MOUNTAIN LAKES
Behavioral Healthcare

ADMINISTRATIVE SERVICES
3200 Willow Beach Road, Guntersville, AL 35976
256-582-4240 • 256-582-4161 (fax)

TO: Board of Directors

FROM: Shelly Pierce, HR Assistant

RE: October Board meeting

DATE: October 16, 2025

The next meeting of the Board of Directors will be held on **Tuesday, October 21, 2025,** at the Metal Health Center in Scottsboro, Alabama. An evening meal will be provided, with the meeting starting at 5:30 pm.

The items below are included in this packet for your advanced review:

- October Board Agenda
- Minutes from the September 16, 2025, Board meeting
- ED Report
  - Consumer Survey Results
  - Board Education Series – CCBHC 101 for Leaders
- Personnel Report
- IT Director's Report
- Clinical Director's Report – proposed revisions to CQI Plan for FY26
- Minutes from the CCBHC Task Force meetings
- Summary of Reports for September from the CQI Committee
- Minutes from the September Leadership Committee meeting
- October newsletter

Any items needing clarification or requiring Board approval will be discussed at that time. We will make the most efficient use of your time by considering only items of major importance and requiring formal action. Unless noted, all other items will be considered correct.

MARSHALL-JACKSON MENTAL HEALTH BOARD, INC.

MOUNTAIN LAKES BEHAVIORAL HEALTHCARE

October 21, 2025

AGENDA

I. Call the meeting to order – David Kennamer, President

II. Approval of minutes of the September 16, 2025, meeting – David Kennamer, President

III. Executive Director's Report

IV. Financial reports through September 30, 2025 – Cammy Holland, Business Manager

V. Written reports
- Personnel – Lane Black, HR Coordinator
- IT – Steve Collins, IT Director
- Clinical – Dana Childs, QA Coordinator/Clinical Administrative Assistant
    - Proposed revisions to CQI Plan for FY26

VI. Board requested items for future meeting

VII. Executive Session

Marshall-Jackson Mental Health Board, Inc.
Mountain Lakes Behavioral Healthcare

Board of Directors Meeting
September 16, 2025

MINUTES

I. Call to Order

David Kennamer, President, called the meeting to order at 5:25 p.m. at the Administrative Office in Guntersville, Alabama.

Present: Joe Huotari
Jo-Anne Hutton
John David Jordan
David Kennamer, President
Bill Kirkpatrick
Andrea LeCroy
Hannah Nixon, Vice-President
Lucien Reed, Treasurer
Jane Seltzer, Secretary

Absent: Victor Manning

Staff: Lane Black, HR Coordinator
Dana Childs, QA Coordinator/Clinical Administrative Assistant
Steve Collins, IT Director
Myron Gargis, Executive Director
Dana McCarley, Program Director, Jackson County Mental Health Center
Shelly Pierce, HR Assistant
Erica Player, Assistant Clinical Director
Dianne Simpson, Clinical Director

Other: Peter John Lambert, Cadence Bank

II. Approval of the minutes of the August 19, 2025, Board meeting – David Kennamer, President

MOTION: Hannah Nixon made a motion that the Board approve the minutes of the August 19, 2025, meeting, as presented. Lucien Reed seconded the motion, which was approved unanimously.

III. Discussion of financing options for CRU – Myron Gargis, Executive Director

Mr. Gargis introduced Peter John Lambert, Market President and Commercial Lender for Cadence Bank. He and Ms. Holland have been in discussions with Mr. Lambert regarding potential financing options for the Crisis Residential Unit (CRU). Mr. Lambert shared that he previously served on the Marshall-Jackson Mental Health Board, Inc. in the early 2000s and recognizes the importance of expanding local services for mental health and substance use disorders.

Following initial conversations with Mr. Gargis and Ms. Holland, Mr. Lambert explored various financing options and recommended utilizing the USDA Rural Development Program. Under this plan, Cadence Bank would provide a construction loan, which would convert to a USDA Governmental Loan upon completion of the facility.

Mr. Lambert noted that Cadence Bank could offer MLBHC a construction loan with an interest rate in the upper 5% range. Upon final approval, the USDA loan program would provide a 40-year fixed-rate loan at 4.875%, with no prepayment penalty. He emphasized his confidence that this long-term financing option is likely the most favorable available and significantly better than typical bank offerings.

Mr. Lambert encouraged Board members to reach out to him with any questions regarding the construction or USDA loan process.

IV. Executive Director's Report

The Executive Director's Report for September (Appendix A) was submitted in written format and made available to all Board members for review prior to the meeting.

During the discussion of CCBHC updates, Mr. Gargis proposed two potential recruitment tools for the Board's consideration: an Employee Referral Program and a Sign-on Bonus. After reviewing the details of both proposals, a recommendation was made to possibly delay any initial monetary payments until the end of the employee's six-month probationary period, rather than issuing payments after two months of employment. Additionally, a step-based payment process was suggested. Mr. Gargis emphasized that the details of each proposal were merely suggestions and could be structured in any way the Board preferred. He also reminded everyone that following COVID, a Recruitment and Retention Plan was implemented using a step-based payment process, and a similar approach could be applied to CCBHC recruitment.

Since the last Board meeting, Mr. Gargis reported that the Leadership Committee had discussed ongoing issues with tenants in the Sebring Drive duplex. He reminded the Board that the duplex was originally purchased to provide affordable housing options for consumers, but it has not been functioning as intended. Three recent tenants were evicted due to nonpayment, and numerous other issues have arisen, including illegal drug use, unauthorized occupants, and property damage. During the discussion, Leadership Committee members expressed a desire to continue pursuing this housing option and recommended implementing a more rigorous screening process. Staff will now complete a consumer referral form, which will be reviewed by upper management before a consumer is approved for residency in the duplex. If the new screening process fails to resolve the previous issues, the Leadership Committee will re-evaluate the use of the duplex and present a recommendation to the Board.

During the August Board meeting, Mr. Gargis shared that, as outlined in the CCBHC Implementation Bulletin on Governance, provider organizations must demonstrate that their governing body reflects the population they serve. CCBHC offers two options for meeting this requirement. The Board elected to pursue **Option 1**: ensuring that at least 51% of its members have lived experience with behavioral health conditions, either personally or through a close family member.

The Department of Mental Health (DMH) has confirmed that providers may self-certify compliance with this requirement if a poll of Board members verifies that the 51% threshold is met. To facilitate this, Board Member Self-Certification Forms were distributed to all members during the meeting. Each member completed and returned the form for polling purposes.

Upon review of the completed forms, it was determined that the Board easily met the 51% lived experience threshold.

V. Financial reports through August 31, 2025 – Cammy Holland, Business Manager

Ms. Holland noted that all standard financial reports were included in the monthly packet and asked if there were any questions regarding these items.

The FY25 Program Summary reflected a net income across all programs.

The current Balance Sheet, including Board Investments, indicated Total Cash of $559,574. This total is $533,143 less than this same time period last year. Continued review reflected Total Accounts Receivable of $3,075,661, which is $489,676 more than in FY24.

The Income Statement, excluding Board Investments, reflected a YTD Net Income of $1,151,026, which is $339,517 more than in FY24.

VI. Approval of Board committee minutes

Per the Board Bylaws, minutes from each committee meeting are to be recorded, submitted to the Board of Directors for approval and appended to the Board minutes.

Minutes from the Finance Committee were distributed for review prior to the Board meeting:

MOTION: Lucien Reed made a motion that the Board approve the minutes of the Finance Committee, as presented. Hannah Nixon seconded the motion, which was approved unanimously.

With the aforementioned motion, minutes from the Finance Committee will be included as Appendix B to the minutes from tonight's Board meeting.

VII. Proposed Budgets for FY26 – Cammy Holland, Business Manager

Mr. Gargis noted that the development of the FY26 Budgets was unlike any previous year in the organization's history. As final approval for the implementation of CCBHC on October 1, 2025 (the start of FY26) is still pending, it was necessary to prepare and present three draft budgets to the Finance Committee for review and approval:

- FY26 Budget for CCBHC
- FY26 Budget for Non-CCBHC
- FY26 Budget for Fee-for-Service (FFS) – Plan B

Following the Finance Committee's review and with no further questions from the Board regarding the FY26 Budgets, the following motion was made:

MOTION: Hannah Nixon made a motion that, if CCBHC is approved for implementation on October 1, 2025, the Board will approve both the FY26 CCBHC Budget and the FY26 Non-CCBHC Budget. If CCBHC is not approved for implementation on that date, the Board will instead approve the FY26 Fee-for-Service (FFS) Budget – Plan B. Jane Seltzer seconded the motion, which was unanimously approved.

VIII. Proposed Goals and Objectives for FY26 – Myron Gargis, Executive Director

As shared with the Board at the last meeting, a few minor revisions were made to the FY26 Goals and Objectives for CCBHC Implementation. Mr. Gargis also noted that, as recommended, FY26 Strategic Goals for

Non-CCBHC Programs were developed by the Leadership Committee. These items, along with the MLBHC 5-7 Year Business Plan (FY26-FY32), were presented to the Board for approval.

MOTION: Hannah Nixon made a motion that the Board approve the aforementioned documents, as presented. Andrea LeCroy seconded the motion, which was approved unanimously.

During the discussion of MLBHC's 5–7 Year Business Plan, a recommendation was made for the Ad Hoc Planning Committee to meet regularly, potentially on a quarterly basis.

IX. Written Reports

The Personnel and IT Reports were submitted in written format for the monthly Board packets. Any items of question or requiring Board action will be discussed during the meeting.

A recommendation was made to include CCBHC or Non-CCBHC status for each of the open positions on the Personnel Report.

X. Board requested items for future meetings

Mr. Gargis announced that the biennial Alabama Department of Mental Health Site Review is scheduled for October 7–10, 2025. Mr. Kirkpatrick requested that Board members be notified of the date and time of the site review exit session, in case their schedules permit attendance.

MOTION: Hannah Nixon made a motion that the Board adjourn the meeting at 7:10 p.m. Andrea LeCroy seconded the motion, which was approved unanimously.

_____

David Kennamer, President
Marshall-Jackson Mental Health Board, Inc.

_____

Jane Seltzer, Secretary
Marshall-Jackson Mental Health Board, Inc.

APPENDIX A

Executive Director's Report – September 16, 2025

Transportation Services Update

Our transportation program continues to play a vital role in ensuring client access to services across both counties. In August:

- **Jackson County:** 37 total client transports
- **Marshall County:** 175 total client transports
    - Of these, **148** were for our **Day Program** clients

FY26 and Long-Term Strategic Planning

Please see the attached drafts of **FY26 CCBHC Implementation Goals, FY26 Non-CCBHC Program Strategic Goals,** and a **5–7-year Strategic Plan.** These draft goal documents were developed and reviewed by our Leadership Committee.

CCBHC Updates

We are awaiting final approval from ADMH & SAMHSA for 10/1/25 implementation.
CCBHC Staff Recruitment: The CCBHC Task Force has proposed a couple of Recruitment tools to assist with filling the available CCBHC positions. Proposed ideas for your consideration:

Employee Referral Program: CCBHC Positions

Eligibility:
All current employees who are not in supervisory roles and do not participate in the interviewing or hiring process for CCBHC positions as part of their job duties are eligible to participate.
Referral Process:
To be eligible for the bonus, the CCBHC applicant must list the referring employee's name on their initial job application. Referrals made after the application is submitted will not qualify.
Incentive Details:

- Bonus Amount: $2,000 per successful referral
- Payout Timing: The bonus will be paid to the referring employee after the referred CCBHC new hire completes two full months of continuous employment.
- Eligible Positions: All open CCBHC job positions are eligible.
- Program Period: October 1, 2025 – December 31, 2025

Sign-On Bonus: CCBHC New Hires

Eligibility:
All individuals hired into CCBHC-designated positions between October 1, 2025 and December 31, 2025 are eligible for the sign-on bonus.
Bonus Details:

- Bonus Amount: $2,000
- Payout Timing: The sign-on bonus will be paid after the new CCBHC employee completes two full months of continuous employment.

Update on Sebring Apartments

HWY 35 Open House/Ribbon Cutting- Friday 9/26/25 from 12:00 PM to 4:00 PM. Lunch will be served.

APPENDIX B

Marshall Jackson Mental Health Board, Inc.

Finance Committee Minutes
September 3, 2025

Participating: Lucien Reed, Chair, Finance Committee
John David Jordan, Finance Committee
David Kennamer, Board President
Myron Gargis, Executive Director
Cammy Holland, Business Manager

Ms. Holland worked closely with Mr. Gargis to develop the draft budgets for FY26. As we are still awaiting final approval for the implementation of CCBHC on 10/1/2025 (FY26), it was necessary to develop and propose the following three draft budgets to the Finance Committee for approval:

- FY26 Budget for CCBHC
- FY26 Budget for Non-CCBHC
- FY26 Budget for FFS – Plan B

These proposed budgets included the Personnel and Compensation Committee's recommendations for wage increases and one time payments for staff members.

Once the budgets were finalized, Mr. Gargis shared these documents, along with other pertinent items as listed in P&P 1.13, via email with all members of the Finance Committee.

With no noted questions or concerns in regard to the draft budgets for FY26, Finance Committee members were in agreement to recommend the draft budgets to the full Board at the September 16, 2025, meeting.

Executive Director's Report – October 16, 2025

❖ Transportation Services Update

Our transportation program continues to be a critical component in ensuring client access to behavioral health services across both Marshall and Jackson Counties. In September, transportation activity remained strong and consistent with program goals:

- Jackson County: 80 total client transports (significant increase)
- Marshall County: 183 total client transports
  - Of these, 162 transports supported participation in our Day Program.

