Summary of Revisions for FY 25 Performance Improvement Plan

- **Plan name changed from Performance Improvement to Continuous Quality Improvement Plan (CQI)**
- **Changed PI Annual Report to CQI Annual Report**
- **Changed PI Committee to CQI Committee**
- **Changed performance improvement to quality improvement.**
- **Changed PI System to CQI process.**
- **Added back:**

Commitments: Patients who are inpatient committed to crisis stabilization units, state hospitals, or other designated mental health facilities are monitored at least quarterly through the CQI process. Consumers who are outpatient committed are monitored to ensure compliance with the terms of the commitment. The judge issuing the order is informed if the terms are not met. The report is monitored at least quarterly through the CQI process.

- **Added:**

Quality Measures: The following quality measures will be reviewed: (1) Time to Services (I-SERV); (2) Depression Remission at six months (DEP-REM-6); (3) Preventive Care and Screening: Unhealthy Alcohol Use Screening and Brief Counseling (ASC); (4) Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD); (5) Screening for Social Drivers of Health (SDOHC).

- **Added:**

Targeted Subpopulations: Data from the Quality Measures, and other data, as available, will be tracked at least quarterly through the CQI process. Outcomes and health disparities for Populations of Focus (POF), as defined by the ADMH CCBHC Implementation Bulletin, will be reviewed. Any disparities noted will be addressed through the implementation of a plan to improve those outcomes.

- **Changed review of these events from at least annually to quarterly:**

Significant Events: The following significant events will be reviewed at least quarterly: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving services; (4) 30 day hospital readmissions for psychiatric or substance use reasons.

MOUNTAIN LAKES
Behavioral Healthcare

Continuous Quality Improvement Plan

Overview and Purpose of Continuous Quality Improvement (CQI) Plan

The Mountain Lakes Behavioral Healthcare Continuous Quality Improvement (CQI) Plan is a formal method of evaluating the quality of care provided as well as promoting and maintaining an efficient and effective service delivery system. This system is designed to identify and assess important processes and outcomes, to correct and follow-up on identified problems, analyze trends, to improve the quality of services provided, and to improve consumer and family satisfaction with services provided. The system provides meaningful opportunities for input concerning the operation and improvement of services from consumers, family members, consumer groups, advocacy organizations, and advocates.

Processes described in this plan apply to all program service areas and functions within the agency, including subcontracted consumer services. The agency's service areas include all certified programs of the Marshall-Jackson Mental Health Board, dba Mountain Lakes Behavioral Healthcare, listed by program name in the organizational chart in **Attachment A**.

The CQI plan is reviewed and approved by the board of directors at least every two (2) years and when revisions are made.

Mission, Vision, Guiding Values, Goals & Objectives

The mission of Mountain Lakes Behavioral Healthcare is to provide a consumer-sensitive, outcome-oriented, behavioral healthcare system, open to affiliate with other organizations to deliver quality services. An effective CQI plan is vital for the success of this mission due to its focus on consumer satisfaction and quality outcomes. See **Attachment B** for the agency's mission statement, vision statement, and guiding values.

The agency's goals and objectives for continuous quality improvement are derived from the mission statement. The agency's overall goals and objectives for the current fiscal year are listed in **Attachment C**.

Philosophy of Continuous quality improvement

In order to maintain a focus on continuous quality improvement, Mountain Lakes Behavioral Healthcare develops, implements, and maintains an effective, agency-wide continuous quality improvement plan for the services provided. This plan establishes a critical review process to review

outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services.

All staff members are trained on principles and techniques of continuous quality improvement and their application in every aspect of service delivery. Throughout various committee meetings, department meetings, emails and trainings, all staff members have an opportunity to identify opportunities for improvement for the organization.

Coordination of the Continuous Quality Improvement Plan

The clinical director and/or designee are responsible for coordination of all continuous quality improvement activities and execution of the CQI plan. The clinical director and designee have completed an ADMH MHSAS Incident Management training and are responsible for adherence to the Continuous Quality Improvement Plan. The quality assurance coordinator is responsible for distribution of appropriate reports, minutes, and other pertinent information to committee members and staff as needed. The executive director or designee is responsible for distributing reports, minutes, and other pertinent information to the board of directors as appropriate.

Assessment Methodology

Several processes are used for the assessment, evaluation, and implementation of improvement strategies for important processes and outcomes within the CQI plan. These include the CQI Annual Report, the Process Design form, and the Corrective Action Plan process.

Information Communication

Findings and recommendations related to all components of the continuous quality improvement plan are reported to either the (CQI) committee or the Leadership Committee. The CQI committee reports directly to the Leadership Committee, which is comprised of clinical and administrative supervisors. Findings and recommendations are reflected in meeting minutes. The minutes of all CQI and leadership meetings are documented and distributed to staff at all levels through email. The board of directors is notified of CQI findings and recommendations by the executive director and through the CQI and Leadership Committee minutes, which are distributed to board members at least quarterly. Annual CQI findings are communicated to consumers, families and advocates upon request through the executive director's office. All CQI information is made available to DMH upon request.

Annual Report

A CQI Annual Report will be compiled each year detailing the organization and outcomes for the year's activities of the CQI plan. This report will include all annual and aggregate reports described in the CQI plan. The report summarizes continuous quality improvement findings, assessment of trends and patterns, actions taken relative to findings, and recommendations for needed improvement. The report will be presented to the continuous quality improvement committee, leadership committee, and the board of directors. The CQI Annual Report will be made available to staff, consumers, families and advocates upon request through the executive director's office.

Process Design

To ensure that new or modified processes are designed well and in a collaborative and interdisciplinary manner, a process design form (**Attachment D**) will be utilized. The following key points are addressed in the process design form:

- Is consistent with the agency's mission, vision, values and plans.
- Meets the needs and expectations of key constituents.
- Is clinically sound and up-to-date.
- Is consistent with sound business practice.
- Establishes baseline performance expectations to guide measurement and assessment activities.

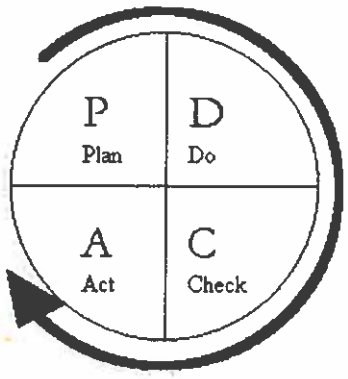
Corrective Action Plans

When a problem is identified that cannot be readily remedied, a Corrective Action Plan (**Attachment E**) is completed and directed to the leadership committee. The leadership committee reviews all Corrective Action Plans with the executive director as reported to determine the urgency of the time frame for the response.

If it is determined immediate action needs to be taken, the executive director will call an emergency meeting. If there is no need for immediate action, the Corrective Action Plan will be reviewed at the next leadership committee meeting.

Once reviewed by the leadership committee, the Corrective Action Plan is routed to appropriate staff to develop and implement corrective action. The staff member(s) will utilize the "Plan, Do, Check, Act" (PDCA) improvement model (described below) while working through the corrective action or any other improvement strategies:

Staff will report the outcome of the corrective action plan to the leadership committee in a timely manner. If necessary, policy and procedure will be developed and implemented as a result of the findings.



The PDCA Cycle provides an ongoing method for testing the change by trying it out, observing the results, and taking action on what is learned about the change. Each step provides challenges that need to be addressed:

Plan – State the objective, predict what will happen and why, develop a plan to carry out the change (Who? What? When? Where?) and determine what data will need to be collected.

Do – Carry out the test, document problems and unexpected observations and begin analysis of the data.

Check – Complete the data analysis, compare the data to the predictions and summarize what was learned.

Act – Determine what modifications should be made and predict what will happen in the next cycle.

