19-29 (-17) are not necessarily cause for concern. The UCAC functions as a community thermometer — who walks through the door reflects the evolving needs of the community, not the success or failure of outreach efforts. A net increase of 90 individuals served reflects steady growth, while the shifting age composition tells a richer story about where community need is most acute.



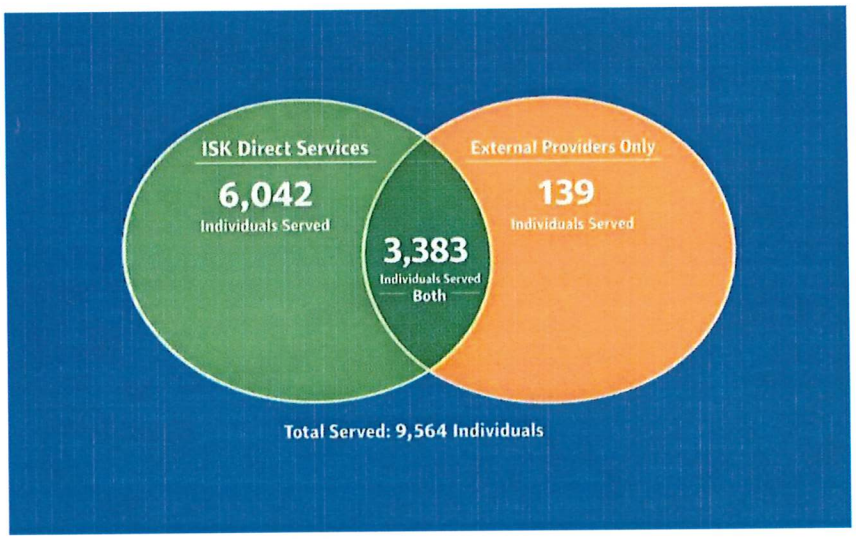
Gender Breakdown For UCAC:



III. DEMOGRAPHICS

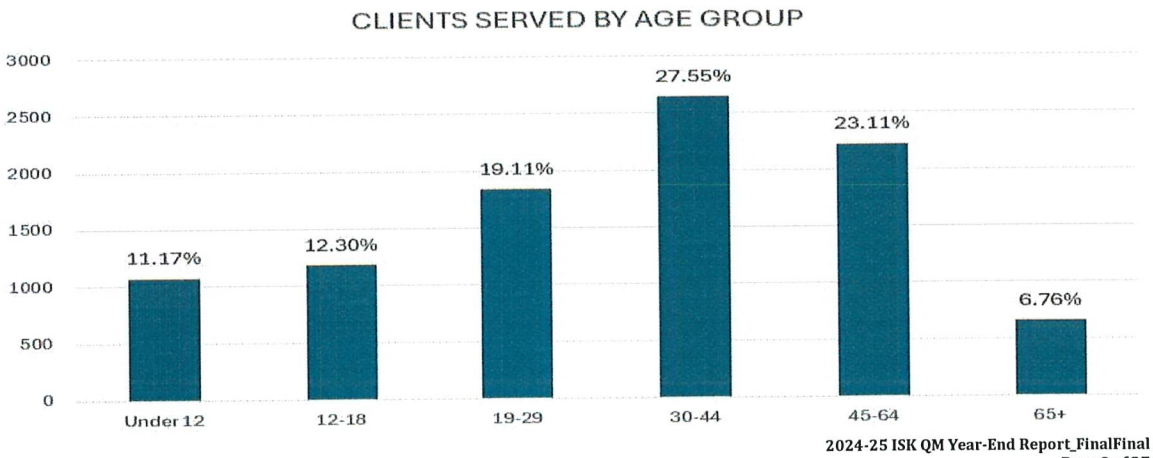
During FY 2024/25 (October 1, 2024 to September 30, 2025), ISK provided services to a total of 9,564 persons (unduplicated count), which is an increase compared to 9,295 individuals during FY 2023/24. These individuals were served directly by the ISK service programs and by a network of provider agencies 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 6,042 individuals through programs such as Psychiatric Services, Emergency Mental Health (EMH), Targeted Case Management, Outpatient therapy and Access/Intake. 139 individuals were served through our network of external providers only. A total of 3,383 individuals received services from both ISK direct operations and an external provider.



There were 2,861 individuals who were new to the network this fiscal year (never previously served) compared to 3,346 individuals who were new to the network during the previous fiscal year.

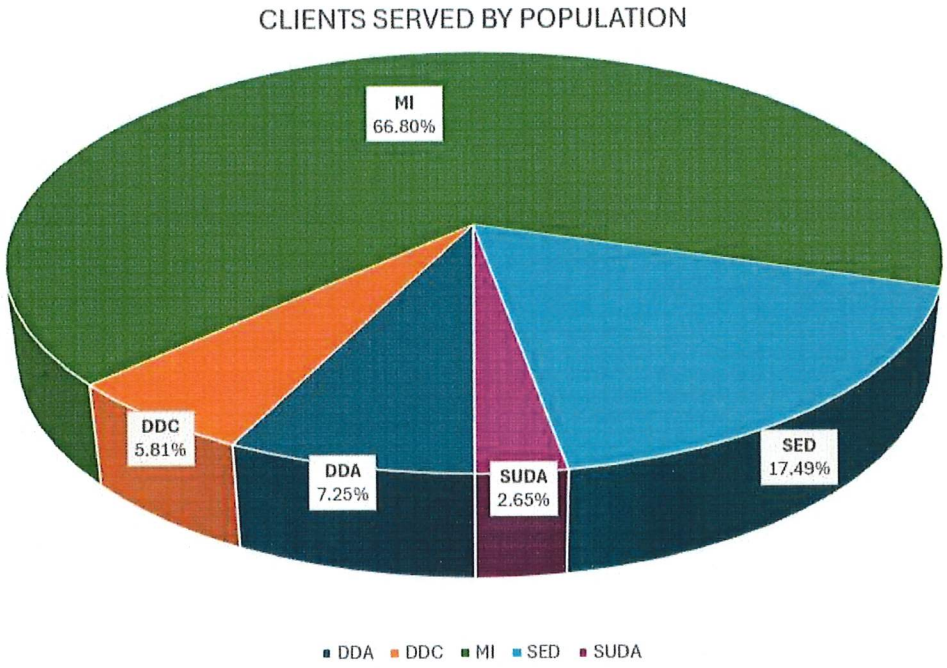
Of the total served, below is a demonstration of the age groups that were served:



Following is a series of tables and charts, which provide a demographic breakdown of the persons served by ISK during FY 2024/25. 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 BH TEDS during the fiscal year was 9,354.

A. Population Served by Persons Served

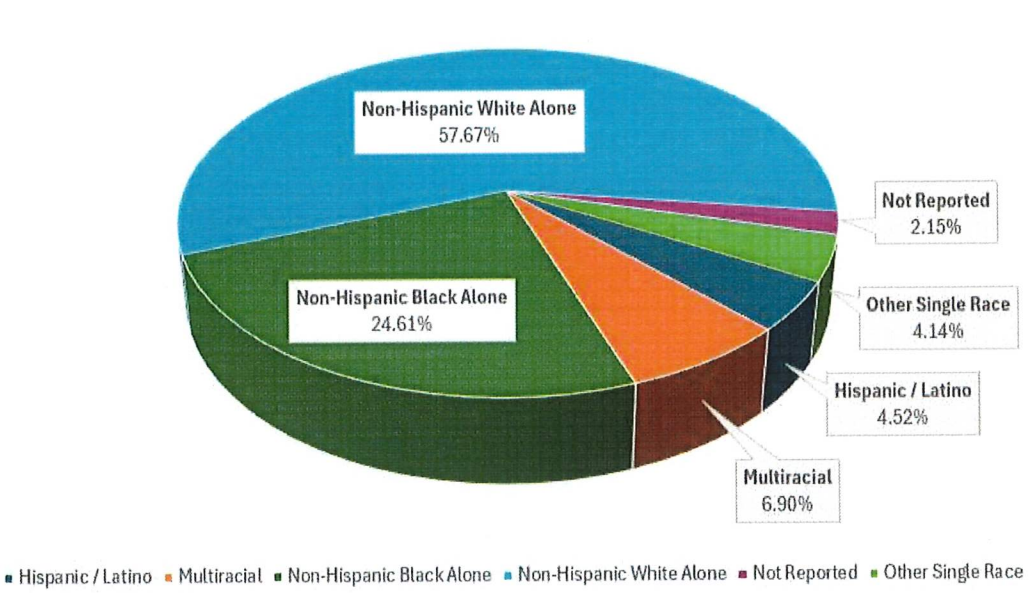
	FY 23/24 = 9,295		FY 24/25 = 9,564	
MIA	5,657	60.86%	6,381	66.72%
SED	1,393	14.99%	1,671	17.47%
I/DDA	711	7.65%	693	7.25%
I/DDC	490	5.27%	555	5.80%
SUD Adult	404	4.35%	253	2.65%
SUD Youth	1	0.01%	3	.03%
Undetermined	639	6.87%	8	.08%