These numbers reflect the continued commitment of our transportation team to reduce barriers to care and support daily attendance and treatment adherence.

❖ Mental Health Statistics Improvement Program (MHSIP)

The MHSIP Annual Survey is conducted each year to measure client satisfaction with the treatment process, access to care, and perceived outcomes. The results of this year's survey are attached for your review and demonstrate positive trends in overall satisfaction and service quality. These findings will help guide quality improvement initiatives for the upcoming year.

❖ School-Based Mental Health (SBMH) Program

We are pleased to announce that the Alabama Department of Mental Health (ADMH) has approved $50,000 in new annual funding to support an additional Therapist for the Jackson County Schools. The new therapist has been hired and is now fully operational.

With this addition, Mountain Lakes Behavioral Healthcare now provides:

- 3 SBMH Therapists in Jackson County
- 9 SBMH Therapists in Marshall County
- Total: 12 School-Based Therapists

Our focus moving forward is to expand and strengthen school-based services in Jackson County to reach more students and families in need of mental health support.

❖ Crisis Residential Unit (CRU) and Claysville Campus

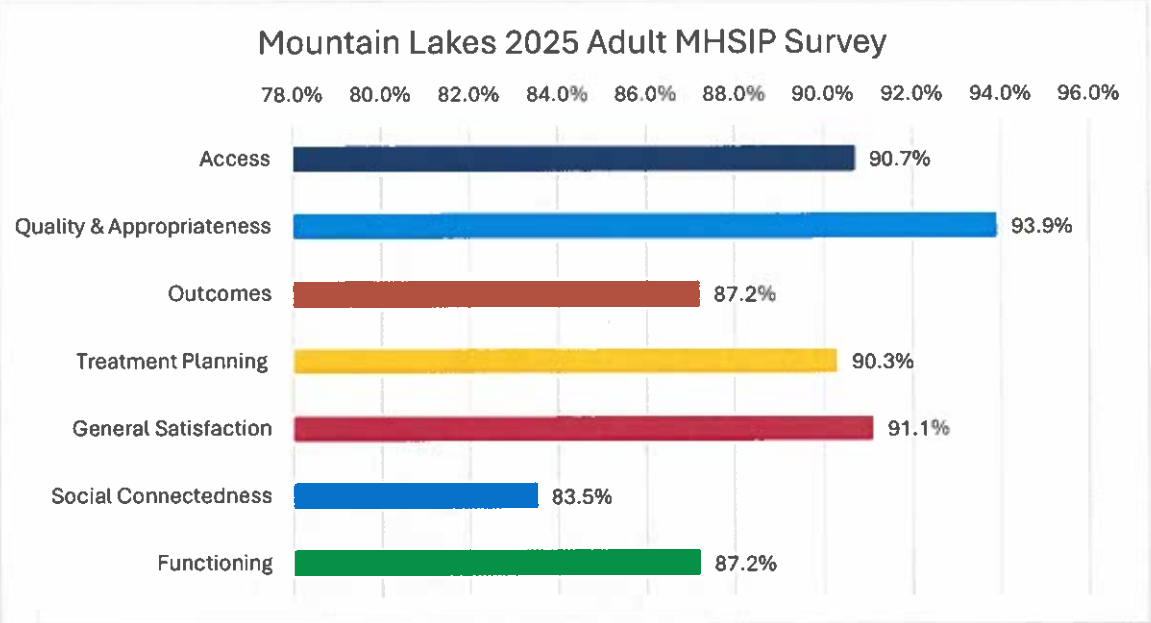
Chapman & Sisson Architects continue to advance design work for the planned 16-bed Crisis Residential Unit (CRU). A meeting is scheduled for tomorrow to review preliminary concepts and discuss the master plan for the 30-acre Claysville property.

As a point of reference, I recently shared photos and updates from the CRU currently under construction in Decatur, which will serve as a helpful model for our own project as we move forward with design and planning.

❖ CCBHC Board Education Training Series

This is the first session in our Board Education Training Series, titled "What is a CCBHC and Why It Matters." This series is designed to help deepen your understanding of the Certified Community Behavioral Health Clinic (CCBHC) model and how it strengthens Mountain Lakes Behavioral Healthcare's mission, vision, and long-term sustainability.

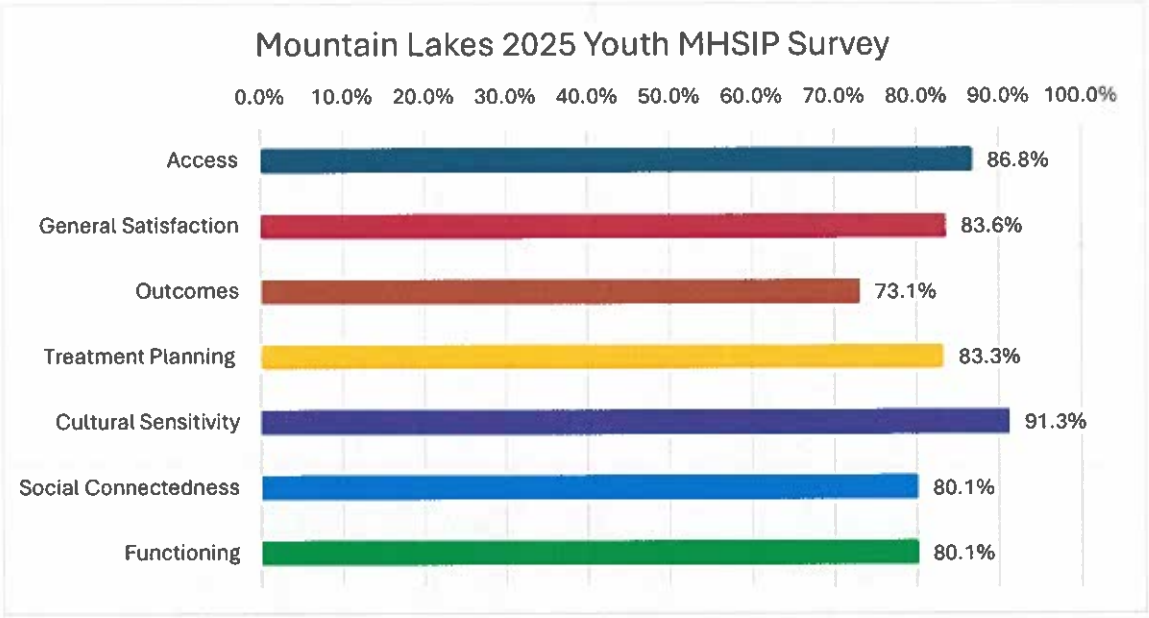
Mountain Lakes 2025 Consumer Survey Results



2025 Adult Consumer Satisfaction Survey Results	2025 Mountain Lakes % Positive	2025 State % Positive
1. Reporting Positively About Access	90.7%	87.6%
2. Reporting Positively About Quality and Appropriateness	93.9%	90.2%
3. Reporting Positively About Outcomes	87.2%	81.5%
4. Reporting Positively About Participation in Treatment Planning	90.3%	81.8%
5. Reporting Positively About General Satisfaction	91.1%	88.7%
6. Social Connectedness	83.5%	78.6%
7. Functioning	87.2%	83.3%

ADMH
Division of Mental Health and Substance Use Services
Office of Quality Improvement and Risk Management

Mountain Lakes 2025 Consumer Survey Results



2025 Youth Consumer Satisfaction Survey Results	2025 Mountain Lakes % Positive	2025 State % Positive
1. Reporting Positively About Access	86.8%	86.4%
2. Reporting Positively About General Satisfaction	83.6%	86.4%
3. Reporting Positively About Outcomes	73.1%	76.9%
4. Reporting Positively About Participation in Treatment Planning	83.3%	86.2%
5. Reporting Positively About Cultural Sensitivity of Staff	91.3%	92.5%
6. Social Connectedness	80.1%	84.2%
7. Functioning	80.1%	84.2%

ADMH
Division of Mental Health and Substance Use Services
Office of Quality Improvement and Risk Management

Mountain Lakes Behavioral Healthcare – Board Education Series: CCBHC 101 for Leaders

Session 1: What is a CCBHC and Why it Matters?

Learning Objective

Understand the national CCBHC model and why certification represents a strategic milestone for MLBH.

Key Takeaways

- CCBHCs were created by SAMHSA to ensure access to comprehensive, high-quality behavioral health services nationwide.
- The model guarantees 24/7 crisis response, outpatient treatment, and coordinated care for all populations.
- CCBHC certification establishes standardized quality and reporting expectations across service domains.
- Providers are reimbursed through sustainable, cost-based funding rather than volume-driven billing.
- Every individual—regardless of diagnosis, age, residence, or ability to pay—has equal access to care.
- The model encourages integration of mental health, substance use, and physical health care.
- CCBHCs emphasize measurement-based outcomes and community accountability.
- Certification positions MLBH among the most advanced behavioral health providers in Alabama and the Nation.

CCBHC in Action at MLBH (Anticipated Impact)

As we continue to build capacity and grow services, MLBH anticipates improved access across all programs, crisis response that gets individuals to the right level of care and avoids jail stays and ER visits, greater consistency in care coordination, and measurable progress toward integrated behavioral, substance use and primary health services under the CCBHC model.

Client Profile:

Amanda, a 27-year-old single mother, recently lost her job after repeated absences due to anxiety and panic attacks. She began using prescription pain medication to cope with stress and soon found herself struggling to manage both her mental health and substance use.

Before CCBHC:

Amanda tried to seek help, but every door she turned to led to another referral or waitlist. The local primary care office suggested counseling but didn't know where to send her. When she finally found a treatment program, it only addressed substance use and not her anxiety. Without coordinated care or family support, Amanda dropped out of treatment and continued to deteriorate.

After CCBHC:

Through MLBH's CCBHC model, Amanda now receives an integrated care plan addressing both her anxiety and substance use in one place. She meets with a therapist, a medication provider, and a care navigator who connects her to job-readiness support and childcare resources. Her care team communicates weekly to monitor her progress, adjust medications, and ensure ongoing engagement.

Key Message:

CCBHC integration breaks down silos between mental health, substance use, primary care, and other social services—helping individuals achieve lasting recovery and stability through coordinated, whole-person care.

Discussion Questions

- What stands out most about the CCBHC philosophy of comprehensive access?
- In what ways does CCBHC certification help MLBH respond to unmet needs in Marshall and Jackson Counties?

MLBH PERSONNEL REPORT

10/21/2025

NEW HIRES

FT	Jeffrey Wilson	Life Skills Specialist	9/17/2025	Dutton
FT	Samantha Mick	Therapist School-Based	9/30/2025	JCMHC
FT	AnnMarie Early	Therapist School-Based	9/30/2025	MCMHC
FT	Barbara Cox	Life Skills Specialist	9/30/2025	Marshall Place
FT	Bradley Smith	Life Skills Specialist	10/9/2025	Substance Use
FT	Elizabeth Roden	Life Skills Specialist	10/9/2025	Dutton
PRN	Maria Alvarez	Life Skills Specialist	10/10/2025	Jackson Place
FT	Crystal Baker	Therapist Mobile Crisis	10/14/2025	Both Counties
FT	Melvin Cooper	Peer Spec. Mobile Crisis	10/14/2025	Both Counties
FT	Katrina Fryer	Primary Care Screener	10/14/2025	MCMHC
FT	Terry Thompson	Life Skills Specialist	10/21/2025	Substance Use
FT	Holly Smith	Primary Care Screener	10/21/2025	JCMHC
FT	Melisa Jimenez	Adult IH Case Manager	10/21/2025	JCMHC
FT	Lineise Arnold	Community Outreach Spec	10/21/2025	JCMHC
FT	Laura Young	Life Skills Specialist	10/21/2025	Dutton

SEPARATIONS (VOLUNTARY)

FT	Tierany Bullard	Intake Coordinator	9/5/2025	MCMHC
PT	Jennifer D Brown	Therapist	9/22/2025	JCMHC
FT	Hannah Bishop	Case Manager	10/16/2025	MCMHC
FT	Emma Vaughan	Transportation Specialist	10/15/2025	MCMHC

SEPARATIONS (INVOLUNTARY)

FT	Brian Carroll	IT Specialist	9/18/2025	Administration
PRN	Mark Slade	Peer Specialist	10/7/2025	Jackson Place
FT	Zachary Sherlin	Life Skills Specialist	10/6/2025	Dutton

NEW POSITIONS ADDED

TRANSFERS

FT	Elizabeth Rucker	From C/A Therapist to Community Outreach Specialist	10/11/2025	MCMHC
FT	Jennifer Riggins	From C/A Case Manager to Employment Specialist	10/11/2025	MCMHC
FT	Julianna Davis	From Community Oureach Speciialist to Therapist/ Veterans & FR	10/11/2025	Both Counties

PROMOTIONS

FT	April Burns	From LSS to Benefits Specialist	10/11/2025	Administration
FT	Wes Morgan	From IT Specialist to Assistant IT Director	10/11/2025	Administration
FT	Miranda Holland	From Case Manager JC		

Continued.....