Components of CQI plan

To achieve its purpose (as described earlier in this document), the CQI plan identifies and monitors important processes and outcomes for the components listed below. Each component will be defined and described in detail within this CQI plan. Additional components may be added at the discretion of the executive director.

- Quality Improvement
- Incident Prevention & Management
- Consumer & Family Satisfaction
- Utilization Review
- Treatment Review

* Seclusion and Restraint component is not applicable (See P & P 5.16 & 5.17)

The agency will also participate in all required performance indicators and quality improvement reporting requirements as required by DMH.

Indicator Selection

Staff members are involved in the selection and monitoring of quality improvement indicators throughout CQI activities. Program directors and program coordinators meet with their respective staff to obtain input regarding these indicators. The CQI committees are comprised of staff from all departments and all disciplines. These processes assure that indicators monitored by the agency have application at all levels of the agency.

Consumers and family members provide input in the selection of QI indicators to be monitored and subsequent improvement activities through customer and family satisfaction surveys. These surveys are randomly conducted in all programs, at least once per year. In order to ensure consumer/family confidentiality, all surveys are anonymous.

In addition, consumers are asked to participate or provide input in the continuous quality improvement work groups to bring a consumer perspective to the analysis of a given problem. Input regarding ways to improve is also gathered from the program certification process. Local needs planning meetings are scheduled by the executive director in collaboration with DMH to identify community needs.

Continuous Quality Improvement Committees

The following committees play a role in the implementation of the continuous quality improvement plan.

LEADERSHIP COMMITTEE

Mission: To provide management oversight of the functions and operations of the organization including annual preparation of the mission, vision, and guiding values statements, goals and objectives, and strategic action plan; establishment of guidelines for organizational planning, directing, implementing, and coordinating services; improving performance to include budgets and allocation of resources; review at least quarterly organizational effectiveness and department/program/services performance standards; and operational plans including budget variance.

Membership: **Chair:** Executive Director
Members: Clinical Director
Program Directors/Coordinators
Human Resources Coordinator
Business Manager
Executive Coordinator

Meeting: At least quarterly

Agenda: As stated

Report: At least quarterly to the Board of Directors
Report all action to the staff

CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

Mission: To ensure quality services are provided in an appropriate manner and that the treatment produces effective results in resolving identified problems.

The continuous quality improvement committee is multi-faceted and reviews indicators as identified in the CQI plan.

Membership: **Chair:** Clinical Director
Members: Executive Director
Program Directors
Program Coordinators
Records Librarians
QA Coordinator
Training Coordinator

Meeting: At least quarterly

Agenda: As stated

Report: Leadership Committee

CONSUMER SATISFACTION COMMITTEE

Mission: To evaluate the level of consumer satisfaction with the services provided by, minimally, conducting each year, one direct consumer survey, a survey of external consumers (if required by the executive director) and a survey of family members of consumers. A formal report of the results from these surveys will be provided for the programs and board of directors.

Membership: Chair: Appointment
Members: Cross-departmental
Cross-sectional

Meeting: As needed

Agenda: As stated

Report: Leadership Committee

These committees are comprised of employees from each discipline/service. These committees may form ad-hoc, task oriented work groups, as needed, for data gathering or to work on specific issues where specialized persons may need to be involved.

Continuous Quality Improvement Component

To promote continuous quality improvement, the agency will follow its process for periodic and timely reviews. Types of reviews that will be conducted include, but are not limited to:

1. Review of deficiencies, requirements and suggestions
   a. The clinical director and designated staff will continuously review any deficiencies, requirements, and quality improvement suggestions related to critical standards from DMH certification site visits, advocacy visits, and/or from other pertinent regulatory, accrediting, guarantors, or licensing bodies.
   b. Action plans will be developed, implemented, and evaluated to correct deficiencies and to prevent reoccurrence of deficiencies cited. This process is documented using the Corrective Action Plan form described earlier in this report. Efficacy of changes made in response to deficiencies cited will be assessed based on the outcomes of future site visits. The outcome of deficiencies addressed is summarized in the CQI Annual Report.
2. Administrative Reviews
   Consumer records will undergo administrative review of a representative sample of consumer records to determine that all documentation required by Alabama Administrative Code and agency policies and procedures is present, complete and accurate. A review of aggregate findings from the administrative reviews will be completed at least annually. Recommendations and actions taken for improvement as indicated by the data will be noted in the CQI Annual Report.
3. Observation of Prevention Staff
   Observation of direct Prevention staff at least twice during the year. Direct feedback to staff will evaluate the following:
   a. Rapport with the targeted audience.
   b. Delivery and accuracy of information.

c. Awareness and sensitivity to cultural responsiveness.
d. Prevention activities are responsive to the developmental needs of the target audience.

4. Substance Abuse Only Outcome Measures:

At a minimum, the following information shall be collected at time of assessment and at transfer or discharge to provide measures of outcome as specified in the following domains. Reports of these outcomes will be provided to DMH in the manner, medium, and period specified:

a. Reduced Morbidity:
Outcome: Abstinence from drug/alcohol use.
Measure: Reduction/no change in frequency of use at date of last service compared to first.

b. Employment/Education:
Outcome: Increased/Retained Employment or Return to/Stay in School.
Measure: Increase in/no change in number of employed or in school at date of last service compared to first.

c. Crime and Criminal Justice:
Outcome: Decreased criminal justice involvement.
Measure: Reduction in/no change in number of arrests in past thirty (30) days from date of first service to date of last service.

d. Stability in Housing:
Outcome: Increased stability in housing.
Measure: Increase in/no change in number of consumers in stable housing situation from date of first service to date of last service.

e. Social Connectedness:
Outcome: Increased social supports/social connectedness.
Measure: Increase in or no change in number of consumers in social/recovery support activities from date of first service to date of last service.

Incident Prevention and Management System Component

The Incident Prevention and Management System establishes a process for reviewing special incident data at least quarterly. These reviews focus on the identification of trends and actions taken to reduce risks and to improve the safety of the environment of care for consumers, families, and staff members. All incidents shall be reported in accordance with Alabama Administrative Code and the ADMH Incident Management Plan.

Staff at all levels and disciplines are trained on incident reporting and all programs operated by the agency are responsible for knowing and following incident reporting procedures. The following incident types are monitored by the agency:

- Incidents, as defined by the agency;
- Reportable incidents, as defined by DMH; and
- Critical incidents, as defined by DMH.

The agency shall conduct, or cause to be conducted, timely and adequate investigations of and responses to reportable incidents involving consumers. Agency staff members responsible for conducting or supervising investigations will attend a DMH special incident investigation training workshop.

Incident data will be reviewed in a timely and appropriate manner, no less than quarterly, through the CQI process. Findings and recommendations from incident reviews will be reported at least quarterly to the executive and clinical leaders including the board of directors. Pertinent data regarding improvement strategies will be communicated to staff level employees. There will be ongoing monitoring of medication errors. In the event significant trends are identified, these will be addressed through a Corrective Action Plan and/or progressive disciplinary actions. Details on the processes for identification, reporting, and investigation of incidents are included in Policy & Procedure 5.9.

Consumer and Family Satisfaction Component

The tools listed below will be utilized to assess the satisfaction of consumers, families with services provided and to obtain input from consumers and their families regarding factors which impact the care and treatment of consumers.