B. Population Served by Race/Ethnicity

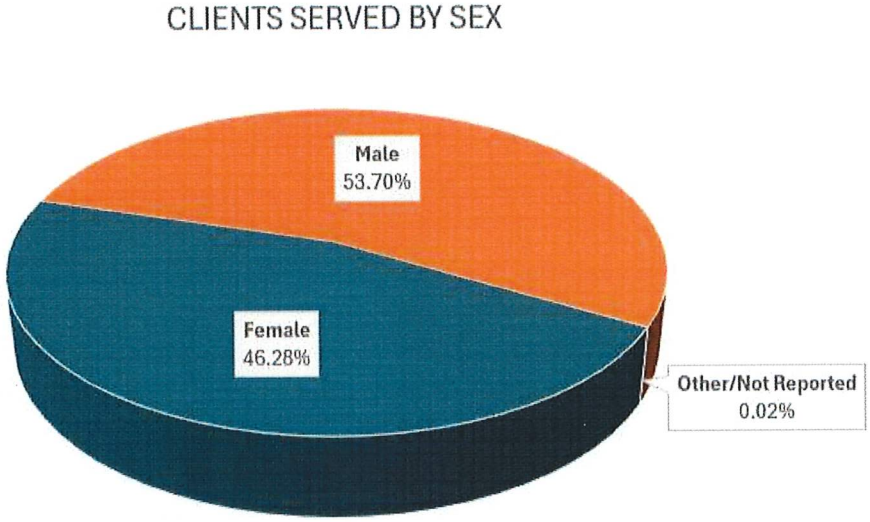
	FY 23/24 = 9,295		FY 24/25 = 9,564	
Non-Hispanic White alone	5,267	56.66%	5,516	57.67%
Non-Hispanic Black/AA alone	2,214	23.83%	2,354	24.61%
Multiracial	604	6.50%	660	6.90%
Hispanic/ Latino	341	3.67%	432	4.52%
Other single race	377	4.06%	396	4.14%
Not reported	492	5.29%	206	2.15%

POPULATION SERVED BY RACE/ETHNICITY



C. Population Served by Sex

	FY 23/24 = 9,295		FY 24/25 = 9,564	
Male	4,996	53.72%	5,136	53.70%
Female	4,299	46.28%	4,426	46.28%
Other / Not Reported	0	0%	2	.02%



D. Special Populations Served

	Count of Persons Served	% of Total Population
Medicaid recipients	8,157	85.29%
Medicare recipients	1,935	20.23%
Uninsured individuals	717	7.50%
Criminal Justice system involved	846	8.85%
Homelessness self-reported	1,575	16.47%
LGBTQ+ identity	869	9.09%

	Count of Persons Served	% of Total Population
Veteran/active military	156	1.63%
Total service population	**9,564**	

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	2,467	43.35%
Substance Use Disorders	1,516	26.64%
PTSD and trauma	1,655	29.08%
Anxiety Disorders	1,798	31.59%
Bipolar Disorder	1,266	22.25%
Schizophrenia/Psychotic dis.	1,242	21.82%
Total service population	**5,691**	

SED Youth	Count of Persons Served	% of Total Population
PTSD and trauma	632	45.40%
ADHD	503	36.14%
Major Depressive Disorders	492	35.34%
Anxiety Disorders	314	22.56%
Substance Use Disorders	59	4.24%
Autism / Pervasive Development Disorder	52	3.74%
Bipolar Disorder	59	4.24%
Total service population	**1,392**	

IDD Adults	Count of Persons Served	% of Total Population
Mild Intellectual disability	311	44.94%
Moderate ID	204	29.48%
Autism / Pervasive Development Disorder	179	25.87%
Anxiety Disorders	104	15.03%
Major Depressive Disorder	82	11.85%
Severe/profound ID	85	12.28%
Schizophrenia/Psychotic dis.	58	8.38%
PTSD and trauma	33	4.77%
Bipolar Disorder	39	5.64%
Cerebral palsy	38	5.49%
Total service population	**692**	

IDD Youth	Count of Persons Served	% of Total Population
Autism / Pervasive Development Disorder	398	71.84%
ADHD	76	13.72%
Mild Intellectual disability	75	13.54%
PTSD and trauma	61	11.01%
Anxiety Disorders	20	3.61%
Major Depressive Disorder	16	2.89%
Moderate ID	23	4.15%
Severe/profound ID	12	2.17%
Total service population	**554**	

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 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

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

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

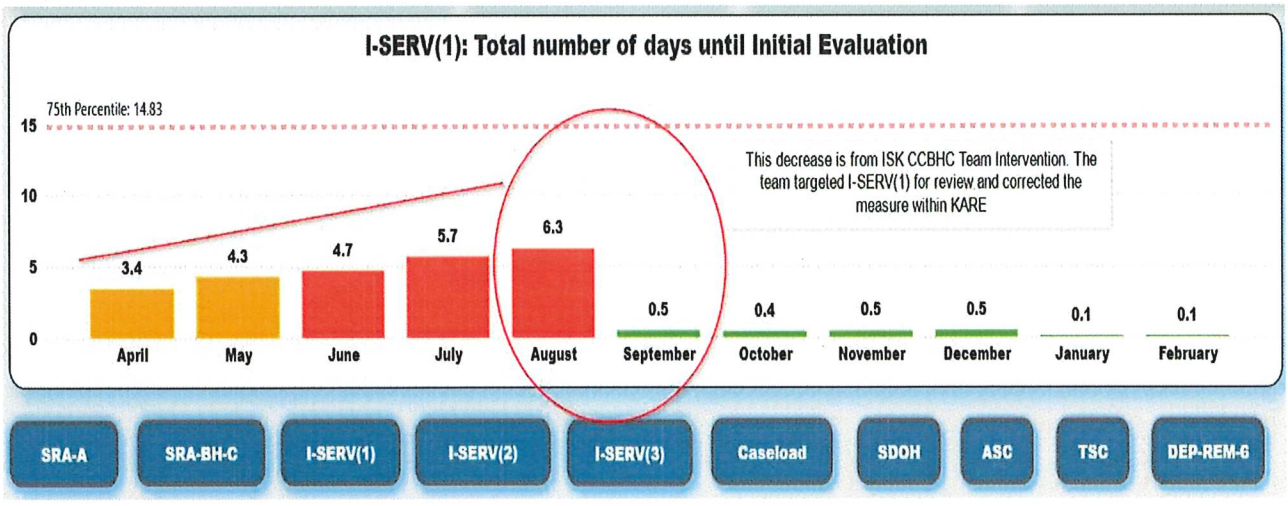
I-SERV Regional Metrics

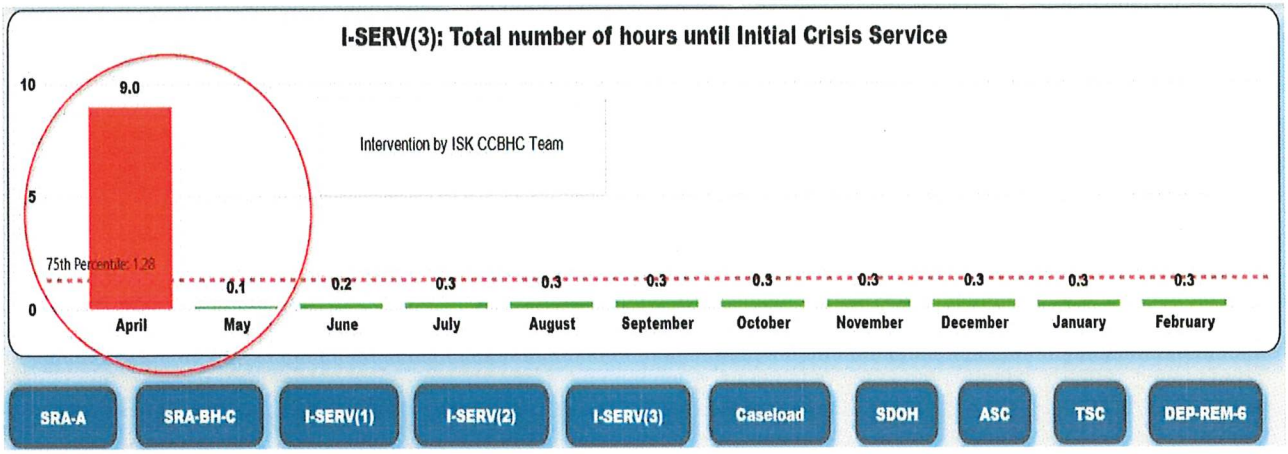
ISK continues to lead in the Michigan CCBHC Demonstration. ISK has a CCBHC Dashboard, that is used to track every metrics on a monthly basis. This dashboard is then used for targeted metric review. This occurred multiple times this last Fiscal Year is ties directly into why I-SERV Figures are so excellent at ISK.

Michigan CCBHC I-SERV Relative Standings (as of 12/31/2025)