MLBH PERSONNEL REPORT

		to Care Navigator MC	10/11/2025 MCMHC
FT	Joanna DeAtley	From Case Manager Care Navigator JC	10/11/2025 JCMHC
FT	Kali Brand	From SB Tpist to C/A Services Program Coordinator II	10/11/2025 Both Counties

VOLUNTARY DEMOTION

FT	Dana McCarley	From Program Director JC to Training Specialist	10/11/2025 Administration

AIH = Adult In-Home
CAIH = Child/Adolescent In-Home
CRNP = Certified Registered Nurse Practitioner
CRSS = Certified Recovery Support Specialist (SA)
NL= Non-Licensed
QSAP = Qualified Substance Abuse Professional
SU = Substance Use
SLP=Sign Language Proficient
RDP = Rehabilitative Day Program
TPR= Treatment Plan Review

OPEN POSITIONS

CARVE OUT
AIH Care Coord. JC (1)

JP LSS FT (1) PRN (2)

DGH FT 3rd shifrt

SU Counselor (1)

Therapeutic Mentor MC (1)

Case Manager Supportive Housing (1)

C/A In Home Therapist MC (1)

C/A In Home Case Manager MC (1)

Therapist Geriatric MC, JC EtowahC (10)

Peer Support Specialist/ Geriatric (1)

CCBHC
Outpatient Therapist (MC) (1)

Therapist Mobile Crisis- Both Counties (4)

Peer Support Specialist Mobile Crisis- Both Counties (4)

MLBH PERSONNEL REPORT

Employment Specialist JC (1)

Care Navigator MC (1)

Care Navigator JC (1)

SA-Intensive Outpatient (IOP) Program Coordinator (1)

SA- IOP Counselor (1)

IT Specialist (1)

Peer Support Specialist/ Parent (1)

Secretary MC (1)

Transportation Specialist (1)

IT Board Report
OCT 2025

Items Completed from last reports:

-Wes working on Smartphone pricing & Contract.
-Figure out CEPH shared Storage redundancy.
-Wes working on alarm system quote for Sboro.
-Sboro Alarm system install.
-Wes working on mlbhc website / marketing quotes.

New Items / Continued:

-CCBHC Avatar changes / conferences Started.
-Pharmacy implementation has started.
-Still waiting on Farmers WAN / Internet Traffic study.
-Sophos Secureworks new Agent version to install.
-Get additional IT Staff in place.
-New Cell Phones to deploy.
-New Board Tablets?
-Start new Video Camera wiring and install for Sboro ASAP.
-Talk about MLBHC website and Podcasts.
-Wes working on quotes / options for HR In-boarding Recruitment system.
-Wes promotion to Assistant IT Director.
-Staff at Netsmart convention this month.
-Network Core switch modification issues.
-More AWS offsite Storage testing.
-More VM tweaking on Proxmox.
-Starting testing Windows Server 2022/2025 version and cost.
-Start testing Unifi IP phone system just in case.
-VZ Cell Phone Booster / Access point for Sboro Cell phones.

Summary of Revisions for FY 26 Continuous Quality Improvement Plan

Added words in red page 1:

The CQI plan is approved by the Medical Director and the Clinical Director. It is reviewed and approved by the board of directors at least every two (2) years and when revisions are made. The CQI Plan will be submitted to ADMH on an annual basis, no later than July 1st of that year.

Under Coordination of Continuous Quality Improvement plan on page 2 added:

"The Medical Director is involved in the aspects of CQI that apply to the quality of the medical components of care, including coordination and integration with primary care."

Added "Assistant Clinical director" to the Leadership committee on page 5 and removed the "Executive coordinator" as this position was removed from the org chart. Added "Assistant Human Resources Coordinator".

Added Assistant Clinical director to the Continuous Quality Improvement Committee on page 5.

Revised page 8:

Incident data will be reviewed at least quarterly, through the CQI process was changed to quarterly from "in a timely and appropriate manner".

Removed from page 8:

"An annual Prevention feedback survey will be completed with community partners, parents of youth participants, youth participants' adult participants and consumers of services."

Added additional CQI Indicator to page 10:

Additional CQI Monitoring Measures: Although not defined as formal CCBHC quality measures, the following areas are required by the CCBHC criteria and will be monitored through the CQI process:

Timely Access to Services- Clients already receiving services who request routine outpatient care must be offered an appointment within 10 business days. Clinical Documentation Review- Records for each master's level provider will be reviewed to ensure documentation meets CCBHC standards for quality and compliance.

Added to table on page 11-12:

Quality	Incident [illegible]	Satisfaction of People Receiving	Utilization	Treatment	INDICATOR	FREQUENCY	FURTHER MONITORING
X					Access to SU crisis residential services	At least quarterly	Ongoing

X					CCBHC quality measures	At least quarterly	Ongoing
X					Timely access to services	At least quarterly	As needed
X					Clinical documentation review	At least quarterly	As needed

Added to page 12-13:

Disparity Impact Statement

At Mountain Lakes Behavioral Healthcare, we recognize that there are significant disparities in access to health care for certain populations in Marshall and Jackson Counties, Alabama. According to data from the Alabama Department of Public Health, Marshall County has a higher poverty rate (18.2%) compared to the state average (17.7%), and a higher percentage of residents without health insurance (13.8%) compared to the state average (10.6%). In Jackson County, the poverty rate is even higher at 21.9%, and the percentage of residents without health insurance is 15.1%. These socioeconomic factors can make it more difficult for individuals in these counties to access mental health services.

The Centers for Disease Control and Prevention (CDC) and U.S. Department of Health and Human Services (HHS) Office of Minority Health developed the Minority Health Social Vulnerability Index (SVI) to identify racial and ethnic minorities considered at greater risk for poor health outcomes. The graphs in **(Attachment F)** show the statistics of social factors that contribute to health disparities in Jackson and Marshall Counties.

Mountain Lakes Behavioral Healthcare is committed to addressing these disparities and improving access to mental health care for all members of our community, primarily Alabama's populations of focus (POF) which include:

• All ages, races, ethnicities, genders, disability statuses, sexual orientations, and gender identities with serious emotional disturbance (SED), severe mental illness (SMI), substance use disorders (SUD), Opioid Use Disorder (OUD), and co-occurring mental and substance disorders (COD), and those with or at risk of HIV and Hepatitis C due to injection drug use.

• Opioid Use Disorder with emphasis on the African American population

• Pregnant and Parenting Women (PPW)

• People experiencing homelessness.

Disparity Impact Plan

The Disparity Impact Plan is data-driven to assist with the identification and service of underserved populations within the service area. Local population demographics are compared with those of individuals referred or served to ensure services are effective, equitable, and reflective of the community. The Community Needs Assessment (CNA) is used to identify any emerging groups facing disparities in the community.

Summary of Revisions for FY 26 Continuous Quality Improvement Plan

Disaggregated data from the CCBHC quality measures and, as available, other data are used to track and improve outcomes for populations facing health disparities. The Disparity Reduction Team (DRT) evaluates demographic data and experience survey results by demographic at least twice per year developing a specific performance improvement plan to address any disparities identified. An outreach and engagement goal will be established to monitor outcomes.

Culturally & Linguistically Appropriate Services (CLAS)

CLAS is defined as services that are respectful of and responsive to individual cultural health beliefs, and practices, preferred languages, health literacy levels and communication needs. Mountain Lakes Behavioral Healthcare upholds the CLAS standards including these areas:

- Governance, Leadership and Workforce
  - Staff members at all levels and disciplines receive training in culturally- and linguistically appropriate service delivery at hire and annually thereafter.
- Communication and Language/Assistance
  - Provides interpretation services, at no cost, to all people receiving services to include those with Limited English Proficiency (LEP) and those who are deaf.
  - All people receiving services with LEP or who are deaf receive verbal and written notices about their right to language assistance services.
- Engagement, Continuous Improvement, and Accountability
  - Race, Ethnicity, Language and LGBTQ data are used in the design and delivery of services.

Additional indicators can be added at the discretion of the Executive Director, Medical 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.

Added to Attachment C-Goals and objectives for CQI page 18 (Will also include agency Goals and Objectives):

Goals and Objectives for Continuous Quality Improvement
FY 26

I. Collect, report, track encounter, outcome, and quality data aligned with CCBHC requirements.

A. Ongoing monitoring of follow-up care for high-risk individuals, including at minimum:

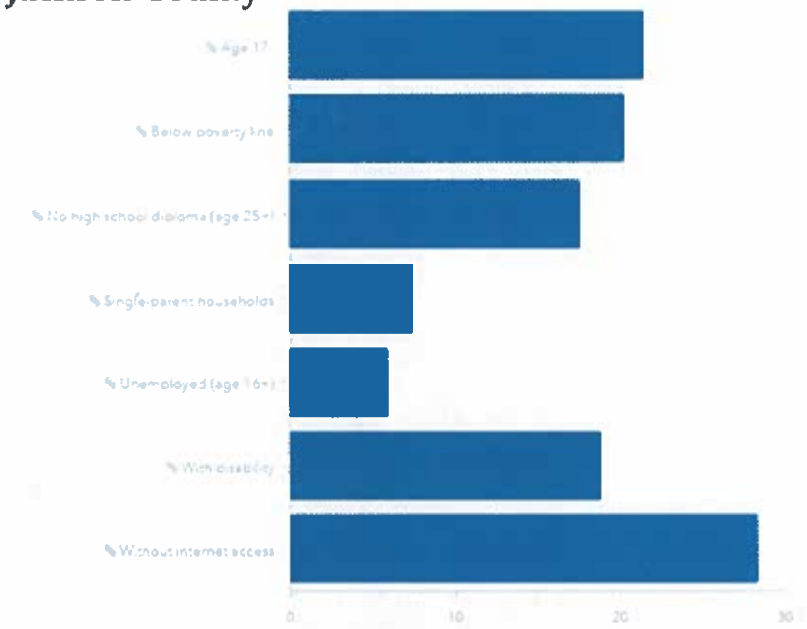
- Those discharged from psychiatric inpatient care within the past year
- Individuals under outpatient commitment orders within the past year
- Persons with documented intent to harm self or others
- Individuals diagnosed with co-occurring mental illness and substance use disorders

B. Using FY25 data as a baseline, reduce the rate of 30-day psychiatric hospital readmissions by 25% through targeted interventions and ongoing performance monitoring.

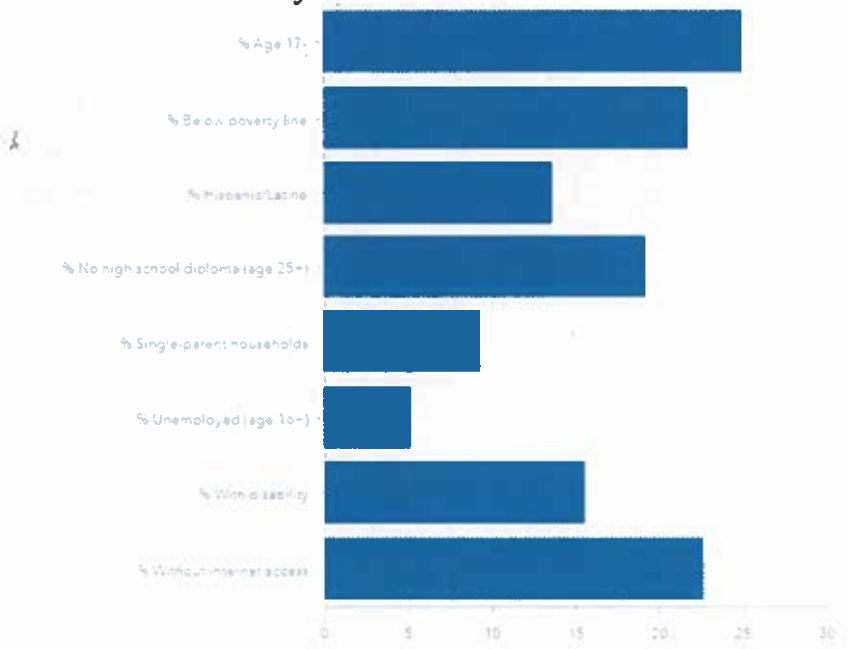
Added Attachment F-Minority Health Social Vulnerability Index pages 24-25:

Minority Health Social Vulnerability Index

Jackson County



Marshall County



The data from this survey indicates that both counties are at a medium-high level of vulnerability.

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 satisfaction with the services provided. The system provides meaningful opportunities for input concerning the operation and improvement of services from people receiving services, family members, groups, advocacy organizations, and advocates.

Processes described in this plan apply to all program service areas and functions within the agency, including subcontracted 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 approved by the Medical Director and the Clinical Director. It is reviewed and approved by the board of directors at least every two (2) years and when revisions are made. The CQI Plan will be submitted to ADMH on an annual basis, no later than July 1st of that year.

Mission, Vision, Guiding Values, Goals & Objectives

The mission of Mountain Lakes Behavioral Healthcare is to provide a person-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 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

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

All staff members are trained in principles and techniques of continuous quality improvement and their application in every aspect of service delivery. Through 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 Medical Director is involved in the aspects of CQI that apply to the quality of the medical components of care, including coordination and integration with primary care. 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 people receiving services, 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 CQI committee, Leadership Committee, and the board of directors. The CQI Annual Report will be made available to staff, people receiving services, 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.

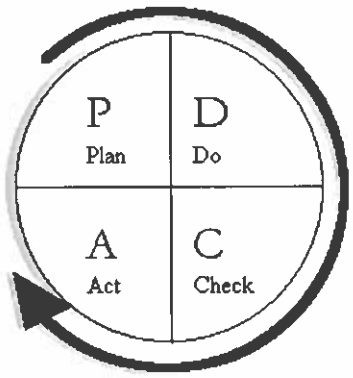
Corrective Action Plans

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
- Satisfaction of People Receiving Services and Their Families
- 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 ensure that indicators monitored by the agency have application at all levels of the agency.

People receiving services, along with their family members, contribute to the selection of quality improvement indicators and related improvement activities through satisfaction surveys. These surveys are randomly conducted in all programs, at least once per year. In order to ensure confidentiality, all surveys are anonymous.