- Mental Health Statistical Improvement Plan (MHSIP) consumer and family satisfaction surveys
- Random consumer surveys
- Substance Use Services Case Reviews shall assess the satisfaction of consumers and families, including but not limited to: (1) The consumer's perception of the outcome of services. (2) The consumer's perception of the quality of the therapeutic alliance. (3) Other perceptions of consumers and families that impact care and treatment, including access to care, knowledge of program information, and staff helpfulness.
- Prevention annual feedback survey (to community partners, parents of youth participants, youth participants, adult participants and consumers of services)
- Feedback from consumer feedback boxes (written information)
- Consumer complaints and grievances (written or verbal information)
- Any other reports made or feedback given to staff or consumer satisfaction committee

This committee reports back to the leadership committee with findings and recommendations at least quarterly. Consumer feedback boxes are also agency-specific indicators for measuring consumer and family satisfaction and are reviewed at least quarterly with consumer satisfaction and leadership committees. An annual Prevention feedback survey will be completed with community partners, parents of youth participants, youth participants' adult participants and consumers of services.

All of these tools are utilized to obtain consumer and family input regarding satisfaction with service delivery and outcomes. Alternate mechanisms may be used when obtaining input from consumers and family members who are deaf, have limited English proficiency, or are illiterate. When verbal or written tools are not sufficient, access to the process will be provided by either bilingual staff fluent in the consumer's preferred language or by a qualified interpreter.

Data collected via these tools, including complaints and grievances, will be reviewed at least annually by the consumer satisfaction, CQI and leadership committees, and reported to the board of directors in the CQI Annual Report. Complaints and grievances requiring action will be reviewed immediately by the executive director or clinical director and reported to the CQI committee to rectify any problems and prevent recurrence of similar problems. The board of directors shall annually review, update as appropriate and approve the grievance, complaint and appeals process.

Utilization Review Component

1. The agency will perform at least quarterly reviews of the findings from the DMH Utilization Review (UR) monitor for all MI residential programs and for all SU levels of care. This review will assess the agency's compliance with Length of Stay (LOS) expectations and will determine and implement actions to improve performance when variations in Length of Stay (LOS) expectations occur.
2. The agency will review at least annually a representative sample in each certified program to assess the appropriateness of admission to that program relative to published admission criteria. For all programs, these reviews will be compiled and shared with the CQI committee at least annually.

Treatment Review Component

A clinical review of a sample of all direct service staff records will be conducted at least annually to determine that the case has been properly managed. An aggregate review of the clinical review findings will be reported to the CQI committee at least annually to assess trends and patterns and to determine actions for improvement based on findings. Clinical reviews assess for the following:

1. The appropriateness of admission to that program is relative to published admission criteria.
2. Treatment plan is timely.
3. Treatment plan is individualized.
4. Documentation of services is related to the treatment plan and addresses progress toward treatment objectives.
5. There is evidence of attempts to actively engage consumer, family and collateral supports in the treatment process to include linguistic and/or auxiliary support services for people who are deaf, hard of hearing, or limited English proficient as well as any other accommodations for other disabilities.
6. Treatment plan modified (if needed) to include linguistic and/or auxiliary support services for people who are deaf, hard of hearing, or limited English proficient as well as any other accommodations for other disabilities.

Continuous Quality Improvement Indicators

In order to identify which data must be gathered, monitored and reported, specific indicators are identified for the agency. These are listed below along with the frequency of monitoring and the period of time that each indicator will continue to be monitored after goal attainment is achieved.

Hospital Discharges: In order to help individuals successfully transition from inpatient to outpatient care, follow up measures for individuals discharged from a local psychiatric hospital, DMH mental illness hospital, crisis stabilization unit, or crisis diversion center are monitored and reported at least quarterly through the CQI process.

Commitments: Patients who are inpatient committed to crisis stabilization units, state hospitals, or other designated mental health facilities are monitored at least quarterly through the CQI process. Consumers who are outpatient committed are monitored to ensure compliance with the terms of the commitment. The judge issuing the order is informed if the terms are not met. The report is monitored at least quarterly through the CQI process.

Quality Measures: The following quality measures will be reviewed: (1) Time to Services (I-SERV); (2) Depression Remission at six months (DEP-REM-6); (3) Preventive Care and Screening: Unhealthy Alcohol Use Screening and Brief Counseling (ASC); (4) Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD); (5) Screening for Social Drivers of Health (SDOH).

Targeted Subpopulations: Data from the Quality Measures, and other data, as available, will be tracked at least quarterly through the CQI process. Outcomes and health disparities for Populations of Focus (POF), as defined by the ADMH CCBHC Implementation Bulletin, will be reviewed. Any disparities noted will be addressed through the implementation of a plan to improve those outcomes.

Residential Occupancy: MI residential program occupancy is reviewed at least quarterly with a focus on filling vacancies with those needing a less restrictive level of care or those needing additional support to avoid hospitalization.

ACSIS Consumer Profile Report: A report which is received from DMH of errors in the consumer information which is reported monthly to the DMH Central Data Repository (CDR), Alabama Community Services Information System (ACSIS). These reports are monitored and reported at least quarterly through the CQI process.

School Based Mental Health Program: Specified outcome data listed in the DMH SBMHC Data Collection Elements are collected from the Child/Adolescent Needs and Strengths Assessments. ADMH outcome reports are disseminated to MLBHC at least annually. This data is then analyzed and reviewed through the CQI process.

Significant Events: The following significant events will be reviewed at least quarterly: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving services; (4) 30 day hospital readmissions for psychiatric or substance use reasons.

Prevention Program: Monitor and assess prevention processes and outcomes to: (1) Identify organizational and capacity issues as they relate to programming. (2) Improve the overall quality of prevention program and practice. (3) Instill a process for informed decision making on appropriate service provision. (4) Ensure program fidelity and documentation.

Quality Improvement	Incident Prevention & Management	Consumer Satisfaction	Utilization Review	Treatment Review	INDICATOR	FREQUENCY	FURTHER MONITORING
X					*Review of deficiencies	Within three months of findings	One year
X					Administrative reviews and findings	At least quarterly	Ongoing
X					Observation of prevention staff	At least twice per year	Ongoing
X					*SA treatment outcomes and outcome measures	Annually	Ongoing
X					ACSIS consumer profile report	At least quarterly	Ongoing
X					SBMH outcomes	At least annually	One year

X					Significant events	At least quarterly	Ongoing
X					Targeted Subpopulations	At least quarterly	Ongoing
X					Prevention activities	At least quarterly	Ongoing
X					Hospital discharge follow up	At least quarterly	Ongoing
	X				*Incident prevention & management	At least quarterly	Ongoing
	X				*Medication errors	At least annually	Ongoing
		X			*Consumer and family satisfaction surveys	At least annually	One year
		X			*Complaints and grievances	At least annually	One year
		X			Consumer feedback	At least quarterly	Ongoing
			X		DMH Utilization review (UR) monitor reports	At least quarterly	Ongoing
			X		*Utilization review admission criteria	At least annually	Ongoing
			X		Inpatient commitments	At least quarterly	Ongoing
			X		Outpatient commitments	At least quarterly	Ongoing
			X		MI residential occupancy	At least quarterly	Ongoing
				X	* Treatment reviews	At least quarterly	Ongoing