Site ID	I-SERV #1 - Average Days to Initial Evaluation				I-SERV #2 - Average Days to Initial Clinical Services				I-SERV #3 - Average Hours to Crisis Services			
	Numerator	Denominator	Average Days	<=75th Percentile?	Numerator	Denominator	Average Days	<=75th Percentile?	Numerator	Denominator	Average Hours	<=75th Percentile?
1	7,907	344	22.99	No	10,621	285	37.97	No	0	193	0.00	Yes
2	13,068	1,126	11.61	Yes	21,257	1,066	19.94	Yes	2,451	2,501	0.98	Yes
3	5,413	211	25.65	No	5,723	202	28.33	No	707	590	1.20	No
4												No
5	17,955	878	20.45	No	27,226	745	36.54	No	1,617	3,222	0.50	Yes
6	1,521	357	4.26	Yes	5,728	317	18.07	Yes	81	605	0.13	Yes
7	759	410	1.85	Yes	1,796	395	4.55	Yes	320	756	0.42	Yes
8	5,123	1,467	3.49	Yes	15,276	1,299	11.76	Yes	124	753	0.16	Yes
9	2,565	207	12.39	Yes	2,457	185	13.28	Yes	0	0	0*	No
10	4,238	527	8.04	Yes	6,805	425	16.01	Yes	477	2	283.50*	No
11	2,830	257	11.01	Yes	6,582	207	31.80	No	284	580	0.49	Yes
12	3,441	349	9.86	Yes	2,755	286	9.63	Yes	3,645	5,179	0.70	Yes
13	4,864	413	11.78	Yes	9,309	402	23.16	Yes	0	0	0*	No
14	7,845	618	12.69	Yes	10,231	580	17.64	Yes	0	0	0*	No
15	2,421	521	4.65	Yes	5,003	435	11.50	Yes	22,340	1,049	21.30	No
16	10,071	1,086	9.27	Yes	19,097	1,004	19.02	Yes	2,732	229	11.93	No
17	7,123	795	8.96	Yes	7,152	794	9.01	Yes	0	0	0*	No
18	4,140	262	15.80	No	4,478	260	17.22	Yes	0	0	0*	No
19	860	1,522	0.57	Yes	15,190	1,340	11.34	Yes	1,111	3,534	0.31	Yes
20	5,564	237	23.48	No	5,840	236	24.75	No	0	0	0*	No
21	16,763	686	24.44	No	66809	617	108.28	No	49	31	0.28	Yes
22	6,420	504	12.74	Yes	7,405	477	15.52	Yes	135	487	0.28	Yes
23	14,480	861	16.82	No	17,850	791	22.57	Yes	20	202	0.10	Yes
24	648	85	7.62	Yes	1,455	69	21.09	Yes	0	0	0*	No
25	21,329	1,380	15.46	No	21,383	1,379	15.51	Yes	1,317	1,138	1.16	Yes
26	27,385	1,882	14.55	Yes	16,846	1,304	12.92	Yes	138	114	1.21	No
27	11,886	449	26.47	No	15,040	416	36.15	No	0	0	0*	No
28	4,470	391	11.43	Yes	7,873	358	21.99	Yes	223	243	0.92	Yes
29	25,260	2,646	9.55	Yes	25,588	2,639	9.70	Yes	9	6	1.5*	No
30	4,906	2,281	2.15	Yes	2,148	89	24.13	Yes	385	1,205	0.32	Yes
31	5,982	574	10.42	Yes	13,960	469	29.77	No	348	375	0.93	Yes
32	13,870	1,228	11.29	Yes	26,198	1,061	24.69	No	134	700	0.19	Yes
33	5,462	644	8.48	Yes	11,662	546	21.36	Yes	1,411	262	5.39	No
34	10,895	866	12.58	Yes	11,419	863	13.23	Yes	0	40	0.00	Yes
35	19,016	2,038	9.33	Yes	18,691	2,811	6.65	Yes	1,324	1,106	1.20	No
			75th Percentile:	15.23			75th Percentile:	24.55			75th Percentile:	1.17

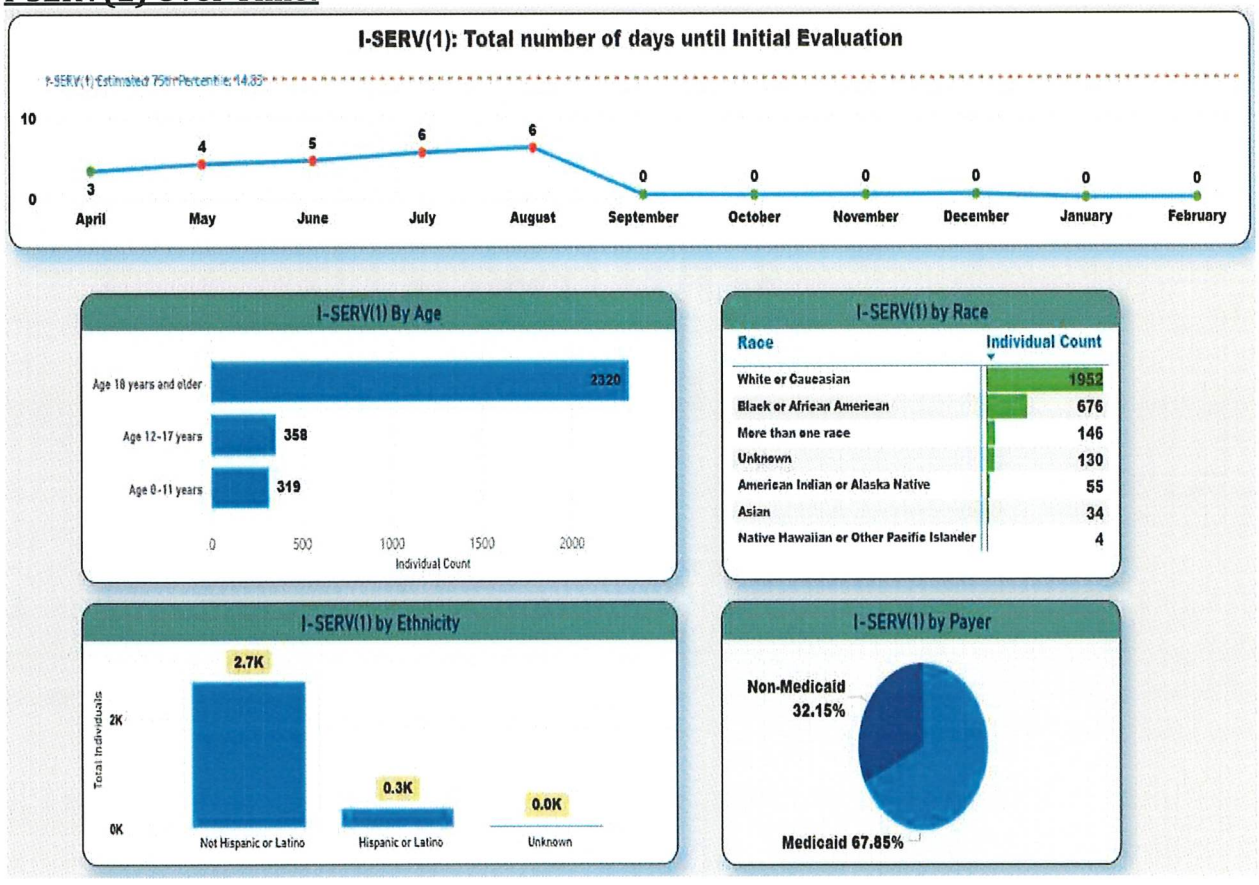
ISK shown in the red box above continues to lead in exceptionally good results for I-SERV figures.





Above you can see images from the CCBHC Dashboard. The Red circles represent CCBHC team intervention. Where we pull individuals falling into a metric, and see why trends are increasing, and use that data analysis to ensure our EHR is appropriately capturing the correct individuals for each measure (Tailoring). This topic was presented to Improving outcomes, illustrating how ISK is highly effective in maintaining excellent metric health. Above shows intervention in both I-SERV(1) and I-SERV(3) where we saw increasing monthly trends that clinically did not align. Each metric was reviewed by the CCBHC team, ensuring the description matched the clinical care pathway that occurs at ISK, while staying compliant working hand in hand with our EHR Vendor.

I-SERV(1) Over Time:



V. ISK Community Health Needs Assessment

The purpose of our 2024 Community Health Needs Assessment (CHNA) is to determine the behavioral health issues within the county of Kalamazoo and assess how those issues are being addressed. The findings from our CHNA lay the foundation for services that are either directly provided by ISK or provided by the many excellent contract service providers in the greater Kalamazoo area. We use this information to better understand the prevalence of

mental health, substance use disorders, and intellectual or developmental disability issues in our community.

The 2024-2025 CHNA identified the following priority areas and below provides a status of progress towards goals associated with these areas:

1. Reach a larger percentage of the population annually.
    - As demonstrated at the beginning of this report, ISK increased the number of individuals served during Fiscal Year 2024-2025.
2. Establish new and innovative approaches to service delivery with commitment to effective and efficient access to crisis services and follow-up care.
    - In May 2025 ISK expanded Mobile Crisis Response services to respond to the community 24/7 for both youth and adults.
    - The UCAC continues to provide crisis services at the location that meets the needs of the individual. During FY 2024-2025, 93 pre-admission screens, utilizing service code T1023, were completed at the UCAC rather than an individual needing to present to a hospital Emergency Department to be screened for inpatient psychiatric admission.
3. Expand urgent care services to include psychopharmacology.
    - Processes are established for coordination of psychiatric needs with the ISK Integrated Health Services Clinic to provide access to psychiatric consultation and scheduling for individuals presenting with urgent needs.
4. Continue to expand working relationships within the community and develop innovative partnerships to address homelessness, transportation, and other social drivers that are impacting mental wellness and recovery.
    - This goal is measured through the work and engagement of ISK Community Health Workers as they support individuals who present with needs related to social drivers of health. ISK Community Health Workers provided supports to 3,846 individuals during the last FY in comparison to 3,826 in the previous year.
    - 65% of all persons served during FY 2024-2025 received an Accountable Health Communities (AHC) Health-Related Social Needs Screening.
5. Increase outreach to underserved communities to reduce stigma and address barriers to care.
    - A community engagement plan is established and implemented by the Chief Project Officer and the Community Engagement and Outreach Manager. This plan is operationalized through building relationships, partnership, and working collaboratively to address barriers to accessing services and supports through ISK.

VI. STAKEHOLDER INPUT

A. Person-Served Survey

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

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

The likert scale for each tool ranges from 1 (Strongly Disagree) to 4 (Strongly Agree), the higher the score, the more positive the service experience of the respondent. A total of 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 = 376 (353 completed, 23 partial completion)

Youth Services Survey for Families (YSS) Satisfaction Survey
n = 161 (150 completed, 11 partial completion)

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.

ISK reviewed and identified themes and priority areas based on the feedback from the completed surveys. Goals were established to improve satisfaction in the areas of:
1. To increase customer satisfaction with services
2. To increase trauma-informed communication with individuals served
3. To increase consistent communication with individuals served.