Additionally, people receiving services are invited to participate in CQI work groups or provide input to help bring their perspectives into the analysis of specific issues. 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
Assistant Clinical Director
Program Directors/Coordinators
Human Resources Coordinator
Business Manager
Assistant Human Resources 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
Assistant Clinical Director
Program Directors
Program Coordinators
Records Librarians
QA Coordinator
Training Coordinators

Meeting: At least quarterly

Agenda: As stated

Report: Leadership Committee

SATISFACTION COMMITTEE for PEOPLE RECEIVING SERVICES

Mission: To evaluate the satisfaction levels of people receiving services, the agency will conduct, at a minimum, one direct services survey each year, a survey of external consumers (if required by the Executive Director), and a survey of family members of people receiving services. The results of these surveys will be provided for staff and the 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 people 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. The efficiency 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
   A representative sample of records for people receiving services will undergo administrative review to ensure that all documentation required by the Alabama Administrative Code and agency policies and procedures is present, complete, and accurate. An aggregate review of findings from these administrative reviews will be conducted at least annually. Recommendations and actions taken for improvement, as indicated by the data, will be documented 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 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 in stable housing situation from date of first service to date of last service.

e. Social Connectedness:
Outcome: Increased social support/social connectedness.
Measure: Increase in or no change in number 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 people receiving services, their families, and staff members. All incidents shall be reported in accordance with the Alabama Administrative Code and the ADMH Incident Management Plan.

Staff at all levels and disciplines are trained in 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 people receiving services. Agency staff members responsible for conducting or supervising investigations will complete the DMH special incident investigation training.

Incident data will be reviewed at least quarterly, through the CQI process. Findings and recommendations from incident reviews will be reported at least quarterly to the Leadership Committee and the board of directors. Pertinent data regarding improvement strategies will be communicated to staff-level employees. Medication errors will be monitored on an ongoing basis. 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.

Satisfaction Component of People Receiving Services and Their Families

The tools listed below will be utilized to assess the satisfaction of people receiving services and their families and to obtain input regarding factors which impact the care and treatment of people receiving services.

- Mental Health Statistical Improvement Plan (MHSIP) satisfaction surveys of people receiving services and their families
- Random surveys of people receiving services
- Substance Use Services Case Reviews shall assess the satisfaction of people receiving services and their families, including but not limited to: (1) Their perception of the outcome of services. (2) Their perception of the quality of the therapeutic alliance. (3) Other perceptions of the 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 people receiving services)
- Feedback from people receiving services through feedback boxes (written information)
- Complaints and grievances from people receiving services (written or verbal information)
- Any other reports or feedback given to staff or satisfaction committee for people receiving services

This committee reports back to the Leadership Committee with findings and recommendations at least quarterly. Feedback boxes are also agency-specific indicators for measuring satisfaction and are reviewed at least quarterly by the Services Satisfaction and CQI Committees.

All of these tools are utilized to obtain input regarding satisfaction with service delivery and outcomes. Alternate mechanisms may be used when obtaining input from people receiving services 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 person receiving services' preferred language or by a qualified interpreter.

Data collected via these tools, including complaints and grievances, will be reviewed at least annually by the people receiving services 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 the recurrence of similar problems. The

board of directors shall annually review, and approve/update 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 people receiving services, their family and collateral supports in the treatment process to include linguistic and/or auxiliary support services for people who are deaf, 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, 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 centers 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. Individuals 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 as required by the Certified Community Behavioral Health Center (CCBHC) certification criteria:

Clinic-Collected Measures:

(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).

State Collected Measures (As they are made available)

(1) Patient Experience of Care Survey; (2) Youth/Family Experience of Care Survey.

(3) Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD);

(4) Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD); (5) Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH); (6) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD); (7) Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD); (8) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD); (9) Plan All-Cause Readmissions Rate (PCR-AD); (10) Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH); (11) Antidepressant Medication Management (AMM-BH); (12) Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD); (13) Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)

Additional CQI Monitoring Measures: Although not defined as formal CCBHC quality measures, the following areas are required by the CCBHC criteria and will be monitored through the CQI process: Timely Access to Services- Clients already receiving services who request routine outpatient care must be offered an appointment within 10 business days. Clinical Documentation Review- Records for each master's level provider will be reviewed to ensure documentation meets CCBHC standards for quality and compliance.

Targeted Subpopulations: Outcomes and health disparities for Populations of Focus (POF), as defined by the ADMH CCBHC Implementation Bulletin DY-1/Clinical- 24-17, will be reviewed at least quarterly through the CQI process. Any disparities noted will be addressed through the implementation of a plan to improve those outcomes. See the Disparity Impact Statement for more details.

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 from ADMH noting errors in the data reported 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 by 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: Prevention processes and outcomes will be monitored and assessed 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	Satisfaction of People Receiving Services &Their Families	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					*SU treatment outcomes and outcome measures	Annually	Ongoing
X					ACSIS 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 follows up	At least quarterly	Ongoing
X					Access to SU crisis residential services	At least quarterly	Ongoing
X					CCBHC quality measures	At least quarterly	Ongoing
X					Timely access to services	At least quarterly	As needed
X					Clinical documentation review	At least quarterly	As needed
	X				*Incident prevention & management	At least quarterly	Ongoing
	X				*Medication errors	At least annually	Ongoing
		X			*People receiving services and their family satisfaction surveys	At least annually	One year
		X			*Complaints and grievances	At least annually	One year
		X			Feedback from people receiving services	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

Disparity Impact Statement

At Mountain Lakes Behavioral Healthcare, we recognize that there are significant disparities in access to health care for certain populations in Marshall and Jackson Counties, Alabama. According to data from the Alabama Department of Public Health, Marshall County has a higher poverty rate (18.2%) compared to the state average (17.7%), and a higher percentage of residents without health insurance (13.8%) compared to the state average (10.6%). In Jackson County, the poverty rate is even higher at 21.9%, and the percentage of residents without health insurance is 15.1%. These socioeconomic factors can make it more difficult for individuals in these counties to access mental health services.

The Centers for Disease Control and Prevention (CDC) and U.S. Department of Health and Human Services (HHS) Office of Minority Health developed the Minority Health Social Vulnerability Index (SVI) to identify racial and ethnic minorities considered at greater risk for poor health outcomes. The graphs in **(Attachment F)** show the statistics of social factors that contribute to health disparities in Jackson and Marshall Counties.

Mountain Lakes Behavioral Healthcare is committed to addressing these disparities and improving access to mental health care for all members of our community, primarily Alabama's populations of focus (POF) which include:

- All ages, races, ethnicities, genders, disability statuses, sexual orientations, and gender identities with serious emotional disturbance (SED), severe mental illness (SMI), substance use disorders (SUD), Opioid Use Disorder (OUD), and co-occurring mental and substance disorders (COD), and those with or at risk of HIV and Hepatitis C due to injection drug use.
- Opioid Use Disorder with emphasis on the African American population
- Pregnant and Parenting Women (PPW)
- People experiencing homelessness
- The rural population
- Those who identify as LGBTQ+, with a particular focus on youth
- Those at risk of gun violence

Disparity Impact Plan

The Disparity Impact Plan is data-driven to assist with the identification and service of underserved populations within the service area. Local population demographics are compared with those of individuals referred or served to ensure services are effective, equitable, and reflective of the community. The Community Needs Assessment (CNA) is used to identify any emerging groups facing disparities in the community.

Disaggregated data from the CCBHC quality measures and, as available, other data are used to track and improve outcomes for populations facing health disparities. The Disparity Reduction Team (DRT) evaluates demographic data and experience survey results by demographic at least twice per year developing a specific performance improvement plan to address any disparities identified. An outreach and engagement goal will be established to monitor outcomes.

Culturally & Linguistically Appropriate Services (CLAS)

CLAS is defined as services that are respectful of and responsive to individual cultural health beliefs, and practices, preferred languages, health literacy levels and communication needs. Mountain Lakes Behavioral Healthcare upholds the CLAS standards including these areas:

- Governance, Leadership and Workforce
  - Staff members at all levels and disciplines receive training in culturally- and linguistically appropriate service delivery at hire and annually thereafter.
- Communication and Language/Assistance
  - Provides interpretation services, at no cost, to all people receiving services to include those with Limited English Proficiency (LEP) and those who are deaf.
  - All people receiving services with LEP or who are deaf receive verbal and written notices about their right to language assistance services.
- Engagement, Continuous Improvement, and Accountability
  - Race, Ethnicity, Language and LGBTQ data are used in the design and delivery of services.

Additional indicators can be added at the discretion of the Executive Director, Medical 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 person-sensitive, outcome-oriented, behavioral healthcare system, open to affiliate with other organizations to deliver quality services."

Attachment A

Attachment B

Mission Statement

To provide a person-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 26

I. Collect, report, track encounter, outcome, and quality data aligned with CCBHC requirements.

A. Ongoing monitoring of follow-up care for high-risk individuals, including at minimum:

- Those discharged from psychiatric inpatient care within the past year
- Individuals under outpatient commitment orders within the past year
- Persons with documented intent to harm self or others
- Individuals diagnosed with co-occurring mental illness and substance use disorders

B. Using FY25 data as a baseline, reduce the rate of 30-day psychiatric hospital readmissions by 25% through targeted interventions and ongoing performance monitoring.

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):

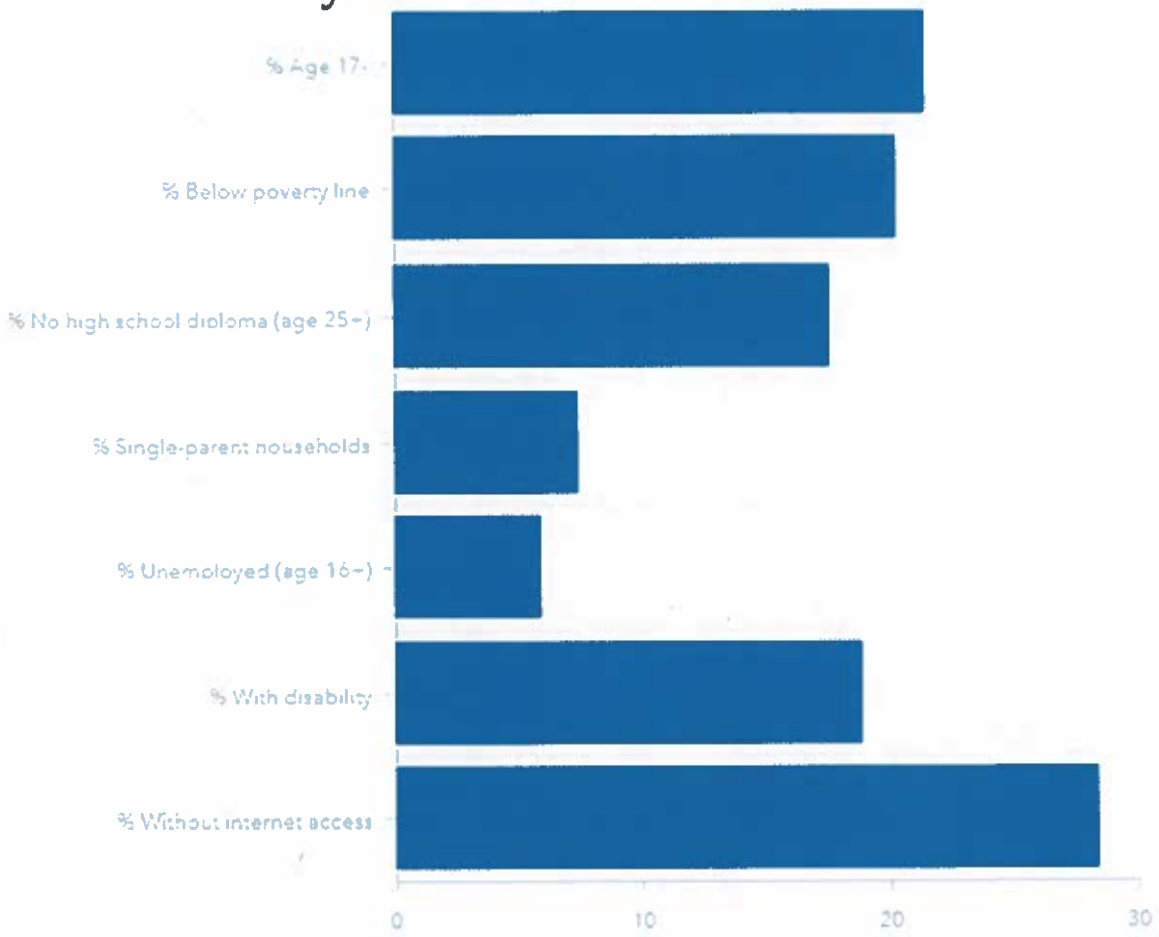
SECTION IV: To be filled out by Continuous quality improvement Committee

Review Date:	Signature:

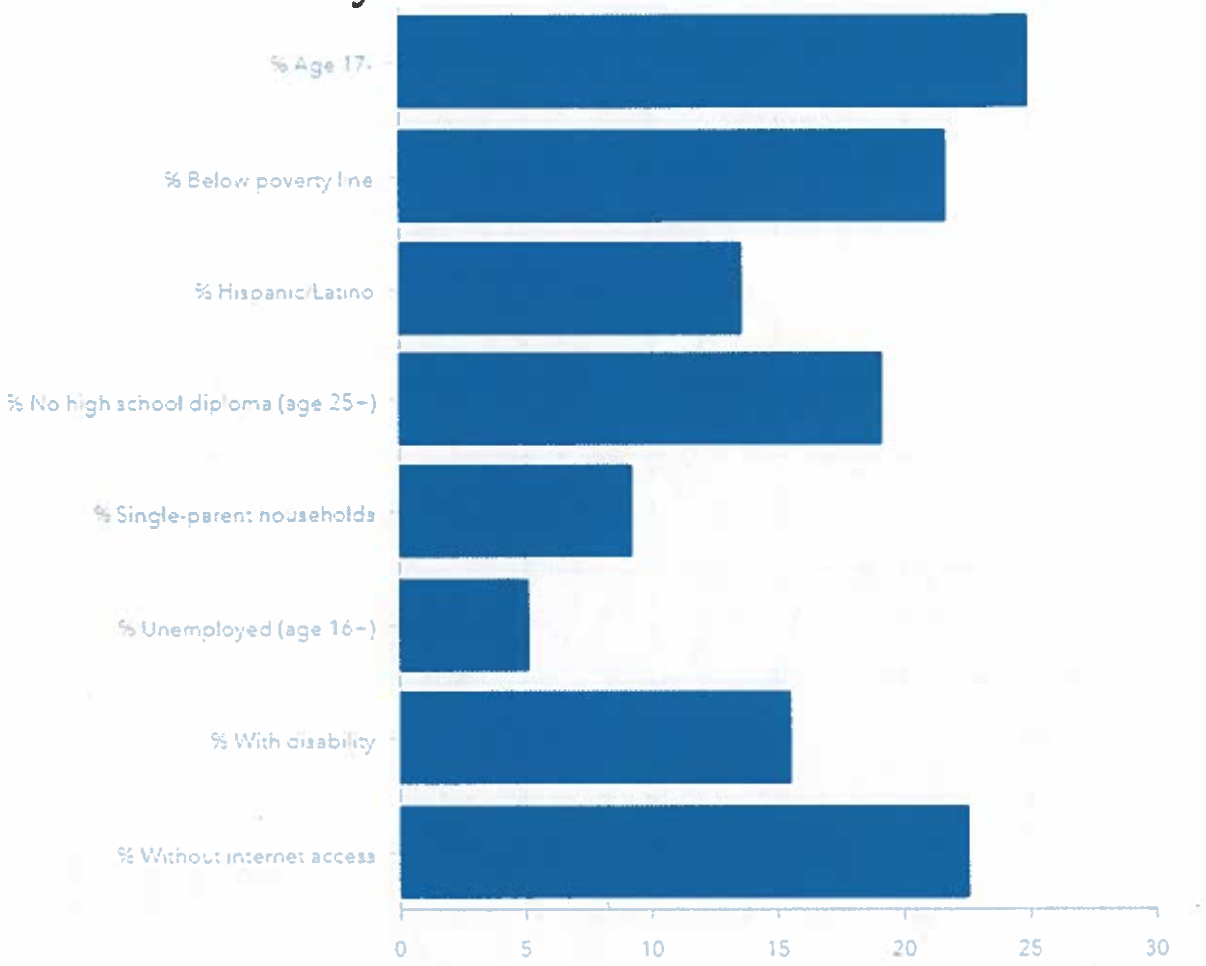
Attachment F

Minority Health Social Vulnerability Index

Jackson County



Marshall County



The data from this survey indicates that both counties are at a medium-high level of vulnerability.

CCBHC Task Force

Meeting Minutes – October 6, 2025

Present: Lane Black, Myron Gargis, Cammy Holland, Dana McCarley, Devin Oppenhouzen, Shelly Pierce, Erica Player, Dianne Simpson and Vanessa Vandergriff

After several weeks of uncertainty, MLBHC was approved for participation in the CCBHC Demonstration Program, effective 10/1/25.

Updates:

- **Data Processing**
  - Devin reported that all tasks related to data processing are progressing well.
- **Required Training**
  - Lane shared that he and Shelly met with the Training Specialists earlier today to discuss various aspects of training.
  - Task force members agreed that all required training for new CCBHC staff should be completed within the first 30 days of employment. Training for current CCBHC staff should be completed during the first quarter of CCBHC implementation (October–December 2025).
  - The group discussed the possibility of using Relias for many of the required training courses. Myron approved contacting Relias to explore training options and associated costs.
  - In previous meetings, the idea of training all staff on CCBHC-related topics—regardless of their current roles—was considered. Prior to today's meeting, Lane and Erica revisited this idea and recommended initially focusing on training CCBHC staff on required topics, with plans to extend training to non-CCBHC staff later. Task force members supported this approach.
- **Human Resources**
  - Lane reported that several current staff members are transitioning into CCBHC roles, and new CCBHC staff will begin in the coming weeks. Resumes continue to be submitted via Indeed and are being forwarded to supervisors for interviews and hiring.
- **CCBHC Services**
  - Myron shared the latest update from SAMHSA, indicating that nursing home and jail services are currently excluded from CCBHC. He remains hopeful that these services may be reconsidered for inclusion in the future.
  - The Policies and Procedures (P&P) for Substance Use Intensive Outpatient Program (SU IOP) need to be reviewed and updated as necessary.

DMH Check-In Meeting

- Dawn Taylor congratulated MLBHC on its inclusion in the CCBHC Demonstration Program and addressed any questions or concerns.

Next Meeting

- The next task force meeting is scheduled for Monday, October 13, 2025, at 9:30 a.m.

CCBHC Task Force

Meeting Minutes – September 29, 2025

Present: Lane Black, Myron Gargis, Cammy Holland, Dana McCarley, Devin Oppenhouzen, Shelly Pierce, Erica Player, Dianne Simpson and Vanessa Vandergriff

Update on CCBHC Implementation

Myron informed the task force that both Medicaid identification numbers have been received. He also noted that DMH and SAMHSA have a virtual meeting scheduled for this afternoon, during which we expect to learn whether our CCBHC implementation has been approved for the October 1, 2025 start date.

Billing Codes

Devin has worked diligently to develop the billing codes and distributed the listings to all task force members. She is currently finalizing the provider cheat sheets, which will be emailed to PDs/PCs later today for distribution to staff.

Weekly Check-In Meeting with DMH

Dawn Taylor led today's DMH Check-In Meeting. She also mentioned the upcoming virtual meeting with SAMHSA and stated that we should receive a decision regarding approval at that time. She assured the group that she would notify Myron as soon as she receives an update.

Dawn then referenced her conversation with Brent Hamer regarding the CCBHC Policies and Procedures (P&Ps) submitted by MLBHC. Brent indicated that the "Policy" sections were acceptable, but the "Procedures" should be more detailed and include a walk-through example for each topic. She provided a few examples of how the documents should be structured and will email those examples to Myron and Dianne. While there is no designated timeline for updating the P&Ps, Dawn requested that each revised document be submitted as it is finalized.

With no further questions or issues, the weekly check-in meeting was adjourned.

Next Meeting

The next task force meeting is scheduled for Monday, October 6, 2025, at 9:30 a.m.

CCBHC Task Force

Meeting Minutes – September 22, 2025

Present: Lane Black, Myron Gargis, Cammy Holland, Dana McCarley, Devin Oppenhouzen, Shelly Pierce, Erica Player and Dianne Simpson

Absent: Vanessa Vandergriff

Update on CCBHC Implementation

Myron advised the task force that we are still awaiting final approval from SAMHSA on October 1, 2025, implementation of CCBHC.

Organizational Charts

The task force reviewed the current CCBHC and Non-CCBHC Organizational Charts and noted a few minor revisions. Shelly will make the revisions and forward the updated charts to the group.

Document Updates

Myron, Lane and Shelly have been updating the Pay Scales and the Salary Classifications Listing, both CCBHC and Non-CCBHC. These documents will soon be ready for distribution.

Hiring and Staffing

In discussion of hiring updates, it was noted that Stacey Rothe has expressed a possible interest in the SU IOP Counselor position. Both Erica and Dana are working to schedule interviews this week for other CCBHC positions.

Billing Codes

Devin continues to work on building codes and will have a cheat sheet ready for the task force to review at next week's meeting.

Weekly Check-In Meeting with DMH

The DMH Check-In Meeting for today was cancelled by Dawn Taylor.

Next Meeting

The next task force meeting is scheduled for Monday, September 29, 2025, at 9:30 a.m.

CCBHC Task Force

Meeting Minutes – September 15, 2025

Present: Lane Black, Myron Gargis, Cammy Holland, Dana McCarley, Devin Oppenhouzen, Shelly Pierce, Erica Player, Vanessa Vandergriff

Absent: Dianne Simpson

Document Updates

Several updated documents were emailed to Myron last week. He distributed these to task force members for review and discussion:

- FY2025 CCBHC Carved Procedure Code Crosswalk
- FY2025 CCBHC Triggering Events / Itemized Claims Procedure Code Crosswalk
- FY2025 CCBHC Non-Triggering Events / Itemized Claims Procedure Code Crosswalk

The task force discussed that the procedure code for Primary Care Treatment has been carved out, eliminating the need to employ a Primary Care Nurse Practitioner. Myron noted that additional changes are expected, and adjustments will be made as necessary.

Hiring and Staffing

Lane distributed an updated Record of Hiring Process Form to help track vacancies and interviews. As discussed in previous meetings, a list of terminated employees was reviewed, and recommendations were made regarding which former staff members to contact about possible re-employment with MLBHC.

Organizational Charts

The group reviewed both the CCBHC and Non-CCBHC Organizational Charts to identify necessary changes based on the updated list of programs/services carved from the CCBHC model. Shelly will revise the charts and share them with task force members prior to the next meeting.

Weekly Check-In Meeting with DMH

Dawn Taylor, CCBHC Project Manager at DMH, shared that she participated in a call earlier today with SAMHSA to review the CCBHC Compliance Checklist. She noted that updated MLBHC documentation reflecting progress toward CCBHC will be resubmitted to SAMHSA within the next few days. Although final approval is pending, implementation appears to be on track for October 1, 2025.

Brent Hamer from the DMH/CCBHC team will be on-site Monday, September 29 at 9:00 a.m. to review MLBHC training documents.

Wage Proposal

Following the DMH Check-In Meeting, Myron shared the proposed wage information:

- The Board will be asked to approve the FY26 Proposed Budgets at tomorrow night's meeting.

- If the Board approves the FY26 Budgets and SAMHSA authorizes MLBHC to implement CCBHC on October 1, 2025, the following wage increases will take effect on October 11, 2025:
- **CCBHC positions** will receive a 30% Market Rate Adjustment (due to the enhanced PPS rate).
    - One-time payments from FY25 for CCBHC positions will be 1%, 2%, or 3%, based on the most recent performance appraisal score.
    - Master's level staff and RNs who received a 16.6% increase in FY25 will receive the remaining 13.4% in FY26, totaling a 30% increase.
    - Future wage increases will be based on the Medicare Economic Index (MEI); no further one-time payments will be issued.
- **Non-CCBHC positions** will receive a 10% across-the-board pay increase.
    - One-time payments from FY25 for Non-CCBHC positions will be 4%, 5%, or 6%, based on the most recent performance appraisal score.
    - If financial stability is maintained for Non-CCBHC programs, the Board's goal is to increase wages by 10% annually for FY26, FY27, and FY28.

Each MLBHC staff member will receive a personalized letter before October 11, 2025, detailing their wage increase and one-time payment.

Next Meeting

The next task force meeting is scheduled for Monday, September 22, 2025, at 9:30 a.m.

CQI Summary Reports
September 18, 2025

- **Report from Clinical Director**
- **Staff Error Report-** Made available to supervisors via team's link and emailed to staff.
- **Wall of Fame/Incentive Plan**

Incentive Plan-

Brookshire, Tom
Burks, Julie
Conner, Brooke
Early-Foster, Alison
Headrick, Tina
Knapp, Ilenna
Miller, Savannah
Riggins, Jennifer
Robinson, Hannah
Romero, Kimberley
Rucker, Elizabeth
Strange, Lilly
Traweek, Elizebeth

Wall of Fame-

Alford, Lindsay	Marshall	Hixon, Ryan	Dutton
Barrett, Rob	Jackson	Holcombe, Mitzi	Geriatrics
Boxley, Sarah	Multiple	Holland, Miranda	Jackson
Brown, Britany	Marshall	Johnson, Dallas	Jackson
Burns, April	M. P.	Knott, Stephanie	Marshall
Campbell, Teana	J. P.	Martin, Stephanie	Marshall
Cheek, Brittany	Cedar	McMurrey, Kimberly	Dutton
Clonts, Lisa	Marshall	Moore, Leah	Geriatrics
Cooper, Rebecca	Dutton	Quinn, Lindsey	Marshall
DeAtley, Joanna	Residential	Ritchie, Denise	Marshall
Dettweiler, Sarah	Jackson	Steed, Tyler	Geriatrics
Estes, Ashlee	Marshall	Wilson, Justin	Dutton
Hanna, Sarah	M. P.	Crowell, Robert	Cedar
Herring, Belinda	Marshall	Sweatman, Susan	Cedar
		Woodham, Cynthia	Cedar

I. **Review and approval of monthly summary report August 21, 2025:** The August meeting minutes were approved with changes noted below. The Cedar Lodge Access Report for July CQI had incorrect June no show and client cancel percentages. Correct totals are listed below.

List MM/DD/YY (M-F) for each scheduled day of month below:	Crisis Residential Admissions	Appt Kept	Appt Not Kept	No Show	Client Cancel	Staff Cancel	Denied	Denial Reason
June 2025 Report								
Totals	48	33	15	12	3	0	3	
Percentages		68.75%	31.25%	25.00%	6.25%	0.00%		

II. Administrative Review Summary/Error Reports August: (July MTD 1.5 %/ YTD 0.7%)

	Cases Reviewed	Docs Reviewed	Docs w/errors	Total Errors	Predominant Errors
TOTAL	16	4013	27	33	Late notes; Late case plan; Service not provided per T-plan

MONTHLY ADMIN REVIEW ERROR RATE: 0.8% YTD ERROR RATE: 0.7%

A summary report was sent to the committee for each program containing details of the errors for review. The breakdown of reviews done for 6-month reviews and other/transfers were submitted for each program. The predominant errors were late note, late case plan and service not provided per T-plan. The monthly error rate was slightly lower, but the yearly error rate was the same as last month.