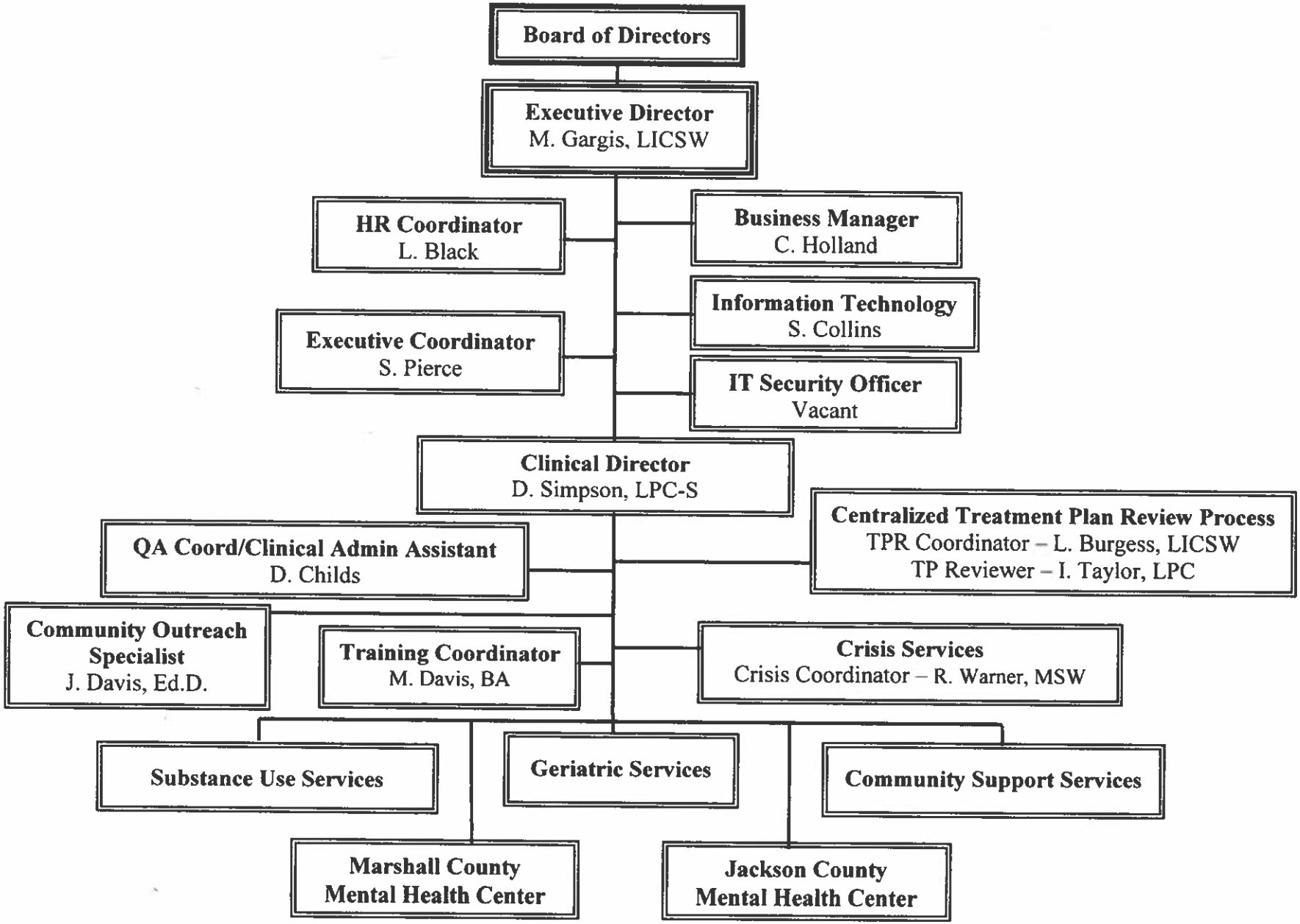
* Also monitored aggregately in the CQI Annual Report

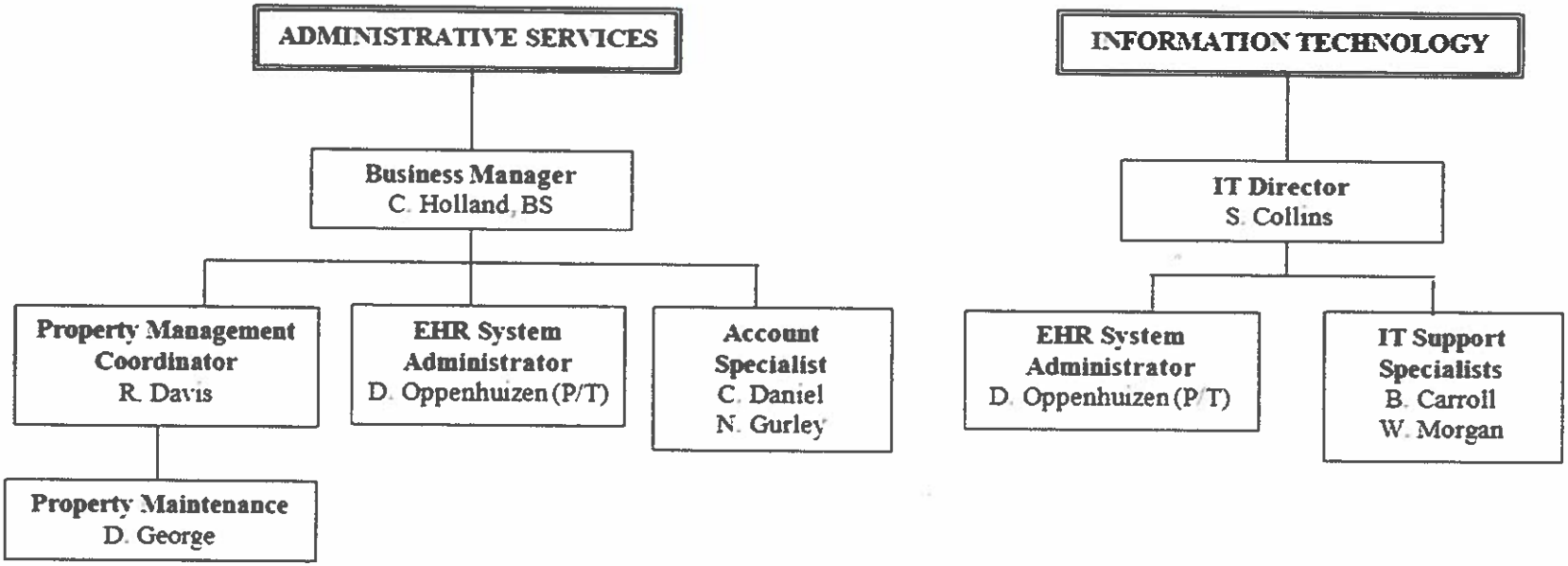
Additional indicators can be added at the discretion of the executive director, clinical director, or CQI committee. Indicators will also be added as DMH specifies additional performance measures to be monitored. The agency will participate in system level activities, including the use of DMH sanctioned external monitoring, to assess and to identify actions for improvement.