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

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

VII. ASSESSMENT OF QUALITY & COMPLIANCE

A. Quality Monitoring Review (QMR)

The QMR process provides a systematic and comprehensive approach to verify that provider and internal ISK direct run services are compliant with contract and regulatory requirements as well as with specific standards for quality of services provided. The QMR system is designed to support compliance with applicable standards and brings about continuous quality improvement of the practices and services provided to persons receiving ISK services. A total of 163 individual locations/sites were reviewed during FY25.

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.

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 24/25 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 FY25. 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 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, 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, HIPAA Privacy, 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 23/24 and FY 24/25:

Nature of Incident	Critical Incidents 2023/24	2024/25
Medication Issues	0	0

Nature of Incident	Critical Incidents 2023/24	2024/25
Health & Safety Issues	55	46
Behavioral / Social Issues	8	20
Non-Violent Practices	0	0
Deaths	75	56
Other Issues	0	
TOTALS	**129**	**122**

In accordance with ISK Incident, Event and Death Reporting policy, FY24/25 deaths of persons served that were classified as Sentinel Events demonstrated the following manner of death:

Manner of Death	FY 23/24	FY 24/25
Suicide	3	4
Homicide	1	2
Accidental / Unexpected	16	9
TOTALS	**20**	**15**

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 2024/25 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 2024/25, ISK Customer Services Office processed the following:

	Medicaid	Non-Medicaid
Local Appeals	28	4
Access 2nd Opinions	0	0
Hospital 2nd Opinions	0	0
Administrative Medicaid (Fair) Hearings	2	1
MDHHS Alternative Dispute Resolution Process		0
Grievances	2	3
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.

VIII. PERFORMANCE MEASUREMENT

A. Performance Indicators

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

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

Indicator #1 - Pre-Admission Screening within 3 hours

The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours

Population	# of Emergency Referrals for Inpatient Screening During the Time Period	Exceptions	Net of Emergency Referrals for Inpatient Screening During the Time Period	# of Dispositions about Emergency Referrals Completed within 3 Hours	Out-of-Compliance	%
Child	248	0	248	246	2	99.19%
Adult	1238	0	1238	1237	1	99.92%
Total	1486	0	1486	1483	3	99.80%

Indicator #2A - Access/1st Request Timeliness

The percentage of new persons during the Period receiving a completed biopsychosocical assessment within 14 calendar days of a non-emergency request for service

Population	# of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	Exceptions	Net of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment	# of Persons Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service	Out-of-Compliance	%
MI / Child	601	0	601	584	17	97.17%
MI / Adult	2020	0	2020	1941	79	96.09%
DD / Child	164	0	164	159	5	96.95%
DD / Adult	30	0	30	19	11	63.33%
Total	2815	0	2815	2703	112	96.02%

Indicator #3 - Access/1st Service Timeliness

Percentage of new persons during the Period starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment

Population	# of New Persons Who Completed a Biopsychosocial Assessment within the Period and Are Determined Eligible for Ongoing Services	Exceptions	Net of New Persons Who Completed a Biopsychosocial Assessment within the Period and Are Determined Eligible for Ongoing Services	# of Persons Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment	Out-of-Compliance	%
MI / Child	595	0	595	364	231	61.18%
MI / Adult	2010	0	2010	1387	623	69.00%
DD / Child	166	0	166	127	39	76.51%
DD / Adult	32	0	32	31	1	96.88%
Total	2803	0	2803	1909	894	68.11%

Indicator #4a - Hospital Discharges Follow-up

The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days

Population	# of Discharges from a Psychiatric Inpatient Unit	Exceptions	Net of Discharges from a Psychiatric Inpatient Unit	# of Discharges Followed up within 7 days	Out-of-Compliance	%
Child	78	13	65	60	5	92.31%
Adult	637	213	424	385	39	90.80%
Total	715	226	489	445	44	91.00%

Indicator #5 - Initial Assessment Denial

Percentage of face-to-face assessments with professionals during the quarter that result in denials.

Population	# of New Persons Receiving an Initial Non-Emergent Face-to-Face Professional Assessment	Exceptions	Net of New Persons Receiving an Initial Non-Emergent Face-to-Face Professional Assessment	# of Persons Assessed but Denied CMHSP Service	%
Child	847	0	847	11	1.30%
Adult	2231	0	2231	19	0.85%
Total	3078	0	3078	30	0.97%

Indicator #10 - Inpatient Recidivism

The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge

Population	# of Discharges from Psychiatric Inpatient Care during the Reporting Period	Exceptions	Net of Discharges from Psychiatric Inpatient Care during the Reporting Period	# of Discharges Readmitted to Inpatient Care within 30 Days of Discharge	%
Child	78	1	77	5	6.49%
Adult	637	5	632	87	13.77%
Total	715	6	709	92	12.98%

B. Accreditation

CARF conducted an accreditation survey of ISK in September 2025. 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).

IX. 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 2024/25 goals & objectives and the status achieved.

#	GOALS	OBJECTIVES / ACTION STEPS	OUTCOME 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. 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 ongoing service within 14 days of completing a non-emergent biopsychosocial assessment. The goal is to reach the MDHHS set benchmark of 72.9%.	1. Completed. At least one performance report data was reviewed per IQIC meeting as indicated in IQIC minutes. 2. Performance Measurement Plan was approved by the ISK Board in January 2025. Plan status was presented in IQIC meetings. Many of the CCBHC measures are rolled into the performance measurement and management plan. Some adjustments are anticipated to meet CARF standards. 3. The ISK CARF survey was completed in September 2025. ISK achieved a full Three-Year Accreditation demonstrating substantial conformance to CARF standards. 4. This data was reviewed monthly in Data Integrity Monitoring Team and reported during IQIC committee meeting. FY25 started with 64% and ended with 70.1%.
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. Met 5 of the 6 quality measures and qualified for the QBP payment. 2. ISK established an engagement team to provide direct outreach to individuals who show a pattern of missing appointments or not engaging in needed services.
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), resilience-oriented	1. Completed. JETT provided status updates during every IQIC meeting as indicated in IQIC minutes. 2. JETT implemented the annual trauma informed care training requirement for FY25 and all ISK staff are now required to take trauma training annually. Training that focused on burnout was offered to ISK staff. Trauma focused supervision was incorporated into the current year's work plan and has been developed and implemented to assist with addressing burnout,

		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.	secondary trauma and compassion fatigue.
4.	Strive to build sustainable financial operations to support the delivery of CCBHC and specialty CMH supports and services	1. Define and develop plans for organizational financial sustainability, including but not limited to: a. Diversification of funding b. Department and staff level tracking of billable service	1. For 2025, we had a surplus of about $8M dollars in CCBHC. We effectively ensured all encounters were processed through SWMBH to collect the PPS-1 payment and leveraged grants where applicable.
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. Surveys were conducted at each ISK location. ISK Stakeholder Survey Committee (SSC) was chartered in July 2024. The purpose and scope of the SSC is to identify and clarify ISK customer survey processes. Survey activities included: a. ISK lobby environment scan survey b. SWMBH survey tools and process c. Discharge survey for end of ISK services d. Community Health Needs Assessment 2. Improvement opportunities were identified and reported during the IQIC meeting on 11/2025. 3. Community Health Needs Assessment was shared during ISK all staff meeting on March 4, 2025.
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.	1. Reportable events were submitted to SWMBH monthly as required. 2. Completed. Trends and analysis of events were reviewed at each IQIC meeting, including improvement efforts to address any negative findings.

		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.	3. The Death Review Committee met regularly throughout the year to review all cause mortality and to identify opportunities for system improvement as applicable. Data from this committee was reported to IQIC in 01/2025.

Integrated Services of Kalamazoo
FY 2024/25 Annual Dashboard Report
(October 1, 2024 - September 30, 2025)

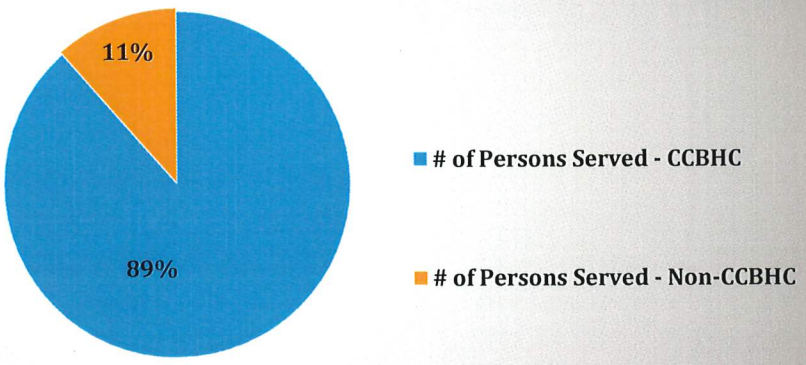
3. # of Persons Served (all ISK - capitated and non-capitated)

4. # of Persons Served - CCBHC

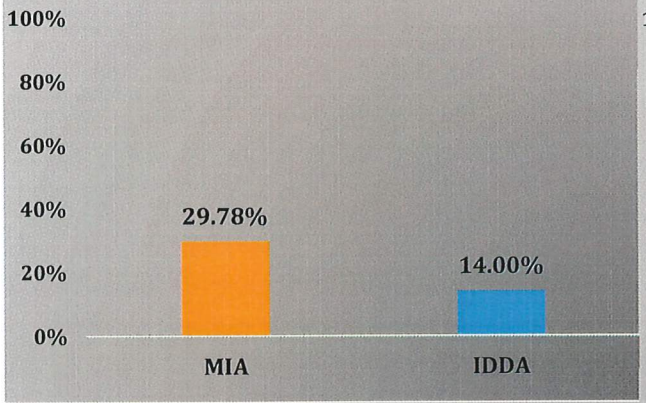
5. # of Persons Served - Non-CCBHC

Note: some individuals served may change ISK funding source during year and would be represented in both areas