III. State Reporting Data Elements (SRDE) Report for July 2025: These errors are reported one month later as they are not received in time to research and compile prior to the CQI review.

Total Errors	Predominant Error Trends
7	Invalid Diagnosis 1 SA or 3- Type; None/This CMHC Only listed after Primary referral source of PCP

V. Cedar Lodge Access report for CQI Monitoring: The goal of this report is to utilize this data to help develop solutions to remove barriers to treatment.

List MM/DD/YY (M-F) for each scheduled day of month below:	Crisis Residential Admissions	Appt Kept	Appt Not Kept	No Show	Client Cancel	Staff Cancel	Denied	Denial Reason
8/1/2025	1	0	1	1				
8/4/2025	2	2	0	0			2	Untreated medical issues- Admitted 8/7 Untreated medical issues- Admitted 8/5
8/5/2025	3	3	0	0			1	Presented under the influence- Rescheduled and admitted 8/25.
8/6/2025	3	2	1	1				
8/7/2025	4	2	2	1	1		1	Did not have doctor's orders for medications- Rescheduled and admitted 8/25
8/8/2025	1	1						
8/18/2025	5	1	4	2	2			
8/19/2025	5	2	3	1	2			
8/21/2025	3	1	2	2			1	Symptoms of Covid- Rescheduled and admitted 8/25
8/22/2025	4	3	1	1			1	No doctor's orders-rescheduled and admitted 8/25
8/25/2025	6	5	1	1			2	-Did not have medications or doctor's orders- Rescheduled and admitted 9/2 -Refused drug screen- Returned to jail, who did not reschedule
8/26/2025	5	4	1	1				
8/27/2025	1	1						
8/28/2025	5	4	1	1			1	Positive for opioids-rescheduled and admitted 9/2
Totals	48	31	17	12	5	0	9	
PERCENTAGES		64.58%	35.42%	25.00%	10.42%	0.00%		

VI. Prevention Activities: 231 Prevention activity sheets were reviewed for August 2025:

Direct Services	# Hours billed in Marshall County	# Hours billed in Jackson County
Block- Community	0	0
Block-Environmental	30	24
Block- Information Dissemination	34	30
Block-Education	0	11
Block-Alternatives	0	0
Block-PIDR	13	0
SOR-Environmental	36	32
SOR-CBP	52	113
Total	165	210

Funded by: Block Grant & SOR Grant – Marshall County

During the month of August, the Prevention team actively engaged in a wide range of community events, school-based initiatives, and resource distribution efforts across Marshall and Jackson Counties. Below is a detailed summary of activities:

1. School & Educational Engagement

Planned and prepared for open-house events in both Marshall and Jackson Counties.
Attended open houses at:
Hollywood Elementary
Boaz Intermediate
Arab Schools
Asbury Schools (distributed 46 pencil pouches and 17 Talk. They Hear You. information cards)
Distributed 400 Drug-Free pencil pouches containing a pencil, eraser, and sharpener at open houses.
Attended DAR Title I meeting, distributing 24 pencil pouches and 18 information pamphlets to parents.
Provided Talk. They Hear You. information at the Grant Library.
Began Too Good for Drugs (TGFD) program at Dutton Elementary School.
Attended the Jackson County Principals Meeting.
Attended School Resource Officer (SRO) meeting in Marshall County to discuss new vape laws and Vape Court.
Updated Vape Court handouts for students and parents.
Updated and administered the Indepth survey; completed 2 Indepth classes in Marshall County and 1 in Jackson County.

2. Community Events & Outreach

Attended End Addiction Sand Mountain event, distributing:
100 Narcan kits (each containing 2 doses of Narcan, 2 fentanyl test strips, and a pair of fentanyl-resistant gloves)
60 Deterra Packets
Attended Remove the Risk event at the Life Resource Center (Jackson County), distributing:
48 fentanyl test strips
27 Deterra pouches
Held an Overdose Awareness Event on August 26, 2025, in Jackson County:
Featured speakers included Mike Reese and Drug Court graduates.

Distributed 24 Narcan boxes, 19 fentanyl test strips, and 10 Deterra pouches.
Event attendance totaled 52 participants.

Set up Talk. They Hear You. informational table at Made on the Mountain (Marshall County).
Distributed Deterra pouches at Made on the Mountain event.
Participated in Marshall Kid n Kin, distributing 13 Deterra, 10 Narcan, and 10 fentanyl test strips.
Set up Remove the Risk at Brunch Pharmacy, distributing 12 Deterra, 1 bag of fentanyl test strips, and 1 box of Narcan.
Attended the Jackson County Interagency Meeting (August 5, 2025).
Planned a Prevention Workshop scheduled for August 15, 2025, at the Jackson County Resource Center.
Attended multiple community meetings, strengthening collaboration with local partners.

3. Resource Distribution
Provided 25 pairs of fentanyl-resistant gloves to each school principal in Jackson County and City Schools.
Gave out 1 box of Narcan, 24 fentanyl test strips, and 20 Deterra to Paint Rock Valley Fire Department.
Distributed 70 boxes (12 doses each) of Narcan to County SRO officers for school use in Marshall County.

4. Planning & Scheduling
Scheduled Drug Take Back Event for October 25, 2025.
Coordinated logistics for prevention workshops and upcoming school-based programming.

Summary:
August was a highly productive month with significant community outreach, overdose awareness programming, school engagement, and distribution of life-saving resources. Prevention efforts successfully reached students, parents, educators, first responders, and the broader community, strengthening awareness, education, and safety throughout Marshall and Jackson Counties.

VIII. Hospital Discharge Follow-up Report for Previous Month:

Location	Local	State/CRU	Total
Marshall	8 (6 Active)	0	8
Jackson	7 Active	0	7
Geriatrics	1	0	1
Total	16	0	16

Tracking reports of hospital discharges and 72-hour follow-ups for clients in Marshall and Jackson County were sent out to the committee. One appointment was not kept in Jackson County, but consumer went back to the hospital.

X. Incident Prevention and Management for Previous Month: There was one report of client aggression for August.

XI. Medication Errors for Previous month: There were 9 medication errors reported for the month of August. One wrong person, one wrong dose, 4 wrong times and 3 missed doses. No trends were identified.

By Personnel

	MAC	RN	LPN	Pharmacist	Other (explain)
Level 1	9				
Level 2					
Level 3					
TOTAL	9				

By Division

	MI	SA	TOTAL
Level 1	6	3	9
Level 2			
Level 3			
TOTAL			

By Error Type

	Wrong Person	Wrong Med	Wrong Dose	Wrong Route	Wrong Time	Wrong Reason	Wrong Documentation	Missed Dose	Other (explain)
Level 1	1		1		4			3	
Level 2									
Level 3									
TOTAL									

XII. Consumer Feedback, Complaints, and Grievances:

FY25-Consumer Feedback	Aug Compliments	Aug Suggestions	Aug Complaints	Aug Comments	Aug Total per location
Guntersville					0
Scottsboro	5	2	5		12
Outreach/Residential		2			2
Cedar Lodge					0
Total MTD	5	4	5	0	14
Total YTD	30	23	31	15	99

XIII. Residential Services Report for Previous month A monthly report was run for August.

FACILITY	CAPACITY	TARGETED PT DAYS	ACTUAL PT DAYS	% OCCUPANCY
Jackson Place	3	93	93	100
Marshall Place	3	93	90	97
Jackson Place Sup Apt.	2	62	62	100
Dogwood Apartments	8	248	183	74
Supportive Housing	12	372	248	67
MLBH Residential Care	10	310	310	100
MLBH Crisis Stabilization	2	62	62	100
Foster Homes	26	806	806	100
Totals		**2046**	**1854**	**91**

XIV. Treatment Plan Reviews for Previous month:

Programs	Total Charts	Admission Criteria not met	Not Timely	Not Individualized	Documentation Does Not Relate to TP And/or Address Progress	No Attempts of Active Engagement Documented	No Modification for Accommodations	Total Errors
Geriatrics	8	0	0	0	0	0	0	0
Jackson	60	0	4	0	1	0	0	5
Marshall	189	0	3	0	0	0	0	4
Substance Abuse	0	0	0	0	0	0	0	0
Residential	0	0	0	0	0	0	0	0
TOTALS	257	0	7	0	1	0	0	9

Standards 580-2-20-.07 (7) (a):

(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 recipient, 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.

The committee was sent a breakdown of the clinical data compiled from the Treatment Plan Reviews. A summary report was sent out to the committee for each program. One trend continues to be treatment plans that were not timely.

XV. Form-Policy & Procedure Revisions/Approvals:

Forms-

- **Advance Directive-mental and health (7 pages)-New-**This is a form that is being made available to the consumers when they receive services with our agency. It is not our form, and the consumer is not required to complete the form. The intention of the form is for the consumer to designate their instructions regarding consent or refusal of medical treatment if they ever become incapacitated. They can also use the form to designate a health care agent. If they designate our facility as the health care agent, staff should ask the customer if they would like us to make a copy to be retained in their MLBHC record. The clinical and assistant clinical director preselected the form to be used for our agency. It has been utilized as a pilot form by case managers this year. *The form has been placed on the MLBHC links server under the Forms Manual>Client Consents tab for staff access.*
- **Audit C Revised-**The hard copy as well as the Avatar version were revised to add a comment box to describe any brief intervention as well as two plans of action to pick from according to the outcome of the screening. The form was sent out to the committee with no changes noted. There is now a fillable PDF/PDF and Word version of this form. *They have now been placed on the MLBHC links server under the Forms Manual>Quality Measures folder for staff access.*
- **Authorization For the Release Information- Spanish Version-New-** The form was translated into Spanish to meet CCBHC requirements. No changes were made from the English version that is currently in use. *The form has been placed on the MLBHC links server under the Forms Manual>Client Consents tab for staff access.* This form along with the English version, has been added to MLBHC website by IT via the executive director's instructions under resources.

- **Client Handbook-English Version (8-page handbook)-Rev-** The client handbook was revised to update the program director's names in each county since we were required to create a Spanish version as a CCBHC requirement. The handbook has been added to MLBHC website by IT via the executive director's instructions under resources. Hard copy books were ordered on 9/19/25 and will be delivered to each location when received.
- **Client Handbook-Spanish Version (8-page handbook)-New-** The Spanish version of the client handbook was created as a CCBHC requirement. The handbook has been added to MLBHC website by IT via the executive director's instructions under resources. Hard copy books were ordered on 9/19/25 and will be delivered to each location when received.
- **Level of Care Guidelines-MI/SED Services-Adult-Childs LOC-MLBHC-New-**Erica Player created this guideline for staff to utilize when completing the LOCUS and CALLOC for their consumers to determine the level of care they will need to receive. The form was sent out to the committee with no changes noted. *It has been placed on the MLBHC links server under the Forms Manual>Intake forms tab for staff access.*
- **Mission-Vision Statement-Guiding Values-Rev-Effective 10/1/25-**One word was changed on the mission statement to align with the CCBHC standards. Consumer was changed to person in the first sentence. *"To provide a person-sensitive, outcome-oriented, behavioral healthcare system, open to affiliate with other organizations to deliver quality services."* The change was made by the clinical director and approved by the executive director as an appendix to the upcoming FY26 CQI Plan. *It has been placed on the MLBHC links server under the Forms Manual>Training for orientation forms tab for staff access.*
- **MLBHC Application for Employment-Revised effective 9/22/25-**This form was revised to add a date of graduation on the form. A fillable PDF was created and added to the MLBHC website. *The fillable PDF along with a PDF and a word format has been placed on the MLBHC links server under the Forms Manual> Administrative forms>New hire forms tab for staff access.*
- **Performance Appraisal-WITH PROD STANDARD percentage-Rev-**The signature line for Clinical Director was changed to Assistant Clinical Director/Clinical Director. The change was made by the assistant clinical director and approved by the executive director. *It has been placed on the MLBHC links server under the Forms Manual>Administrative forms>New hire forms tab for staff access.*
- **Performance Appraisal-WITHOUT PROD STANDARD-Rev-** The signature line for Clinical Director was changed to Assistant Clinical Director/Clinical Director. The change was made by the assistant clinical director and approved by the executive director. *It has been placed on the MLBHC links server under the Forms Manual>Administrative forms tab for staff access.*
- **Productivity Standard-Revised effective 10/1/25-**This form was revised by the clinical director to match the new productivity standards. She noted that they will NOT be signed for the Triggering Event measurement at this time. The staff will need to be aware of their target and track it daily. However, there will be a 3-month trial period. It will re-evaluate at that time, and adjustments will be made, if needed, to take effect 1-1-26. Supervisors will need to update the form for any changes for residential or outreach staff. The form was approved by leadership. *It has been placed on the MLBHC links server under the Forms Manual>Administrative forms>New hire forms tab for staff access.*
- **Reportable-Critical Incident Requirement-Rev-** This form was revised to change the phone number for the Clinical director to a new work phone #256-673-7154 as well as the QA Coordinators new work phone #256-302-9370. *It has been placed on the MBLHC links server under the Forms Manual> Administrative forms tab for staff access.*
- **Sliding Fee (Scale) Schedule-English Version-**Rev effective 10/1/25- The form was revised to meet CCBHC criteria by taking out the SMI criteria reference. It was added to MLBHC website

per executive director. *The form has been placed on the MLBHC links server under the Forms Manual>Client Consents tab for staff access.*

- **Sliding Fee (Scale) Schedule-English Version-**Rev effective 10/1/25-A Spanish version of this form was created to match the English version. It was added to MLBHC website per executive director. *The form has been placed on the MLBHC links server under the Forms Manual>Client Consents tab for staff access.*
- **Training and Education-Rev-**This form was revised in Avatar by the clinical director as well as the hard copy to add a check box for staff to document training on the expanded services offered by MLBHC as a CCBHC which is the "Welcome to better care handout" described below. *The form has been placed on the MLBHC links server under the Forms Manual>Client Consents tab for staff access.*
- **(MLBHC) Treatment Plan-Hard copy/Fillable/PDF (3 pages) -Rev-**The treatment plan was revised by management staff to better align with CCBHC requirements. Staff are being trained in the new form in Avatar prior to use of the new format. *The hard copy back up form has been placed on the MLBHC links server under the Forms Manual>Treatment Plan tab for staff access.*
- **Welcome to Better Care Handout-English-New-**The clinical director created an overview handout for all current and new consumers explaining the new CCBHC model of care. Staff should be instructed to have each consumer sign a training and education form in Avatar to acknowledge the receipt of this overview. The form was sent out to the committee with no changes noted. *It has been placed on the MLBHC links server under the Forms Manual>Client consents tab for staff access*. The handbook has been added to MLBHC website by IT via the executive director's instructions under resources.
- **Welcome to Better Care Handout-Spanish-New-** The clinical director created a Spanish version of the overview handout for all current and new consumers explaining the new CCBHC model of care. Staff should be instructed to have each consumer sign a training and education form in Avatar to acknowledge the receipt of this overview. The form was sent out to the committee with no changes noted. *It has been placed on the MLBHC links server under the Forms Manual>Client consents tab for staff access.* The handbook has been added to MLBHC website by IT via the executive director's instructions under resources.