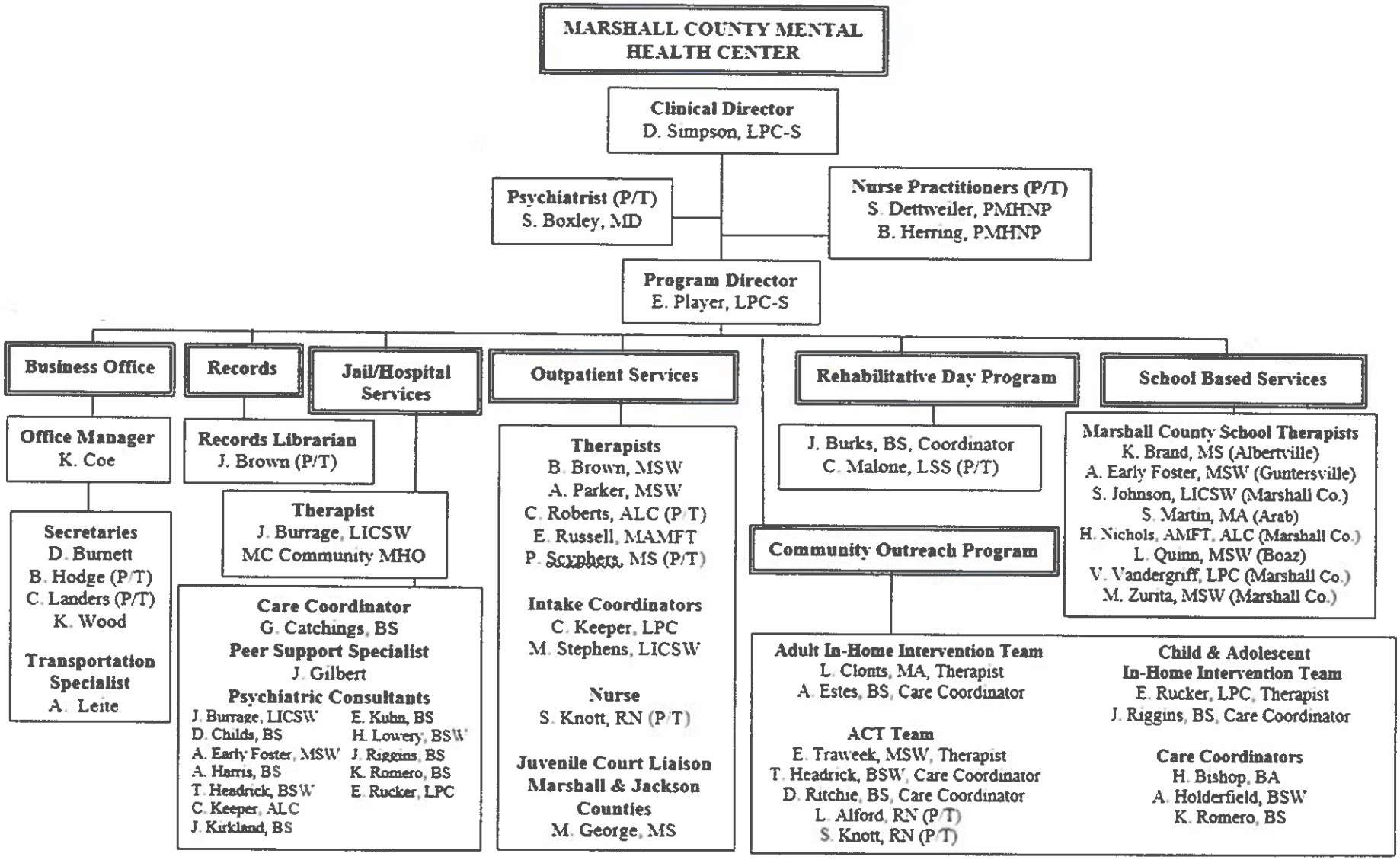
Evaluation and Resolution

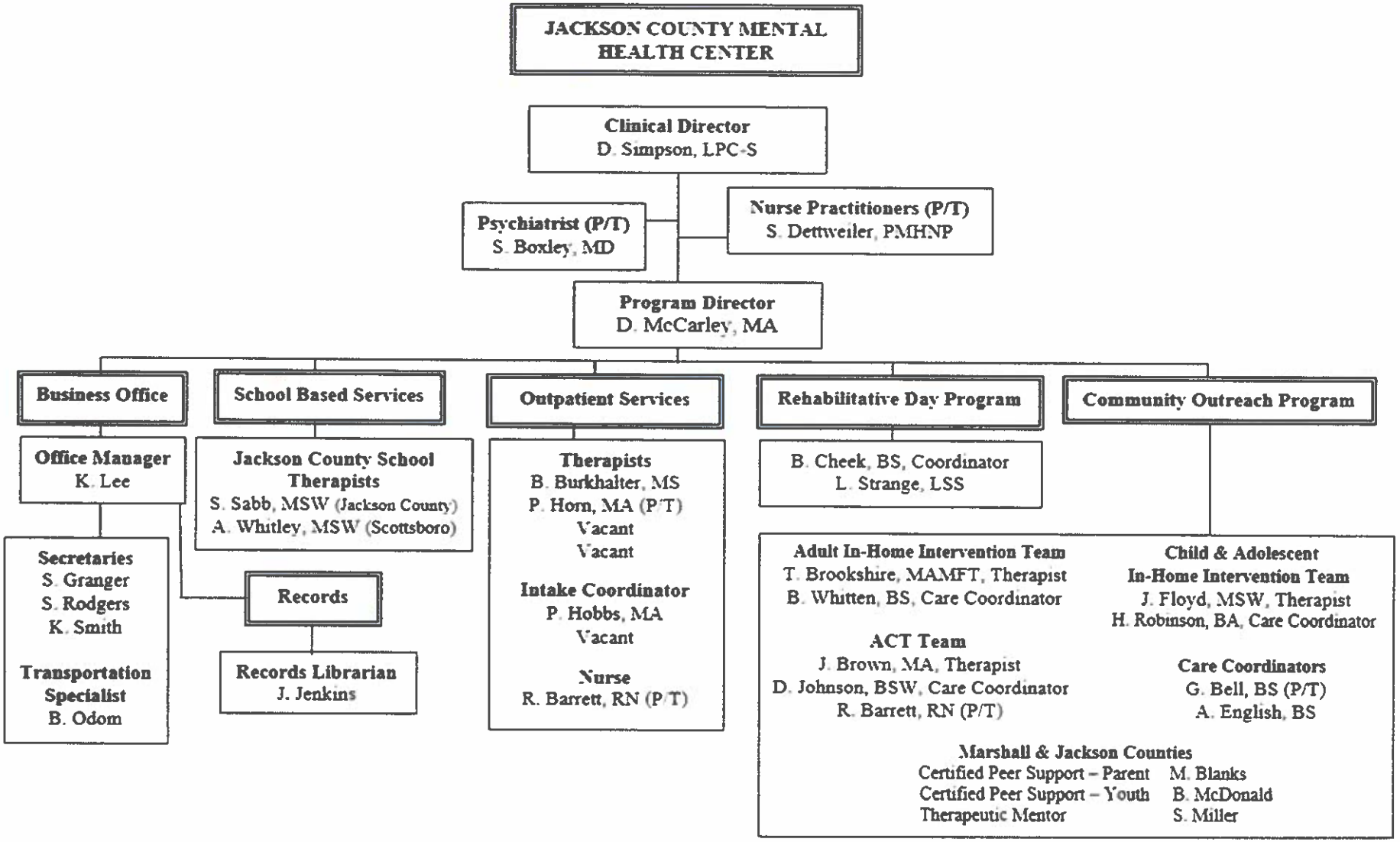
Mountain Lakes Behavioral Healthcare operates on the premise that quality service delivery effort is achievable and measurable. Errors identified in the review processes above are reported and, when possible, corrected. If review findings suggest significant variations between the standard and actual practice, or if significant trends develop, process design forms or corrective action plans will be developed and implemented in response to findings. Continuous quality improvement is the driving force behind Mountain Lakes Behavioral Healthcare's commitment to its mission of "providing a consumer-sensitive, outcome-oriented, behavioral healthcare system, open to affiliate with other organizations to deliver quality services."