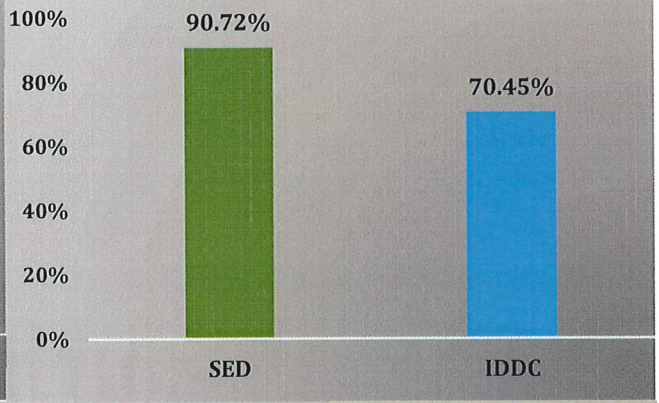
3, 4 & 5 - Number Served by Funding Source
N = 9564



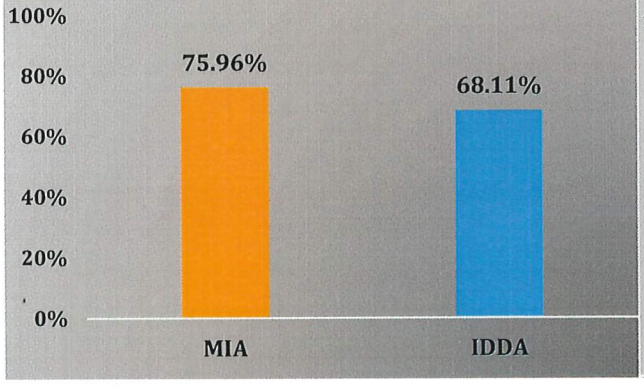
11 & 12 - % Served who Obtained or Maintained Competitive Employment



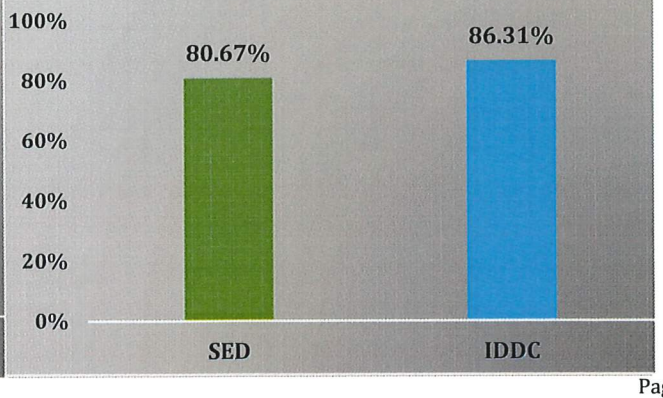
13 & 14 - % Obtained or Maintained Enrollment in School by Population



15 & 16 - % Living Independently by Population

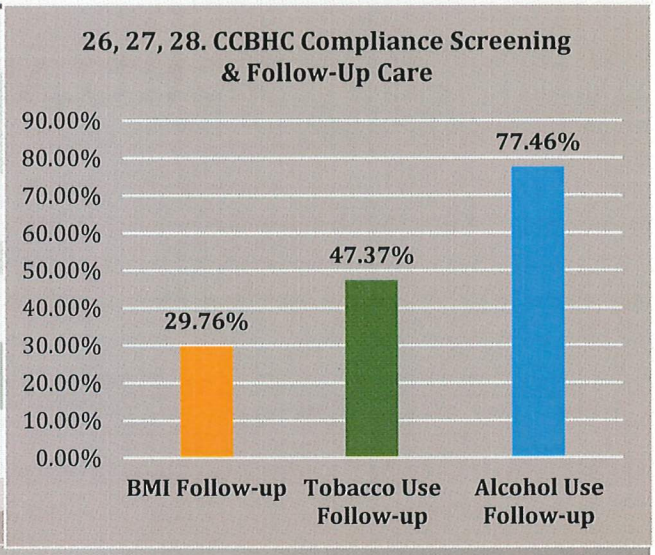


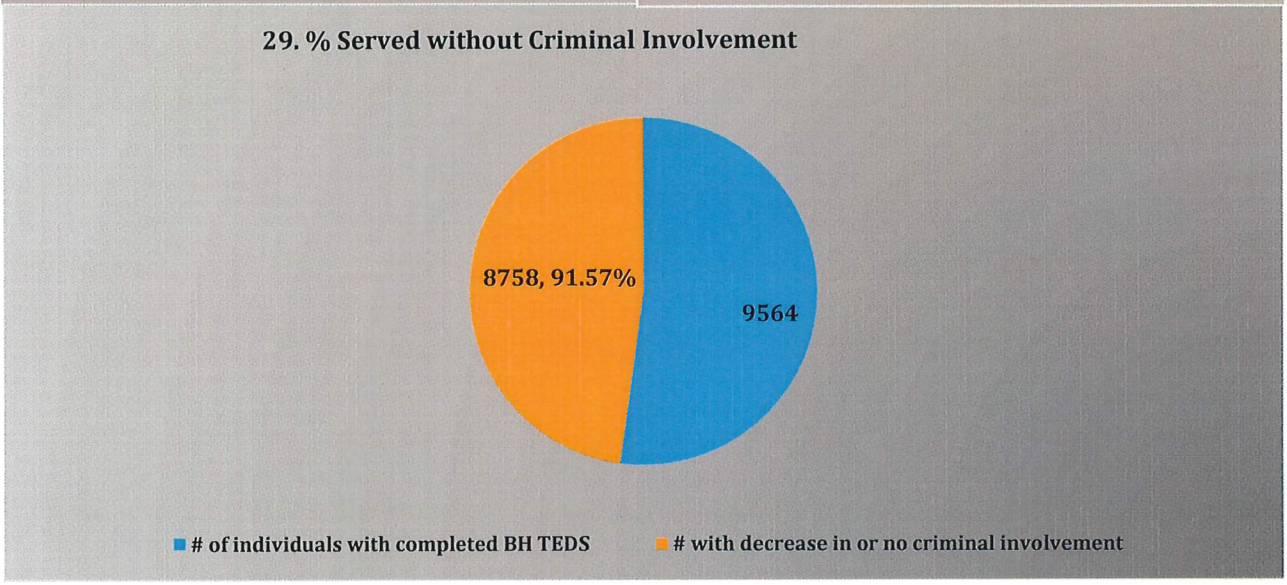
17 & 18 - % Living with Family by Population



Integrated Services of Kalamazoo
FY 2024/25 Annual Dashboard Report
(October 1, 2024 - September 30, 2025)

19. # of individuals in Self-Determination arrangements (MIA)	6
20. # of individuals in Self-Determination arrangements with Fiscal Intermediary (I/DDA)	194
21. # of individuals in Choice Voucher arrangements (I/DDC)	100
22. # of individuals in Peer Directed	1016
23. # of individuals in Peer Mentor Services (I/DDA)	10
24. # of individuals in Youth Peer or Parent Support Partner Services (SED)	206
25. # of individuals in Youth Peer or Parent Support Partner Services (I/DDC)	69





VI.b

Integrated Services of Kalamazoo

Board Member Corporate Compliance Training

Ashley Esterline, LMSW, CHC

ISK Director of Network Compliance

Corporate Compliance Officer

Corporate Compliance – What is it?

✅ In 1998 the Office of Inspector General (OIG) developed voluntary Compliance Program Guidance (CPG) to assist Health Care Providers in combating fraud, waste, and abuse.

📜 In 2005 Congress established a Medicaid Integrity Program (MIP). This required all Medicaid-funded providers to have a Corporate Compliance program.

🛡️ The Deficit Reduction Act requires entities to create/provide written policies applicable to all employees, contractors, and agents regarding:

- *False Claims Act* – laws that pertain to civil/criminal penalties for making false claims/statements
- *Whistleblower Protections* – rights of employees to be protected as Whistleblowers when they report suspected violations of such laws
- How the organization will develop methods to detect and prevent fraud, waste, and abuse

Board Oversight Responsibilities

- *Duty of Care* – Making informed decisions using good judgement.
- *Duty of Loyalty* – Act in the best interest of ISK, never for self-benefit or personal gain.
- *Duty of Obedience* – Serve in a manner that is faithful to and consistent with ISK's Mission, Vision, and Values.

Board Oversight Responsibilities

- **Compliance Program Oversight**
  - Assures ISK complies with applicable law(s), and guarantees the Compliance Program is effective by managing oversight of the Corporate Compliance Officer
- **Review Updates from Corporate Compliance Officer**
  - Bi-annual Board Attendance
  - Quarterly Board Finance and Compliance Meetings
- **Promote Transparency and Accountability**

ISK Compliance Activities

- Annual Quality Monitoring Reviews
- Annual and quarterly SWMBH Audits
- Quality Record Reviews
- MDHHS Audits
- Targeted Quality and Compliance Reviews

ISK Compliance Risk Management

- **Federally Funded Health Care Program Ownership and Control Disclosure Forms**
  - Corporate Compliance Officer collects/reviews Disclosures to ensure no federal funds are used to pay for items or services furnished by an individual/organization who is debarred, suspended, or otherwise excluded from participation in any Federal Health Care Program.
- **Exclusion Screenings**
  - Occurs on a recurring monthly basis to mitigate unforeseen exclusions that may arise.
- **Fraud, Waste, and Abuse education, reporting, and investigation**
- **Annual Risk Assessment**
  - Ranks risks according to likelihood of occurrence and potential consequence. Updated and reviewed quarterly by Compliance Committee.