P & P: Procedure revisions for CQI approval

- **Mental Illness Outpatient Services-Program Description (See P & P 6.1.2 for Policy and Procedures)-Rev-**This procedure was revised at the request of DMH to clarify our target population SMI and or SED, the age ranges we serve as well as the location of geographic service areas for our program. The revised P & P was forwarded to DMH and changes were approved. *The revision was added to the MLBHC links server under Policy Docs>Policy and procedures tab on the server.*

P & P: Board Approved Policy Revisions-None

XVI. Miscellaneous Items: None

Leadership Committee
Sept 18, 2025

MINUTES

Present: Lane Black, Myron Gargis, Cammy Holland, Dana McCarley, Shelly Pierce, Erica Player, Gerald Privett, Sherneria Rose, Dianne Simpson, Susan Sweatman and Vanessa Vandergriff.

Absent: none

I. Approve minutes of the August 21, 2025, meeting

Minutes of the August 21, 2025, meeting were distributed to all staff via e-mail. Minutes were approved, as presented.

II. Committee reports for the month

EEG from 8/27/25

Attendance: Christy Keeper, Jaslynn Wilkinson, Savannah Miller, Dallas Johnson, Hannah Bishop, Brooke Connor, Hannah Robinson
Guests: Margie Crabtree, JD Boatwright

1. Survey Launch

- Employee engagement survey launched today.
- Extended deadline from **Sept 3 → Sept 5**.
- Staff encouraged to remind teams to complete.
- Survey results to guide **goal-setting meeting in mid-September**.

2. Review of 2025 Events & Activities

- **Q1 – Christmas Party:** Positive reviews, considered one of the best.
- **Q2 – Hockey Game Outing:** Mixed feedback; not inclusive for non-sports fans and not disability friendly.
- **Q3 – T-Shirts, Massages, Ice Cream:** Overall well received; massages especially popular. Some complaints about T-shirt color. New hires appreciated them.
- **Q4 – Potluck:** Good attendance from group home staff and clients, but low turnout from other locations. Clients and staff expressed appreciation.
- **Professional Development - Emails (Neuroscience lessons):** Mixed reactions; some confusion but no major negative feedback.

3. Challenges & Advocacy

- Attempts to advocate for **weather policy** and **state retirement plan** were declined by leadership.
- Discussion on prioritizing **mental health resources** for staff (finding accessible therapy options, promoting well-being).

4. Upcoming Q1 Event (October Tailgate)

- **Date:** Tentatively set for **October 17, 2025** (during school fall break).
- **Location:** Civitan Park in Guntersville (pending approval).
- **Time:** 12 PM – 4 PM.
- **Activities:**
  - Relay events, puzzle painting, flag football (possible bracket or random team wristbands), optional dodgeball.
  - Wristbands to assign teams randomly.
  - Medals/goat awards & personality awards (with rules).
- **Food:** Hot dogs, hamburgers, chips, sodas. Dallas & Savannah to oversee food. Jeremy to grill.
- **Desserts:** TBD (Kona Ice, s'mores, or staff-provided desserts).
- **Budget Estimated:** budget was discussed

5. Future Engagement Ideas

- Consider **small seasonal activities** in place of a Christmas party (e.g., door decorating contest, gingerbread & cider social, holiday dress-up days).
- EEG to take more initiative in planning smaller festive/engagement activities.

6. Action Items

- **All members:** Encourage survey participation.
- **Christy:** Send Jackson County attendance list from potluck to Diane (for productivity tracking).
- **Christy:** Confirm Civitan Park availability with Vanessa.
- **Dallas & Savannah:** Coordinate food sourcing (hot dogs, burgers, chips, drinks).
- **Jeremy:** Confirm grilling duties.
- **Brooke & Jaslynn:** Help organize/run games.
- **All members:** Revisit dessert decision & finalize details in 2 weeks.

Next Meeting: September 10th at 3:00 PM.

EEG from 9/10/25

Attendance: Christy Keeper, Jessica Floyd, Margie Crabtree, Miranda Holland, Jimmie Boatwright, Jaslynn

Key Updates

- Survey launched: **59 responses** (up from 45).
- Recap: 2025 events successful; planning underway for 2026.
- Advocacy: Weather day policy not approved; retirement plan declined.

2026 Goals (Draft)

1. **Quarterly events** (continue tradition).
2. **One major annual event** (wellness or professional development).
3. **Small themed/holiday activities** (Halloween, door decorating, etc.) – small prizes approved.

Survey Highlights

- **Popular:** Christmas party, massages, T-shirts, outings.
- **Requests:** More non-sport outings (movies, comedy, theater), gym discounts, family-friendly events.
- **Professional Development:** Lunch & Learns, mini mental health conference (May/Sept), topics: LGBTQ+ services, IEP/504, ethics, crisis response, DBT/EMDR.
- **Advocacy:** Wellness days, flexible schedules, appreciation tokens, tuition reimbursement, meditation room.

Upcoming Event – Tailgate/Picnic

- **Date/Time:** October 17, 12–4 PM
- **Location:** TBD (Civitan Park or Guntersville Park; Vanessa confirming).
- **Activities:** Flag football, relay races, picnic, puzzle activity, crafts, and fun "personality awards" voted on at event.
- **Food:** Dallas & Savannah working with Meat Marketplace for donations/catering.
- **Budget:** ~$2,500 (similar to Christmas event).
- **Responsibilities:**
  - Jessica – Sign-in station.
  - Hannah & Jimmie – Crafts.
  - Christy – Confirm location & coordinate logistics.

2026 Event Draft Plan

- **Q1 (Oct–Dec 2025):** Tailgate event (Oct 17).
- **Q2 (Jan–Mar):** Outing (movies, comedy, craft fair).
- **Q3 (Apr–Jun):** Family Fun Day (water park, bounce houses, snow cones).
- **Q4 (Jul–Sep):** Smaller event (massages, T-shirt contest).

Action Items

- **Christy:** Draft goals email; finalize survey summary; confirm tailgate location; send neuroscience minute.
- **Jessica:** Prepare sign-in station (Q1 event).
- **Hannah & Jimmie:** Coordinate crafts (Q1 event).
- **Dallas & Savannah:** Secure food donations for tailgate.
- **All Members:** Provide input on 2026 "big goal."

Next Meeting: September 24, 2025 – 3:30 pm

Human Rights from 9/8/25

Tricia Hopper, Leona Stancil (via telephone), Erica Player, Dianne Simpson, Sherneria Rose, Margurite Rollins, Susan Sweatman, Marshall Place consumer, Lee Denmark, consumer committee member

Not present: Kathleen Rice, Carrie Thomas, Sherry Bailey

Sherneria Rose introduced L.D., a new consumer committee member.

Consumer Feedback – Marshall Place
Two consumers shared feedback regarding their experience at Marshall Place. Concerns included the food provided by Cedar Lodge, with requests for more fruits, vegetables, and high-fiber options. They also expressed a desire for a fully functional kitchen and new carpeting. Dianne noted that a kitchen upgrade had been assessed, but the home's wiring cannot support it.

Positively, both consumers stated they enjoy living at Marshall Place, appreciate having private rooms they can personalize, and are satisfied with their television and regular outings. They also commended the staff for their care.

Approval of Previous Minutes
Minutes from the June 2, 2025 meeting were reviewed. Motion to approve by Leona, seconded by Susan. Approved unanimously.

Rights Restriction Request
Sherneria Rose presented a request to restrict a consumer's rights related to caffeine intake for a residential consumer. The consumer's physician had previously prohibited caffeine due to increased agitation and aggression. After the restriction was lifted, the consumer consumed two caffeinated drinks during an outing and became aggressive. Staff requested a new restriction: no more than one 20 oz. caffeinated beverage per outing, excluding Mountain Dew and energy drinks. The consumer and guardian agreed to the restriction on 9/8/25. The committee unanimously approved the request. The restriction will be reviewed quarterly.

Policy Review – Right to Refuse Services (P&P 10.14)
Sherneria presented a case involving a consumer who consistently refuses medical and psychiatric treatment, resulting in significant health decline and inability to perform daily activities of living. Although the consumer prefers alternative treatments, she has also refused occupational and physical therapy. Tricia noted that the option to see an osteopathic physician, Dr. Ginas, was offered.

The committee determined this constitutes self-neglect and recommended reporting to DHR. They discussed adding language to the policy regarding DHR involvement but decided against it, citing potential conflict with Alabama Administrative Code 580-2-20 .04(17), which protects the right to refuse treatment without fear of reprisal.

Additional Case – Medical Refusal
Sherneria presented another case involving a consumer who refuses all medical tests and treatments. The physician suspects severe kidney failure and potential need for dialysis. The committee considered guardianship but concluded that forced treatment would still be required. No changes to policy were recommended, in alignment with the Administrative Code.

Committee Membership Updates
Sherneria announced Carrie Thomas's resignation due to relocation. Margurite reported that Kathleen Rice remains interested in serving but was unable to attend. The committee discussed the need to recruit new members
Next meeting was scheduled for December 1, 2025 at 5:00 at Cedar Lodge.

III. Program Financial Reports: October, 2024 – August, 2025

- YTD net income of $1,151,026 (not including Board investments).
- **Marshall Co. OP & OR – Net income $467,679**
- **Jackson Co. OP & OR – Net income $68,202**
- **Geriatrics – Net income $65,292**
- **Residential –**
  - Supervised Apartments – **Net income $24,353**
  - EBP Supportive Housing – **Net income $7,670 (program designed to break even)**

- Dutton – **Net income $265,362**
- Jackson Place – **Net income $105,293**
- Marshall Place – **Net income $9,250**

- **SU Services – Net income $130,541**
- **Prevention Services – Net income $4,153**

IV. Reports & Program Updates:

- **Executive Director's Report – Myron Gargis**
  - We're still awaiting final approval for implementation of CCBHC on 10/1/25.
  - The CCBHC Task Force developed and proposed two potential recruitment tools for the Board's consideration: an Employee Referral Program for existing employees and a Sign-on Bonus for new hires. Myron shared these draft proposals for LC review. Once these items have final approval, they will be shared with all employees.
  - Earlier this week, the Board approved the proposed budgets for FY26, which included pay increases. As there are many pay increase variables for FY26, individualized letters will be sent to each staff member prior to 10/11/25.
  - The Board also approved the FY26 Goals and Objectives for CCBHC and Non-CCBHC Programs. Myron will soon share these documents with all staff members.
  - The Scottsboro MHC will have their Open House on Friday, 9/26/25 from Noon – 4:00 pm
  - Myron received an email from DMH of a forthcoming contract amendment for an additional JC SB TH ($50K). There is already an applicant in mind for this position.
  - At this week's meeting, Myron updated the Board on the LC's desire to continue pursuing placement of consumers at the Sebring Duplex, but with the implementation of a more rigorous screening process. Staff will now complete a consumer referral form, which will be reviewed by upper management before a consumer is approved for residency in the duplex. Myron shared a draft Sebring Referral and Independent-Living Screening Form with LC members. A few minor revisions were noted, with all in agreement that the form was very thorough. It was also noted that residency in this duplex is designed to be short term, therefore, leases will be for 12 months and non-renewable.
- **Clinical Director's Report – Dianne Simpson**
  - Dianne asked LC members to remind staff that the age of consent will change to 16 yo, as of 10/1/25.
  - Dianne developed and shared a CCBHC Readiness Training Form with LC members. This form will allow a method of tracking to verify that all staff are properly trained in all areas. Dianne noted that this form also ties directly to the FY26 Goals and Objectives for Non-CCBHC programs.
- **Administrative Services – Cammy Holland**
  - Cammy provided an update on new CCBHC service codes. Devin has worked diligently to already build many of the new codes and be ready for the switch to CCBHC. Staff will be instructed to have all notes finalized by 9:00 pm on Tuesday, September 30. Beginning, Wednesday, October 1, CCBHC staff will switch to using the new codes.
  - Cheat sheets for billing codes have been created and should be shared with providers.
- **HR Office – Lane Black**
  - Lane has been working to incorporate CCBHC required training items on the current training spreadsheets. A DMH/CCBHC rep will be on-site Monday, September 29, to meet with HR/Training staff and review training documentation.

- Lane distributed the listing of current vacancies throughout the organization. Please advise him of any corrections.
- The following recommendations were made regarding the Employment Section of the MLBHC website.
  - Convert the Employment Application so that it can be accessed and completed on a smart phone and
  - Add the four Peer Support Applications (CPS-A MI, CPS-A SU, CPS-P and CPS-Y).
- During discussion of recruitment and transfers, Myron noted the following items:
  - Approval to go ahead and advertise to backfill the staff positions that are transferring to CCBHC.
  - Waive the 12 months of employment requirement on transfers for current staff members wishing to move to CCBHC positions.

- **Jackson County OP & OR – Dana McCarley**
  - Dana noted this was her last LC meeting as a Program Director. She is working to divide up PD duties so that she can focus more time with JD on the training plan for CCBHC.
  - Interviews for several positions have taken place, with more scheduled next week. These include PC Screeners, JC PD, Community Outreach Specialist, Employment Specialist, Therapists, Case Managers, and Care Navigators.
  - All staff are being informed on personnel changes, CCBHC updates, DAP notes, client enrollment for CCBHC, and directing them to focus on the facts and client services rather than rumors.
  - Erica and Dana are working on plans for therapist coverage for JC with Tara Erwin, JC OP TH, becoming family/group therapist and Brittany Burkhalter, JC OP TH, going on maternity leave in November. This will take JC from five OP TH schedules down to two.
  - Dana is also working on sending samples of DAP notes for different service codes.
- **Marshall County OP & OR – Vanessa Vandergriff**
  - Vanessa reported that things are going well in MC.
  - It is likely that another OP TH will be needed due to high caseloads.
  - All SB TH positions have been filled.
- **Geriatrics – Gerald Privett**
  - Myron has given approval to grow the program by recruiting and hiring additional Therapists.
  - Gerald made a recommendation to possibly cross-train Geri TH to see consumers in other programs.
- **Residential – Sherneria Rose**
  - There is a possible candidate for employment at JP, but we are awaiting a response from DMH-ODS on provision of the ASL exam.
  - Staff at MP are preparing for the new productivity standard and have received re-training on service documentation.
- **SU Services – Susan Sweatman**
  - Staff recruitment continues at Cedar Lodge.
  - The current census is 22-23.

V. Review of wait times

For August, 2025, the following wait times were reported:

MC Intake	4 days	MC MD/CRNP	21 days
JC Intake	4 days	JC MD/CRNP	13 days

Average	4 days	Average	17 days

VI. Unfinished Business

- **None noted**

VII. New Business

- **Proposed changes to productivity with implementation of CCBHC** – Dianne developed and shared a draft document on proposed productivity changes with the implementation of CCBHC. Instead of hours, CCBHC staff will focus on the number of triggering events provided per day. Dianne noted that she had also created a spreadsheet that staff members could utilize to enter and monitor their productivity. LC discussed and agreed on a few minor revisions to the productivity numbers. Dianne will make the revisions and then share this revised document with LC members.
- In discussion of productivity and financial information, Myron noted that although each Non-CCBHC program will be monitored individually, financial stability of these programs must be sustained as a group.

VIII. Adjournment

The Leadership Committee meeting was adjourned at 4:30 p.m.

MOUNTAIN LAKES
Behavioral Healthcare

New Directions October 25

MLBHC Hosts Successful Grand Opening in Scottsboro

On Friday, September 26, 2025, Mountain Lakes Behavioral Healthcare proudly celebrated the Grand Opening of our new Scottsboro location. It was a wonderful turnout, and we're incredibly grateful to everyone who came out to support us.

The ribbon cutting was led by Myron Gargis, joined by our dedicated staff, members of the Board, the Chamber of Commerce, and several supportive members of the community. It was a special moment that marked not just the opening of a new building, but the beginning of a new chapter for behavioral healthcare in our area.

Guests enjoyed a delicious lunch catered by **Holy Smokes BBQ**, and we were excited to showcase a beautiful balloon arch created by **Moon Stone Custom Events**—a local business owned by our very own **Savannah Miller**! The festive setup made the day feel all the more special.

After the ribbon cutting and meal, attendees had the chance to explore the building, meet our team, and learn more about the services we offer. There were lots of great conversations about the future of Mountain Lakes Behavioral Healthcare and how we can continue making a positive impact in the community.

We're so thankful for the support we received and couldn't have asked for a better way to open our doors. Here's to continued growth, connection, and service in Scottsboro and beyond!

A very special guest of MLBHC attended the Open House. Ms. Faye Shrader is pictured above with Executive Director, Myron Gargis. Ms. Shrader served on the Marshall-Jackson Mental Health Board, Inc. for 24 years (1991-2015).

What's Going On ???

October Anniversaries

Brian Bonifay	1 year
Miranda Holland	1 year
Shannon Kelley	1 year
Courtney Landers	2 years
Stephanie Martin	2 years
Jennifer Riggins	8 years
Mitzi Holcombe	9 years
Dianne Simpson	28 years

October Birthdays

October 1	Margie Crabtree
October 2	Christopher Whitworth
October 3	Crystal Malone
October 4	Jennifer L Brown
October 6	Gabby Catchings
October 6	Amanda Higdon
October 15	Brooke Conner
October 24	Nicole Gurley
October 24	Hannah Lowery
October 25	Gerald Privett
October 30	Anna Benton

~ October Meetings ~

Thursday, October 16th
CQI Committee meeting 1:00 pm
Leadership Committee meeting (following PI)
Quarterly meeting - All attend at Admin

Tuesday, October 21st
Board meeting 5:30 pm
Hwy 35 Facility - Scottsboro
(Confirm attendance with Shelly Pierce)

Welcome To Our New Staff Members

School Based Therapists



Hannah Cranford, MSW, Albertville
AnneMarie Early, MSW, Albertville
Samantha Mick, MSW, Jackson County

Life Skills Specialists


Jeff Wilson, Dutton Group Homes
Barbara Cox, Marshall Place Group Home

TAILGATE PARTY

Hosted by

MOUNTAIN LAKES
BEHAVIORAL HEALTH CARE

FRIDAY, OCTOBER 17, 2025
12:00 PM – 4:00 PM
19272 US-431, GUNTERSVILLE, AL 35976

- **FOOD & DRINKS**
- **MUSIC & GAMES**
- **FOOTBALL FUN & FELLOWSHIP**
- **GIVEAWAYS & PRIZES**

Come celebrate with us!

Bring your team spirit, lawn chairs,
and appetite for fun. Everyone is welcome.

During the September meeting, the Board of Directors took action to approve the following FY26 Goals and Objectives for CCBHC Implementation.

1. Governance & Leadership

Goal: Ensure strong organizational governance to support CCBHC transition, compliance, and sustainability.

- **Objective 1.1:** Maintain an internal CCBHC Task Force that meets at least monthly to monitor implementation progress.
- **Objective 1.2:** Present quarterly updates on CCBHC implementation to the Board of Directors, including financial performance, compliance benchmarks, and service data.
- **Objective 1.3:** Finalize and approve all policies and procedures required under the CCBHC model by December 31, 2025.

2. Staffing & Training

Goal: Recruit, train, and retain qualified staff to deliver the full CCBHC service array.

- **Objective 2.1:** Hire all key staff required under the CCBHC staffing model, including care navigators, licensed providers, peers, mobile crisis teams, and primary care screening staff by March 31, 2026.
- **Objective 2.2:** Develop a comprehensive CCBHC training plan and complete training for 100% of staff on core topics (trauma-informed care, suicide prevention, evidenced based practices, cultural competence, etc.) by March 31, 2026.
- **Objective 2.3:** Establish a structured onboarding and role-specific competency checklist for all CCBHC staff by February 28, 2026, and ensure 100% completion within the first 30 days of hire.

3. Service Delivery & Access

Goal: Expand and enhance services to meet the CCBHC service array requirements and ensure timely access to care.

- **Objective 3.1:** Achieve all access timeframe requirements for intake and crisis services by February 1, 2026.
- **Objective 3.2:** Ensure all nine required CCBHC services are actively delivered by March 31, 2026.
- **Objective 3.3:** Expand the Mobile Crisis Team to operate 24/7 with response times compliant with CCBHC standards by June 30, 2026.

4. Care Coordination

Goal: Build effective care coordination systems across primary care, hospitals, law enforcement, and schools.

- **Objective 4.1:** Finalize and sign all required written care coordination agreements by March 31, 2026.
- **Objective 4.2:** Implement warm handoff procedures for clients transitioning between levels of care and across partner agencies by March 31, 2026.
- **Objective 4.3:** Assign a designated care navigator for at least 75% of clients with high-risk or complex needs by April 30, 2026.

5. Quality Reporting & Compliance

Goal: Build a robust quality assurance and performance monitoring system aligned with CCBHC requirements.

- **Objective 5.1:** Fully implement a data reporting dashboard for required CCBHC quality measures by March 31, 2026.
- **Objective 5.2:** Submit quarterly quality measure reports to SAMHSA and DMH beginning Q2 FY26.
- **Objective 5.3:** Conduct biannual client satisfaction surveys by April 30 and September 15, 2026.

6. Financial Sustainability (PPS & Billing)

Goal: Maximize Prospective Payment System (PPS) reimbursements and ensure financial sustainability.

- **Objective 6.1:** Ensure at least 85% of qualifying service days trigger the PPS daily rate by March 31, 2026.
- **Objective 6.2:** Train all front-line clinical staff and supervisors on PPS billing practices and triggering services by November 30, 2025.
- **Objective 6.3:** Monitor monthly PPS rate performance and conduct quarterly audits starting Q2 FY26.

While Mountain Lakes Behavioral Healthcare's primary organizational focus during FY26 will be the implementation and fidelity to the Certified Community Behavioral Health Clinic (CCBHC) model, several vital programs will continue to operate outside of the CCBHC umbrella. This document outlines achievable, growth-oriented goals for those non-CCBHC programs to ensure continued excellence, integration, and strategic alignment.

Strategic Priority:

Ensure growth, alignment, and quality in non-CCBHC programs while supporting the system-wide transition to the CCBHC model.

Goal A: Strengthen Core Program Operations

- Implement one operational or clinical enhancement in each non-CCBHC program by June 30, 2026.
- Develop written staffing plans and contingency coverage for each residential facility by February 28, 2026.

Goal B: Advance Quality & Documentation Standards

- Develop documentation templates aligned with evidence-based practices across all non-CCBHC programs by May 31, 2026.
- Ensure 100% of residential and day program staff receive documentation training by April 30, 2026.

Goal C: Support Workforce Development

- Ensure all non-CCBHC staff receive at least two professional development trainings by September 30, 2026.
- Develop onboarding guides and checklists specific to each program type by March 2026.

MLBHC Benefits for 2026

Open Enrollment - The month of November provides an opportunity for full-time staff members to make any benefit changes that may be necessary for the coming calendar year. Please be thinking ahead to any benefit changes that you might need to make. You may contact the HR Office during November for assistance with benefit enrollment/changes. All benefit changes take effect on January 1, 2026.

The rates below are effective from January 1, 2026 through December 31, 2026

LOCAL GOV Medical (BCBS of Alabama)

Employee portion: Ind coverage $204.16/month ($102.08/pp)
Employee portion: Fam coverage $496.96/month ($248.48/pp)

Premiums for Delta Dental and VSP Vision will not change for the upcoming year.

Delta Dental Insurance

Employee portion: Ind coverage $33.03/month ($16.52/pp)
Employee portion: Fam coverage $76.27/month ($38.14/pp)

VSP Vision Insurance

Silver	Employee portion: Ind coverage $7.72/month ($3.86/pp) Employee portion: Fam coverage $16.59/month ($8.30/pp)
Gold	Employee portion: Ind coverage $10.05/month ($5.03/pp) Employee portion: Fam coverage $21.60/month ($10.80/pp)
Platinum	Employee portion: Ind coverage $13.99/month ($7.00/pp) Employee portion: Fam coverage $30.08/month ($15.04/pp)

MLBHC Wall of Fame

(August 2025 I = Incentive)

Marshall OP & OR

Lindsay Alford
Britany Brown
Julie Burks (I)
Lisa Clonts
Ali Early-Foster
Ashlee Estes
Tina Headrick (I)
Belinda Herring
Ileana Knapp (I)
Stephanie Knott
Stephanie Martin
Lindsey Quinn
Jennifer Riggins (I)
Denise Ritchie
Kimberly Romero
Elizabeth Rucker (I)
Elizebeth Traweek (I)

Geriatrics

Mitzi Holcombe
Leah Moore
Tyler Steed

JC OP & OR

Rob Barrett
Tom Brookshire (I)
Brooke Conner (I)
Sarah Dettweiler
Miranda Holland
Dallas Johnson
Savannah Miller (I)
Hannah Robinson (I)
Lilly Strange (I)

Multi Programs

Sarah Boxley

Residential

April Burns
Teana Campbell
Rebecca Cooper
Joanna DeAtley
Sarah Hanna
Ryan Hixon
Kimberly McCurrey
Justin Wilson

Substance Use

Brittany Cheek
Bob Crowell
Susan Sweatman
Cindy Woodham

FY26 Holidays for full-time MLBHC staff

- **Thanksgiving (2 days)**
  - Thursday/Friday, November 27/28
- **Christmas (2 days)**
  - Wednesday/Thursday, December 24/25
- **New Year (2 days)**
  - Wednesday/Thursday, December 31/Jan 1
- **Good Friday**
  - Friday, April 3
- **Memorial Day**
  - Monday, May 25
- **Independence Day**
  - Friday, July 3
- **Labor Day**
  - Monday, September 7
- **Floating Holiday**
  - 1 day per fiscal year

JC RDP visits the library

Lilly Sparks, Coordinator for Jackson County Rehabilitative Day Program, recently took the consumers on a field trip to visit the Scottsboro Library.
From the looks of the photos below, it seems everyone enjoyed their day.