Attachment A


Board of Directors
Executive Director
M. Gargis, LICSW
HR Coordinator
L. Black
Business Manager
C. Holland
Information Technology
S. Collins
Executive Coordinator
S. Pierce
IT Security Officer
Vacant
Clinical Director
D. Simpson, LPC-S
Centralized Treatment Plan Review Process
TPR Coordinator – L. Burgess, LICSW
TP Reviewer – I. Taylor, LPC
QA Coord/Clinical Admin Assistant
D. Childs
Community Outreach Specialist
J. Davis, Ed.D.
Training Coordinator
M. Davis, BA
Crisis Services
Crisis Coordinator – R. Warner, MSW
Substance Use Services
Geriatric Services
Community Support Services
Marshall County Mental Health Center
Jackson County Mental Health Center


ADMINISTRATIVE SERVICES
Business Manager
C. Holland, BS
Property Management Coordinator
R. Davis
Property Maintenance
D. George
EHR System Administrator
D. Oppenhuizen (P/T)
Account Specialist
C. Daniel
N. Gurley
INFORMATION TECHNOLOGY
IT Director
S. Collins
EHR System Administrator
D. Oppenhuizen (P/T)
IT Support Specialists
B. Carroll
W. Morgan


MARSHALL COUNTY MENTAL HEALTH CENTER
Clinical Director
D. Simpson, LPC-S
Psychiatrist (P/T)
S. Boxley, MD
Nurse Practitioners (P/T)
S. Dettweiler, PMHNP
B. Herring, PMHNP
Program Director
E. Player, LPC-S
Business Office
Office Manager
K. Coe
Secretaries
D. Burnett
B. Hodge (P/T)
C. Landers (P/T)
K. Wood
Transportation Specialist
A. Leite
Records
Records Librarian
J. Brown (P/T)
Jail/Hospital Services
Therapist
J. Burrage, LICSW
MC Community MHO
Care Coordinator
G. Catchings, BS
Peer Support Specialist
J. Gilbert
Psychiatric Consultants
J. Burrage, LICSW
D. Childs, BS
A. Early Foster, MSW
A. Harris, BS
T. Headrick, BSW
C. Keeper, ALC
J. Kirkland, BS
E. Kuhn, BS
H. Lowery, BSW
J. Riggins, BS
K. Romero, BS
E. Rucker, LPC
Outpatient Services
Therapists
B. Brown, MSW
A. Parker, MSW
C. Roberts, ALC (P/T)
E. Russell, MAMFT
P. Scyphers, MS (P/T)
Intake Coordinators
C. Keeper, LPC
M. Stephens, LICSW
Nurse
S. Knott, RN (P/T)
Juvenile Court Liaison
Marshall & Jackson Counties
M. George, MS
Rehabilitative Day Program
J. Burks, BS, Coordinator
C. Malone, LSS (P/T)
School Based Services
Marshall County School Therapists
K. Brand, MS (Albertville)
A. Early Foster, MSW (Guntersville)
S. Johnson, LICSW (Marshall Co.)
S. Martin, MA (Arab)
H. Nichols, AMFT, ALC (Marshall Co.)
L. Quinn, MSW (Boaz)
V. Vandergriff, LPC (Marshall Co.)
M. Zurita, MSW (Marshall Co.)
Community Outreach Program
Adult In-Home Intervention Team
L. Clonts, MA, Therapist
A. Estes, BS, Care Coordinator
ACT Team
E. Traweek, MSW, Therapist
T. Headrick, BSW, Care Coordinator
D. Ritchie, BS, Care Coordinator
L. Alford, RN (P/T)
S. Knott, RN (P/T)
Child & Adolescent In-Home Intervention Team
E. Rucker, LPC, Therapist
J. Riggins, BS, Care Coordinator
Care Coordinators
H. Bishop, BA
A. Holderfield, BSW
K. Romero, BS