Board Compliance Reports

📊 **Bi-annual Reports and Risk Assessment Updates**

- Number, type, and outcome of investigations
- Update on on-going compliance audits
- Update on annual Compliance goals/risks

📝 **Quarterly Review with Board Finance and Compliance Committee**

- Report on Compliance Goals, investigations, risks, and outcomes

Corporate Compliance Contract

ISK Compliance Hotline
(you may report anonymously):
1-866-939-4823 or
Direct Line: 269-364-6986

Ashley Esterline, aesterline@iskzoo.org
Director of Network Compliance
Corporate Compliance Officer

ISK Corporate Compliance Email compliance@iskzoo.org

By mail or in person:
Integrated Services of Kalamazoo
Attn: Corporate Compliance
610 S. Burdick St.
Kalamazoo, MI 49007

Integrated Services of Kalamazoo

Corporate Compliance/Risk Management

FY26 Q2 Recoupment/Reallocation Data Report

Summary	Source	Risk	Quality Improvement/Training/ Education	Recoupment/Reallocation (If Appropriate)	Federal or State Reporting Required?
FY 26 Q2 Investigations Completed					
FY 26 Q2 Investigations In-Process					
Provider submitted claims for Community Living Supports (CLS) that appeared to be up-coded.	ISK Specialized Residential Team	High	ISK Compliance investigation completed. Provider education on code/modifier reporting and appropriateness of documentation discussed. CAP received from Provider.	Yes – Recoupment in Process Total: $307,713.17 Full recoupment to be completed in June 2026	No

Integrated Services of Kalamazoo

Corporate Compliance / Risk Management
FY26 Q2 Report

Program Name:	**COMPLIANCE & RISK MANAGEMENT**	**Report Period:**	☐ October ☐ January ☒ April ☐ July
Person Completing Report:	Ashley Esterline, LMSW, CHC – Corporate Compliance Officer		
Overview:	Contained in this Status Report is a summary of the Compliance Program's goals and activities for FY26 as of March 31, 2026.		

Goals & Outcomes per work plan	Goal:	Status:
	1. ISK will ensure the long-term sustainability and regulatory compliance of both direct-operated services and the Provider Network by strengthening oversight, promoting adherence to policies and regulations, and supporting the delivery of high-quality, cost-effective care.	1. The Compliance Department maintained a strong focus on the Quality Record Review (QRR) process in Q2, with targeted efforts updating tools and requirements to ensure continued compliance with CARF, SWMBH, and MDHHS expectations. The FY25 MDHHS Waiver Audit was formally concluded during the quarter, with acceptance of ISK's corrective action plans and additional positive feedback from the Department recognizing the strength of implementation efforts. Ongoing staff education and training were delivered through annual Quality Monitoring Review (QMR) sessions, as well as targeted trainings provided by the Compliance team to reinforce expectations and support continued adherence to regulatory standards.
	2. ISK will provide oversight, monitoring, and implementation support for State and Federal regulatory changes and policies to ensure ongoing compliance and operational readiness.	2. Significant efforts were undertaken to provide training and updates to direct-operated programs and the Provider Network—particularly DCOs—regarding revised requirements under the proposed updated CCBHC Handbook criteria. Dedicated workgroups were established to support effective and consistent implementation. Compliance and Customer Services also collaborated to finalize a standardized CCBHC Customer Handbook for use across the region, with implementation planned for Q3. Focused workgroups remain active in response to the evolving Michigan Mental Health Framework initiative. While potential impacts to the PIHP system continue to shift, the previously proposed RFP has been rescinded by MDHHS. Leadership continues to closely monitor developments and remains prepared to respond to any new or revised direction from the MDHHS.
	3. ISK will monitor and identify high-risk areas related to fraud, waste, and abuse, and implement strategies to mitigate such occurrences.	3. Following the annual audit conducted by the MDHHS, the Compliance Department implemented and monitored both individual and systemic corrective action plans to support sustained compliance. These efforts include

		ongoing training and technical support, which will remain a priority throughout the fiscal year. In addition, focused review of Community Living Supports (CLS) services—delivered through both the Provider Network and self-determined arrangements—have continued. Dedicated efforts have ensured that CLS services are provided in accordance with Medicaid Provider Manual requirements and aligned with each individual's person-centered plan.

INTEGRATED SERVICES OF KALAMAZOO

Period Ended
March 31, 2026

Monthly Finance Report

This financial report is for internal use only. It has not been audited, and no assurance is provided.

INTEGRATED SERVICES OF KALAMAZOO

Statement of Net Position
March 31, 2026

	March 2025 (unaudited)	March 2026
Assets		
Current assets		
Cash and investments	$ 18,783,779	$ 27,208,725
Accounts receivable	5,085,859	6,811,755
Due from other governments	17,010,259	12,722,181
Prepaid items	1,403,716	1,751,844
Total current assets	42,283,613	48,494,505
Non-current assets		
Capital assets, net of accumulated depreciation	14,882,979	14,367,472
Net pension asset, net of deferred outflows	8,442,339	8,070,705
Total non-current assets	23,325,318	22,438,177
Total assets	$ 65,608,931	$ 70,932,682
Liabilities		
Current liabilities		
Accounts payable	$ 12,033,238	$ 10,241,391
Due to other governments	156,389	5,116,286
Due to providers	381,930	-
Accrued payroll and payroll taxes	3,117,833	2,649,452
Unearned revenue	132,102	122,391
Total current liabilities	15,821,492	18,129,519
Net position		
Designated	8,654,636	8,722,022
Undesignated	24,523,412	31,389,003
Investment in fixed assets	13,277,168	14,125,075
Net gain (loss) for period	3,332,223	(1,432,936)
Net position	$ 49,787,439	$ 52,803,163

INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position

October 1, 2025 through March 31, 2026
Percent of Year is 50.00%

	Original 2026 Budget	YTD Totals 3/31/26	Remaining Budget	Percent of Budget - YTD
Operating revenue				
Medicaid:				
Traditional Capitation	$ 86,641,701	41,775,147	$ 44,866,554	48.22%
Healthy Michigan Capitation	9,119,193	2,883,121	6,236,072	31.62%
Formula Fundings	3,900,516	1,950,258	1,950,258	50.00%
CCBHC Demonstration	34,258,759	16,468,260	17,790,499	48.07%
CCBHC Quality Bonus	1,326,190	-	1,326,190	0.00%
County Allocation	1,550,400	775,200	775,200	50.00%
Client Fees	1,069,711	398,014	671,697	37.21%
Other grant revenue	6,780,003	3,023,936	3,756,067	44.60%
Other earned contracts	1,958,805	1,121,426	837,379	57.25%
Interest	157,232	72,904	84,328	46.37%
Local revenue	508,606	10,277	498,329	2.02%
Total operating revenue	$ 147,271,116	$ 68,478,543	$ 78,792,574	46.50%
Operating expenses				
Salaries and wages	$ 32,403,237	14,791,696	17,611,541	45.65%
Employee benefits	12,643,544	5,272,093	7,371,451	41.70%
Staff development	300,933	56,686	244,247	18.84%
Payments to providers	93,008,476	43,712,128	49,296,348	47.00%
Administrative contracts	8,262,621	4,432,963	3,829,658	53.65%
IT software and equipment	928,129	450,298	477,830	48.52%
Client transportation	52,900	19,300	33,600	36.48%
Staff travel	386,676	143,736	242,940	37.17%
Office expenses	685,668	267,976	417,692	39.08%
Insurance expense	168,769	79,068	89,701	46.85%
Depreciation expense	585,704	283,463	302,240	48.40%
Utilities	363,874	184,272	179,602	50.64%
Facilities	36,265	65,246	(28,981)	179.92%
Local match	305,108	152,554	152,554	50.00%
Total operating expenses	$ 150,131,903	$ 69,911,479	$ 80,220,424	46.57%
Change in net position	(2,860,787)	(1,432,936)	$ (1,427,851)	
Beginning net position	54,236,100	54,236,100		
Ending net position	$ 51,375,313	$ 52,803,163		

INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position

October 1, 2025 through March 31, 2026

Percent of Year is 50.00%

	Specialty Services		Healthy Michigan		SUD Block Grant		Totals		
	Budget	YTD Totals 3/31/26	YTD Budget	YTD Totals 3/31/26	YTD Budget	YTD Totals 3/31/26	YTD Budget	YTD Totals 3/31/26	Variance
Operating revenue									
Medicaid:									
Traditional Capitation	$ 43,320,851	$ 45,870,312	$ -	$ -	$ -	$ -	$ 43,320,851	$ 45,870,312	$ 2,549,462
Healthy Michigan Capitation	-	-	4,559,597	3,732,345	-	-	4,559,597	3,732,345	(827,251)
Settlement Estimate	2,213,715	(4,095,166)	(1,534,489)	(849,225)	-	-	679,225	(4,944,391)	(5,623,616)
Client Fees	3,635	-	41	-	-	-	3,676	-	(3,676)
Total operating revenue	$ 45,538,200	$ 41,775,146	$ 3,025,149	$ 2,883,120	$ -	$ -	$ 48,563,349	$ 44,658,267	$ (3,905,082)
Operating expenses									
Internal services	$ 1,132,792	$ 1,314,005	$ 6,978	$ 4,276	$ -	$ -	$ 1,139,770	$ 1,318,281	178,512
External services	38,122,565	35,637,660	2,600,795	2,545,951	-	-	40,723,360	38,183,611	(2,539,749)
Delegated managed care	6,282,844	4,823,482	417,376	332,894	-	-	6,700,219	5,156,375	(1,543,844)
Total operating expenses	$ 45,538,200	$ 41,775,147	$ 3,025,149	$ 2,883,121	$ -	$ -	$ 48,563,349	$ 44,658,268	$ (3,905,081)
Change in net position	-	(0)	-	(0)	-	-	-	-	

INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position

October 1, 2025 through March 31, 2026

Percent of Year is 50.00%

	State General Fund		CCBHC		Other Funding Sources		Totals		
	YTD Budget	YTD Totals 3/31/26	YTD Budget	YTD Totals 3/31/26	YTD Budget	YTD Totals 3/31/26	YTD Budget	YTD Totals 3/31/26	Variance
Operating revenue									
General Fund	$ 1,950,258	$ 1,950,258	$ -	$ -	$ -	$ -	$ 1,950,258	$ 1,950,258	$ -
CCBHC Demonstration	-	-	18,655,253	17,201,435	-	-	18,655,253	17,201,435	(1,453,818)
Other Federal and State Grants	-	-	-	-	3,010,006	3,023,936	3,010,006	3,023,936	13,931
Earned Revenue	-	-	-	-	532,245	271,212	532,245	271,212	(261,033)
Interest	-	-	-	-	78,616	72,904	78,616	72,904	(5,712)
County Allocation	-	-	-	-	775,200	775,200	775,200	775,200	-
Local Revenue	3,562	-	-	-	254,303	10,277	257,865	10,277	(247,588)
Transfer from GF	-	-	36,950	483,239	-	-	36,950	483,239	446,290
Total operating revenue	$ 1,953,820	$ 1,950,258	$ 18,692,202	$ 17,684,674	$ 4,650,370	$ 4,153,529	$ 25,296,391	$ 23,788,460	$ (1,507,931)
Operating expenses									
Internal Programs	$ 443,264	$ 387,660	$ 19,165,063	$ 19,147,100	1,391	$ 1,679	$ 19,609,717	$ 19,536,439	$ (73,278)
External Programs	1,215,002	914,259	-	-	328,250	427,515	1,543,252	1,341,774	(201,478)
Other Federal and State Grants	-	-	-	-	3,359,068	2,537,036	3,359,068	2,537,036	(822,033)
HUD Grants	-	-	-	-	910,935	812,619	910,935	812,619	(98,316)
Managed Care Administration	258,604	165,100	-	-	-	-	258,604	165,100	(93,504)
Homeless Shelter	-	-	-	-	192,758	150,526	192,758	150,526	(42,232)
Transfer from GF	36,950	483,239	-	-	-	-	36,950	483,239	446,290
Local match expense	-	-	-	-	152,554	152,554	152,554	152,554	-
Non-DCH Activity Expenditures	-	-	-	-	28,557	42,012	28,557	40,691	12,135
Total operating expenses	$ 1,953,819	$ 1,950,258	$ 19,165,063	$ 19,147,100	$ 4,973,512	$ 4,123,941	$ 26,092,395	$ 25,219,978	(872,417)
Change in net position	0	(0)	(472,861)	(1,462,426)	(323,143)	29,588	$ (796,004)	(1,431,518)	(635,514)

INTEGRATED SERVICES OF KALAMAZOO

CCBHC

October 1, 2025 through March 31, 2026
Percent of Year is 50.00%

	CCBHC Medicaid	CCBHC Healthy MI	CCBHC Non-Medicaid	CCBHC YTD Totals
Operating revenue				
CCBHC revenue	$ 12,400,375	$ 4,067,885	$ -	$ 16,468,260
FFS Revenue	-	-	398,014	398,014
CCBHC SAMSHA Grant	-	-	335,160	335,160
Total CCBHC Revenue (PPS-1 of $304.05 x encounters)	$ 12,400,375	$ 4,067,885	$ 733,174	$ 17,201,435
Operating expenses				
Internal services	$ 9,749,040	$ 3,019,788	$ 1,907,633	$ 14,676,460
DCO Contracts	2,883,420	982,602	604,617	4,470,640
Total operating expenses	$ 12,632,460	$ 4,002,390	$ 2,512,250	$ 19,147,100
Operating change in net position	(232,085)	65,495	(1,779,075)	(1,945,665)
Reclassification to cover Non-Medicaid	-	-	483,239	483,239
Total change in net position	$ (232,085)	$ 65,495	$ (1,295,836)	$ (1,462,426)

CCBHC Cost per daily visit

	2023	FY 2024	FY 2025	3/31/26
Total CCBHC Cost	$ 27,687,187	$ 31,777,786	$ 35,393,270	$ 19,147,100
Daily Visits	99,802	110,326	125,458	62,531
Cost per daily visit	277.42	288.04	282.11	306.20

AUTISM SERVICES
Report Period: October 1st, 2025 through March 31st, 2026

	UTILIZATION COMPARISONS FY 25/26									
	FY 24/25 Actual		FY 25/26 Budget		FY 25/26 Actual			Clients Served Difference	Cost Difference	Cost YTD
		Dollars	Clients Served	Dollars	Clients Served			Favorable (Unfavorable)	Favorable (Unfavorable)	Favorable (Unfavorable)
OCTOBER	187	$944,462	194	$1,098,509	168	$979,255		26	$119,254	$119,254
NOVEMBER	175	$899,151	194	$1,098,509	169	$794,516		25	$303,993	$303,993
DECEMBER	170	$801,707	194	$1,098,509	187	793,941		7	$304,568	$304,568
JANUARY	190	$943,870	194	$1,098,509	194	762,474		0	$336,035	$336,035
FEBRUARY	197	$898,764	194	$1,098,509	184	1,080,095		10	$18,414	$18,414
MARCH	193	$1,054,656	194	$1,098,509	174	966,400		20	$132,109	$132,109
APRIL	189	$1,160,440	194	$1,098,509		-				
MAY	188	$1,027,319	194	$1,098,509		-				
JUNE	192	$1,048,980	194	$1,098,509		-				
JULY	184	$1,018,918	194	$1,098,509		-				
AUGUST	187	$934,104	194	$1,098,509		-				
SEPTEMBER	187	$1,120,200	194	$1,098,509		-				
TOTALS	2,239	$11,852,571	2,328	$13,182,110	1,076	$5,376,681		88	$1,214,373	
MONTHLY AVERAGES	187		194		179					
GROSS ANNUAL COST		$11,852,571		$13,182,110		$5,376,681			$1,214,373	

Favorable/(Unfavorable): Total 1,214,373

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YOUTH COMMUNITY INPATIENT SERVICES
Report Period: October 1st, 2025 through March 31st, 2026

	UTILIZATION COMPARISONS FY 25/26									
	FY 24/25 Actual		FY 25/26 Budget		FY 25/26 Actual			Days Difference	Cost Difference	Cost YTD
		Dollars	Clients Served	Dollars	Days			Favorable (Unfavorable)	Favorable (Unfavorable)	Favorable (Unfavorable)
OCTOBER	111	$96,759	85	$84,863	101	$101,060		(16)	($16,197)	($16,197)
NOVEMBER	117	$114,545	85	$84,863	98	$98,100		(13)	($13,237)	($13,237)
DECEMBER	52	$51,318	85	$84,863	74	$74,090		11	$10,773	$10,773
JANUARY	97	$95,247	85	$84,863	61	$62,291		24	$22,572	$22,572
FEBRUARY	100	$97,792	85	$84,863	31	$31,030		54	53,833	53,833
MARCH	77	$75,342	85	$84,863	95	$94,860		(10)	(9,997)	(9,997)
APRIL	80	$78,400	85	$84,863						
MAY	82	$80,360	85	$84,863						
JUNE	42	$41,160	85	$84,863						
JULY	47	$46,178	85	$84,863						
AUGUST	35	$34,329	85	$84,863						
SEPTEMBER	50	$48,608	85	$84,863						
TOTALS	890	$860,038	1,020	$1,018,350	460	$461,431		50	$47,747	$47,747
MONTHLY AVERAGES	74		85		77					
GROSS ANNUAL COST		$860,038		$1,018,350		$461,431			$47,747	

Favorable/(Unfavorable): Total 47,747

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COMMUNITY INPATIENT SERVICES
Report Period: October 1st, 2025 through March 31st, 2026

	UTILIZATION COMPARISONS FY 25/26									
	FY 24/25 Actual		FY 25/26 Budget		FY 25/26 Actual			Days Difference	Cost Difference	Cost YTD
		Dollars	Clients Served	Dollars	Days			Favorable (Unfavorable)	Favorable (Unfavorable)	Favorable (Unfavorable)
OCTOBER	637	$551,635	608	$702,343	575	$638,067		33	$64,276	$64,276
NOVEMBER	640	$702,827	608	$702,343	704	$779,060		(96)	($76,717)	($76,717)
DECEMBER	708	$777,481	608	$702,343	588	$650,541		20	$51,802	$51,802
JANUARY	577	$635,283	608	$702,343	652	$732,357		(44)	($30,014)	($30,014)
FEBRUARY	405	$447,214	608	$702,343	459	$512,948		149	189,395	189,395
MARCH	640	$706,244	608	$702,343	550	$614,768		58	87,575	87,575
APRIL	525	$577,375	608	$702,343						
MAY	503	$552,904	608	$702,343						
JUNE	618	$680,211	608	$702,343						
JULY	810	$890,502	608	$702,343						
AUGUST	662	$725,577	608	$702,343						
SEPTEMBER	675	$739,152	608	$702,343						
TOTALS	7,400	$7,986,405	7,296	$8,428,119	3,528	$3,927,741		120	$286,317	$286,317
MONTHLY AVERAGES	617		608		588					
GROSS ANNUAL COST		$7,986,405		$8,428,119		$3,927,741			$286,317	

Favorable/(Unfavorable): Total 286,317

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COMMUNITY LIVING SUPPORTS (CLS), PERSONAL CARE (PC) & CRISIS RESIDENTIAL
ALL POPULATIONS
Report Period: October 1st, 2025 through March 31st, 2026

					YTD		
					FY 25/26 Budget	FY 25/26 Actual	
SERVICE	Month	Avg. Daily Rate	No. Served	Days of Service	Dollars	Dollars	Favorable / (Unfavorable)
PC/CLS	Nov	$295	393	69,322	$20,484,851	20,469,497	$15,354
CRISIS RES.		$582	47	410	$498,050	$238,431	$259,619
CLS (SIP)	Nov	NA	329		$7,122,496	6,767,986	$354,510
Annual Cost							$629,483

Personal Care (P.C.)-hands on of daily personal activities such as laundry, feeding, bathing, etc.

Community Living Supports (CLS)-services to increase or maintain personal self -sufficiency with a goal of community inclusion, independence and productivity.

Specialized Residential (S.R.)-Licensed setting where Personal Care and Community Living Supports occur.

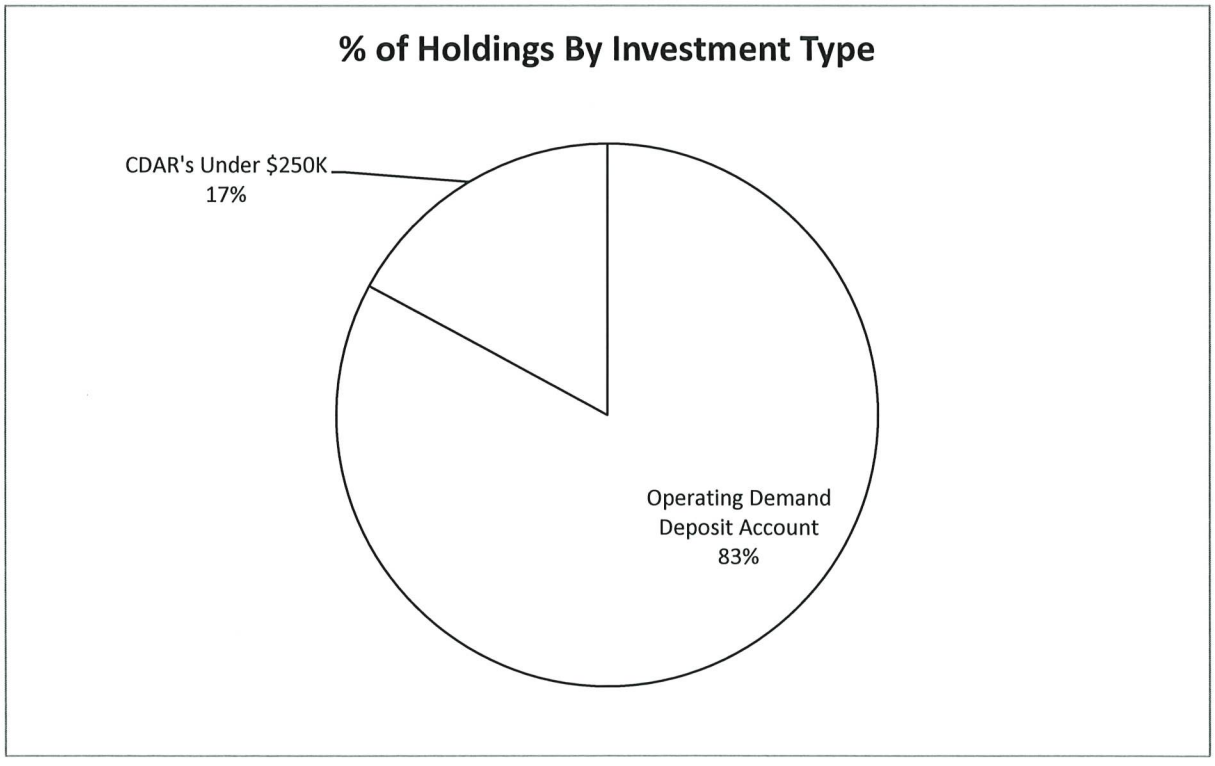
Supported Independent Program (SIP)-more independent setting where Personal Care and Community Living Supports occur.

Quarterly Cash & Investments Report
Quarter Ending March 31st, 2026

Financial Institution	Type of Investment	Cost Basis	Maturity Date	% Yield
CASH				
PNC	Operating Demand Deposit Account	$20,765,286	NA	0.03%
	Payroll Account	$5,000		
	Accrued Leave Reserve	$2,078,724		
	Pretax Reimbursement Account	$73,135		
	Various Petty Cash Funds	$780		
	Total Cash Accounts	**$22,922,925**		
INVESTMENTS				
CDAR's (via Independent Bank)	CD's Issued Under FDIC Limit of $250,000	$4,285,800		3.16%
Total CDAR's		$4,285,800		
	Total Investments	**$4,285,800**		
TOTAL CASH AND INVESTMENTS		**$27,208,725**		

% of Holdings By Institution	
PNC - Cash	84.25%
CDAR's (via Independent Bank)	15.75%
	100.00%

% of Holdings By Investment Type	
Cash	84.25%
CDAR's	15.75%
	100.00%



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Integrated Services of Kalamazoo

MOTION

Subject:	March 2026 Disbursements	
Meeting Date:	**April 27, 2026**	**Approval Date:**
Prepared by:	Charlotte Bowser	**April 27, 2026**

Recommended Motion:

"Based on the Board Finance meeting review, I move that ISK approve the March 2026 vendor disbursements of $12,792,204.43."

Summary of Request:

As per the March 2026 Vendor Check Register Report dated 04/10/2026 that includes checks issued from 03/01/2026 to 03/31/2026.

I affirm that all payments identified in the monthly summary above are for previously appropriated amounts.

Staff: **Charlotte Bowser, Finance Director**

Date of Board Consideration: **April 27, 2026**

INTEGRATED
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MOTION

Subject:	CLOSED SESSION – Personnel Evaluation	
Meeting Date:	March 23, 2026	Approval Date:
Prepared by:	*Karen Longanecker*	March 23, 2026

RECOMMENDED MOTION:

"PURSUANT TO A REQUEST BY JEFF PATTON, I MOVE THAT THE ISK BOARD OF DIRECTORS GO INTO CLOSED SESSION PURSUANT TO Section 8(1)(a) OF THE OPEN MEETINGS ACT TO CONDUCT A PERSONNEL EVALUATION PRIOR TO JEFF PATTON'S RETIREMENT."

SUMMARY OF REQUEST:

ROLL-CALL:	Yes	No
Karen Longanecker	____	____
Michael Seals	____	____
Nkenge Bergan	____	____
Patrick Dolly	____	____
Catherine Huynh	____	____
Patricia Guenther	____	____
Ramona Lumpkin	____	____
Melissa Woosley	____	____
Michael Raphelson	____	____
Abigail Wheeler	____	____
MOTION PASSED:	____	____

Budget:_____
Staff:_____

Date of Board
Consideration: March 23, 2026

Integrated Services of Kalamazoo

BOARD OF DIRECTORS RESOLUTION
MERITORIOUS STATUS
FOR

Charles Thomas

WHEREAS, Charles Thomas, has fittingly served as Program Coordinator in the Quality & Contracts departments for Integrated Services of Kalamazoo for 26 years, with proven unwavering dedication, professionalism, and excellence; and

WHEREAS, Charles has been instrumental in strengthening team collaboration, supporting organizational growth, and advancing best practices that align with the mission and values of ISK; and

WHEREAS, his integrity, compassion, and attention to detail have earned the respect and admiration of colleagues, community partners, and leadership alike; and

WHEREAS, Charles' contributions have left a lasting impact on the organization, staff, community and the individuals and families served. He has remained a steady and trusted presence. His work is not merely measured in reports or outcomes, but in the lives that he has touched, empowered, and made better; and

NOW, THEREFORE, BE IT RESOLVED, that the Integrated Services of Kalamazoo Board of Directors hereby expresses its deepest gratitude and appreciate to Charles for his years of dedicated service is pleased to grant **MERITORIOUS STATUS** to **Mr. Charles Thomas** with all the rights and privileges appertaining thereto. We congratulate Charles on his well-earned retirement and extend our sincere wishes for continued health, happiness and new adventures in this next chapter of life.

INTEGRATED
Services of Kalamazoo
Community • Independence • Empowerment

Dated this 17th of April 2026

Karen Longanecker
Karen Longanecker
ISK Board Chair

Jeffrey Patton
Jeffrey Patton
ISK Chief Executive Officer

Integrated Services of Kalamazoo

BOARD OF DIRECTORS RESOLUTION
MERITORIOUS STATUS
FOR

James "Jim" Jump

WHEREAS, Jim has faithfully served as Supervisor of Adult with Mental Illness Programs for 14 years, dedicating his career to improving the lives of our persons served; and

WHEREAS, through his compassionate leadership, clinical insight, and advocacy, Jim has been instrumental in helping to ensure that adults in our community receive care rooted in dignity, respect, and hope; and

WHEREAS, Jim has guided his team to lead with wisdom and steadiness, while implementing a culture of accountability, collaboration, and excellence in service delivery; and

WHEREAS, during times of changes or challenges, Jim prioritized the well-being of our persons served with ethical practices and program integrity. Jim has exemplified the very spirit of public service, showing leadership without ego, and dedication without compromise; and

NOW, THEREFORE, BE IT RESOLVED, that the Integrated Services of Kalamazoo Board of Directors hereby expresses its deepest gratitude and appreciate to Jim for his years of dedicated service is pleased to grant **MERITORIOUS STATUS** to **Mr. James Jump** with all the rights and privileges appertaining thereto. We congratulate Jim on his well-earned retirement and extend our sincere wishes for continued health, happiness, and new adventures in this next chapter of life.

INTEGRATED
Services of Kalamazoo
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Dated this 30th of April 2026

Karen Longanecker
Karen Longanecker
ISK Board Chair

Jeff Patton
Jeffrey M. Patton
ISK Chief Executive Officer