JACKSON COUNTY MENTAL HEALTH CENTER
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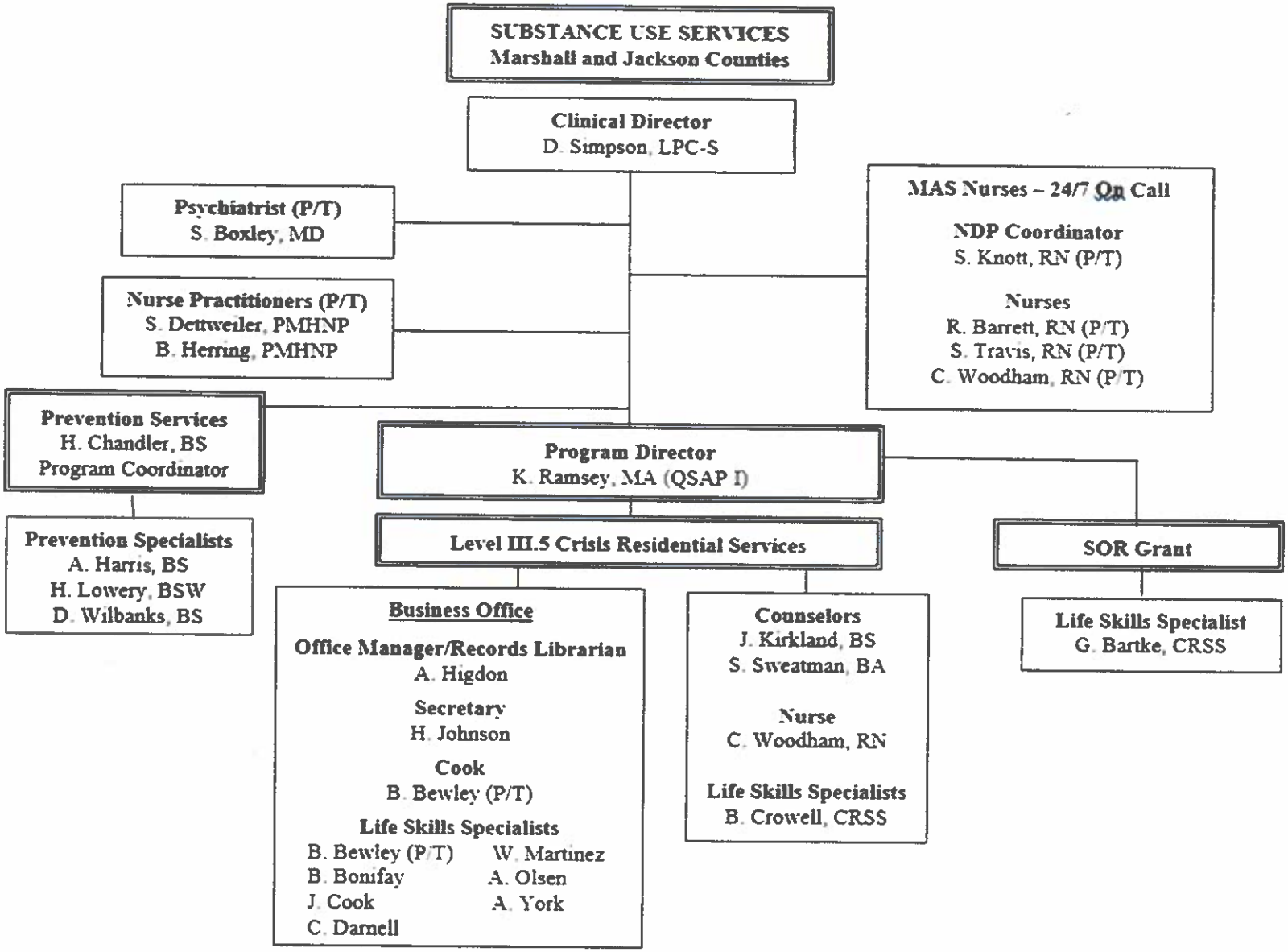
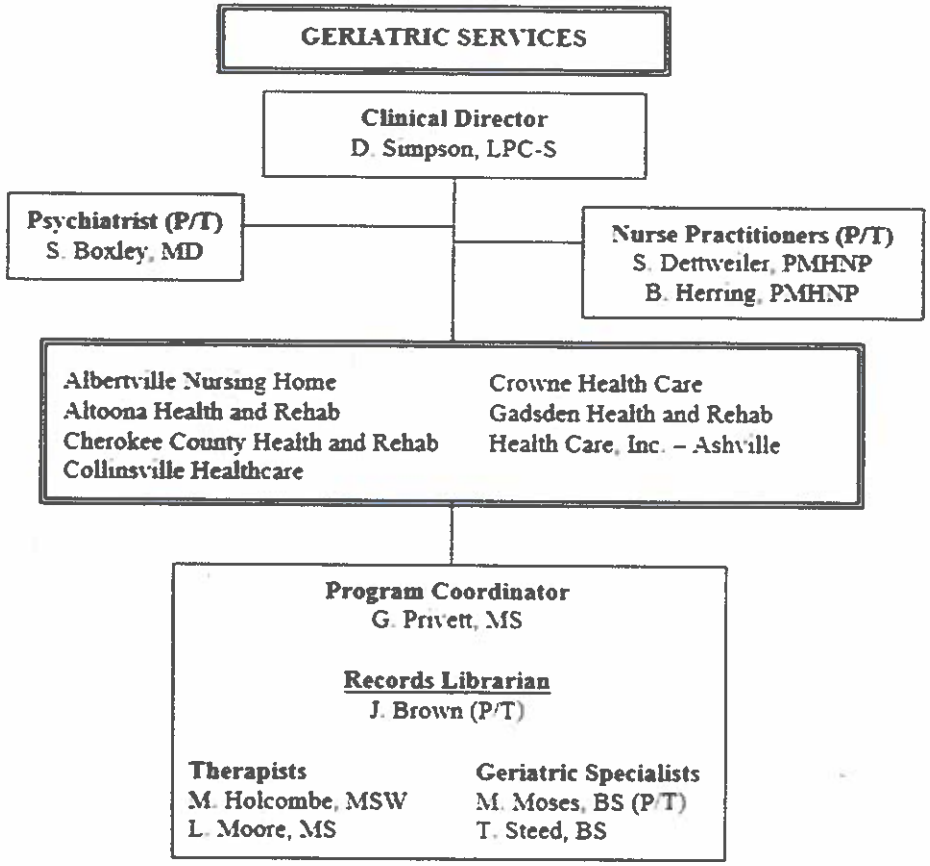
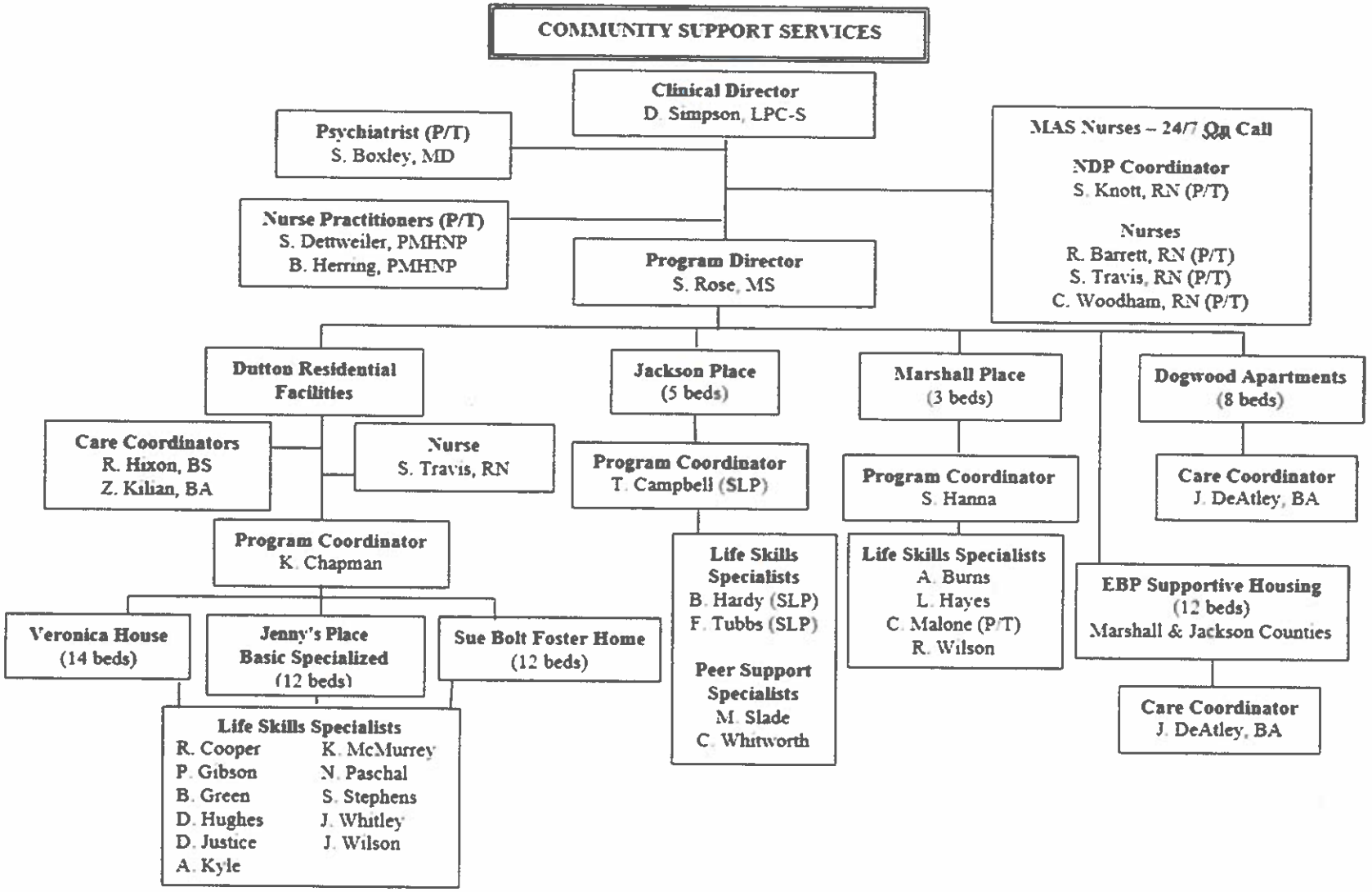
S. Dettweiler, PMHNP
Program Director
D. McCarley, MA
Business Office
School Based Services
Outpatient Services
Rehabilitative Day Program
Community Outreach Program
Office Manager
K. Lee
Secretaries
S. Granger
S. Rodgers
K. Smith
Transportation Specialist
B. Odom
Jackson County School Therapists
S. Sabb, MSW (Jackson County)
A. Whitley, MSW (Scottsboro)
Records
Records Librarian
J. Jenkins
Therapists
B. Burkhalter, MS
P. Horn, MA (P/T)
Vacant
Vacant
Intake Coordinator
P. Hobbs, MA
Vacant
Nurse
R. Barrett, RN (P/T)
B. Cheek, BS, Coordinator
L. Strange, LSS
Adult In-Home Intervention Team
T. Brookshire, MAMFT, Therapist
B. Whitten, BS, Care Coordinator
ACT Team
J. Brown, MA, Therapist
D. Johnson, BSW, Care Coordinator
R. Barrett, RN (P/T)
Child & Adolescent In-Home Intervention Team
J. Floyd, MSW, Therapist
H. Robinson, BA, Care Coordinator
Care Coordinators
G. Bell, BS (P/T)
A. English, BS
Marshall & Jackson Counties
Certified Peer Support – Parent M. Blanks
Certified Peer Support – Youth B. McDonald
Therapeutic Mentor S. Miller


SUBSTANCE USE SERVICES
Marshall and Jackson Counties
Clinical Director
D. Simpson, LPC-S
Psychiatrist (P/T)
S. Boxley, MD
Nurse Practitioners (P/T)
S. Dettweiler, PMHNP
B. Herring, PMHNP
MAS Nurses – 24/7 On Call
NDP Coordinator
S. Knott, RN (P/T)
Nurses
R. Barrett, RN (P/T)
S. Travis, RN (P/T)
C. Woodham, RN (P/T)
Prevention Services
H. Chandler, BS
Program Coordinator
Program Director
K. Ramsey, MA (QSAP I)
Prevention Specialists
A. Harris, BS
H. Lowery, BSW
D. Wilbanks, BS
Level III.5 Crisis Residential Services
SOR Grant
Business Office
Office Manager/Records Librarian
A. Higdon
Secretary
H. Johnson
Cook
B. Bewley (P/T)
Life Skills Specialists
B. Bewley (P/T)
B. Bonifay
J. Cook
C. Darnell
W. Martinez
A. Olsen
A. York
Counselors
J. Kirkland, BS
S. Sweatman, BA
Nurse
C. Woodham, RN
Life Skills Specialists
B. Crowell, CRSS
Life Skills Specialist
G. Bartke, CRSS


GERIATRIC SERVICES
Clinical Director
D. Simpson, LPC-S
Psychiatrist (P/T)
S. Boxley, MD
Nurse Practitioners (P/T)
S. Dettweiler, PMHNP
B. Herring, PMHNP
Albertville Nursing Home
Altoona Health and Rehab
Cherokee County Health and Rehab
Collinsville Healthcare
Crowne Health Care
Gadsden Health and Rehab
Health Care, Inc. – Ashville
Program Coordinator
G. Privett, MS
Records Librarian
J. Brown (P/T)
Therapists
M. Holcombe, MSW
L. Moore, MS
Geriatric Specialists
M. Moses, BS (P/T)
T. Steed, BS


COMMUNITY SUPPORT SERVICES
Clinical Director
D. Simpson, LPC-S
Psychiatrist (P/T)
S. Boxley, MD
Nurse Practitioners (P/T)
S. Dettweiler, PMHNP
B. Herring, PMHNP
Program Director
S. Rose, MS
MAS Nurses – 24/7 On Call
NDP Coordinator
S. Knott, RN (P/T)
Nurses
R. Barrett, RN (P/T)
S. Travis, RN (P/T)
C. Woodham, RN (P/T)
Dutton Residential Facilities
Care Coordinators
R. Hixon, BS
Z. Kilian, BA
Nurse
S. Travis, RN
Program Coordinator
K. Chapman
Veronica House
(14 beds)
Jenny's Place
Basic Specialized
(12 beds)
Sue Bolt Foster Home
(12 beds)
Life Skills Specialists
R. Cooper
P. Gibson
B. Green
D. Hughes
D. Justice
A. Kyle
K. McMurrey
N. Paschal
S. Stephens
J. Whitley
J. Wilson
Jackson Place
(5 beds)
Program Coordinator
T. Campbell (SLP)
Life Skills Specialists
B. Hardy (SLP)
F. Tubbs (SLP)
Peer Support Specialists
M. Slade
C. Whitworth
Marshall Place
(3 beds)
Program Coordinator
S. Hanna
Life Skills Specialists
A. Burns
L. Hayes
C. Malone (P/T)
R. Wilson
Dogwood Apartments
(8 beds)
Care Coordinator
J. DeAtley, BA
EBP Supportive Housing
(12 beds)
Marshall & Jackson Counties
Care Coordinator
J. DeAtley, BA

Attachment B

MOUNTAIN LAKES
Behavioral Healthcare

Mission Statement

To provide a consumer-sensitive, outcome-oriented, behavioral healthcare system, open to affiliate with other organizations to deliver quality services.

Vision Statement

To provide a comprehensive, cost effective, multi-disciplinary array of quality behavioral healthcare services for the effective treatment and prevention of mental illness and substance abuse, and to be recognized as the best provider of behavioral healthcare in our market area.

Guiding Values

- To treat our customers in a manner in which we would like to be treated.
- To be honest, forthright, and respectful with everyone.
- To be totally committed to excellence in all that we do.
- To continuously improve our work performance and the effectiveness of the services provided.
- To actively seek opportunities and initiate ideas to expand and secure the organization's growth and development.
- To work diligently and accurately so as to assure quality outcome and cost effectiveness.
- To create a work environment that encourages communication, participation, and creative thinking by all employees.
- To recognize the purpose of the organization as a whole as being more important than any given part or specific program.

Attachment C

Goals and Objectives for Continuous quality improvement
FY 25

I. To become certified by DMH as a Certified Community Behavioral Health Clinic (CCBHC) by achieving the DMH & SAMHSA Certification Criteria.

A. Improve and format the Community Needs Assessment to meet the DMH implementation standards (1.a.1 & DY-1/Clinical - 24-3)
B. Prepare to submit required data to DMH through the Netsmart CareManager solution and as required by the SAMHSA CCBHC Data Reporting Template (DY-1/Clinical - 24-1 & DY-1/ Clinical - 24-15).
C. Train staff on and implement all required Evidence Based Practices (EBPs) (DY-1/Clinical - 24-2) & DY-1/Clinical - 24-14).
D. Increase scope of service capacity as described in the Required Additional Capacity requirements (DY-1/Clinical - 24-2).
E. Revise and improve the continuity of operations/disaster plan per SAMHSA & DMH guidelines (2.a.8; DY-1/Clinical - 24-3).
F. Establish and implement primary care screening protocols (DY-1/Clinical - 24-4).
G. Provide Targeted Case Management services during care or housing transitions for all required population groups (DY-1/Clinical - 24-5).
H. Develop and implement a Supported Employment Program (DY-1/Clinical - 24-7).
I. Increase crisis services by directly providing or establishing a Designated Collaborating Organization (DCO) agreement for mobile crisis services and 24/7 Crisis Receiving/Stabilization services (DY-1/Clinical - 24-9 & DY-1/Clinical - 24-19).
J. Train on and implement all required screening tools and collect all required initial evaluation information (DY-1/Clinical - 24-10).
K. Ensure that all state and federal guidelines regarding veteran care are followed and ensure that people with lived experience as veterans help guide CCBHC implementation and operations (DY-1/Clinical - 24-13).
L. Actively track outcomes and any disparities for the populations of focus (POF), through our Continuous Quality Improvement process (DY-1/Clinical - 24-17).
M. Develop care coordination agreements with all required entities and any other entities that are identified through the Community Needs Assessment process (DY-1/Clinical - 24-18).
N. Establish a Prospective Payment System (PPS) daily rate with the assistance of FTI Consulting (DY-1/Fiscal - 24-1).
O. Ensure that individuals with lived experience have meaningful input in the governance of MLBH, as described in the CCBHC Governance Criteria (DY-1/Governance - 24-1).

Intermediate Level Goal (2-4 years)

- Increase local bed capacity by establishing a Crisis Stabilization Unit (CSU) for involuntarily committed adults & establishing a Crisis Receiving/Stabilization program for voluntary adult admissions.

Attachment D

New Process Design Evaluation Criteria
FY _____

New Process:_____

CRITERIA	EVIDENCE OF COMPLIANCE WITH CRITERIA
A. Is consistent with our mission, vision, values and plans.	**A.**
B. Meets the needs and expectations of key constituents.	**B.**
C. Is clinically sound and up-to-date. (Example: Using recent literature, practice guidelines or parameters.)	**C.**
D. Is consistent with sound business practice.	**D.**
E. Establishes baseline performance expectations to guide measurement and assessment activities.	**E.**

Attachment E

Mountain Lakes Behavioral Healthcare
CORRECTIVE ACTION PLAN

SECTION I: To be filled out by person identifying issue or concern

Date:	Identified By:

Issue/Concern:

SECTION II: To be filled out by Management Group

Management Review Date:	Response due by:

Tasked To (person or committee responsible):

SECTION III: To be completed by person(s) responsible for developing and implementing corrective action

Statement of Issue/Concern:

Action Taken:

Results of Action:

Follow-up Plan (include method of evaluation and date of follow-up):

SECTION IV: To be filled out by Continuous quality improvement Committee

Review Date:	Signature: