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, Executive Management Coordinator
RE: January Board meeting
DATE: January 16, 2025

The next meeting of the Board of Directors will be conducted on **Tuesday, January 21, 2025,** at the Administrative Office in Guntersville. An evening meal will be provided, with the meeting starting at 5:30 pm.

If you prefer to participate via teleconference, the connection information is listed below.

January Board of Directors Meeting
Jan 21, 2025, 5:30 – 6:30 PM (America/Chicago)
Please join my meeting from your computer, tablet or smartphone.
https://meet.goto.com/893004573
You can also dial in using your phone.
Access Code: 893-004-573
United States: +1 (872) 240-3311

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

- January Board Agenda
- Minutes
  - November 19, 2024, Board meeting
  - December 9, 2024, Board work session
- Financial Reports through December 31, 2024
- Personnel Report
- IT Director's Report
- Clinical Director's Report
- FY24 PI Annual Report
- Recent local newspaper article
- Summary of Reports for November and December from the CQI Committee
- Minutes from the November and December Leadership Committee meetings
- January 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

January 21, 2025

AGENDA

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

II. Introduction and welcome of newest Board member – Myron Gargis, Executive Director
- Andrea LeCroy representing Marshall County

III. Approval of minutes – David Kennamer, President
- November 19, 2024, Board meeting
- December 9, 2024, Work session

IV. Executive Director's Report

V. Financial reports through December 31, 2024 – Myron Gargis, Executive Director

VI. Acceptance of the FY24 Financial Audit – Myron Gargis, Executive Director

VII. Annual Board review of Policies and Procedures – Myron Gargis, Executive Director

VIII. Written Reports
- Personnel – Lane Black, HR Coordinator
- IT – Steve Collins, IT Director
- Clinical – Dianne Simpson, Clinical Director

IX. Board requested items for future meeting

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

Board of Directors Meeting
November 19, 2024

MINUTES

Prior to tonight's monthly meeting, MLBHC's Reboot Committee hosted a Board Appreciation Dinner for Board members and their guests.

I. Call to Order

David Kennamer, President, called the meeting to order at 6:15 p.m. at the Administrative Office in Guntersville, Alabama. Virtual participation in this month's meeting was also available.

Present: Jo-Anne Hutton
John David Jordan
David Kennamer, President
Bill Kirkpatrick
Victor Manning, Treasurer
Hannah Nixon, Vice-President
Lucien Reed
Jane Seltzer, Secretary

Absent: Joe Huotari

Staff: Lane Black, HR Coordinator
Dana Childs, QA Coordinator/Clinical Administrative Assistant
Myron Gargis, Executive Director
Cammy Holland, Business Manager
Shelly Pierce, Executive Coordinator
Dianne Simpson, Clinical Director

Other: Janet Jordan, Guest
Nell Kennamer, Guest
Kathy Kirkpatrick, Guest
Kristi Manning, Guest

II. Update on MLBHC Investments – Scott Belgard, Financial Advisor – LPL Financial

Scott Belgard, Financial Advisor with LPL Financial, attended tonight's meeting to share an update on MLBHC's investments. Mr. Belgard distributed detailed information related to MLBHC's investments and provided an opportunity for Board members to ask any questions they might have in regard to these items.

III. Approval of the minutes of the October 15, 2024, meeting – David Kennamer, President

MOTION: Victor Manning made a motion that the Board approve the minutes of the October 15, 2024, meeting, as presented. Jane Seltzer seconded the motion, which was approved unanimously.

IV. Executive Director's Report

The Executive Director's Report for November was submitted in written format and made available to all Board members for review prior to the meeting. This report is included as Appendix A to the minutes from tonight's Board meeting.

Mr. Gargis noted that the FY24 Financial Audit should be finalized in the next couple of weeks. As the final audit numbers are needed as soon as possible for the CCBHC cost report, a recommendation was made to conduct a brief virtual meeting on Tuesday, December 10, 2024, at 5:30 p.m. to discuss and approve the FY24 Financial Audit. Board members were in agreement with this recommendation. Connection information for the virtual meeting will be scheduled and emailed to all Board members.

V. Financial reports through October 31, 2024 – Cammy Holland, Business Manager

Ms. Holland noted that all regular financial reports were included in the monthly packet and asked if there were any questions in regard to these items. As mentioned at the October meeting, Board members can now expect to also receive an Accounts Receivable Aging Report in their monthly packet.

The FY25 Program Summary reflected a net income for several programs, but a net loss for Marshall County MHC, Jackson County MHC, Geriatrics, Marshall Place, Substance Use and Substance Use Prevention.

The current Balance Sheet, which included Board Investments, indicated Total Cash of $468,009. This total is $1,622,309 less than this same time period last year. Continued review reflected Total Accounts Receivable of $1,863,317, which is $346,538 less than in FY24.

The Income Statement, which does not include Board Investments, reflected a YTD Net Loss of $37,218, which is $75,565 less than in FY24.

VI. Proposed revisions to CQI (Continuous Quality Improvement) Plan for FY25 – Dianne Simpson, Clinical Director

To allow adequate time for Board members to review the revisions to the FY25 CQI Plan, a decision on approval of this item was tabled from the last meeting.

Ms. Simpson noted that the change in title of the document (Performance Improvement Plan to Continuous Quality Improvement Plan) and the majority of the revisions for FY25 were made to more closely align with verbiage used by Community Certified Behavioral Health Clinics (CCBHCs). A summary of the revisions, along with the completed document, were provided to Board members last month.

MOTION: Victor Manning made a motion that the Board approve the revised CQI Plan for FY25, as presented. Hannah Nixon seconded the motion, which was approved unanimously.

VII. Q4 updates to FY24 Strategic Action Plan – Myron Gargis, Executive Director

All 4th quarter updates to the FY24 Strategic Action Plan were emailed to Board members for review prior to the meeting. Board members were provided an opportunity to ask questions in regard to any items on last fiscal year's Strategic Action Plan.

VIII. Written Reports

The Personnel, IT and Clinical 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.

IX. Decision on December, 2024, Board meeting

After brief discussion on the possibility of conducting a Board meeting during the month of December, 2024, the following motion was made:

MOTION: Hannah Nixon made a motion that the Board elect not to conduct a monthly meeting in December, 2024. Victor Manning seconded the motion, which was approved unanimously.

The next monthly meeting will be held on Tuesday, January 21, 2025, at the Administrative Office in Guntersville, Alabama.

X. Board requested items for future meetings

There were no items requested for future Board meetings.

MOTION: Hannah Nixon made a motion that the Board adjourn the meeting at 6:55 pm. Victor Manning seconded the motion, which was approved unanimously.

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

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

APPENDIX A

Executive Director's Report – November 19, 2024

- Transportation service updates – October – Jackson County had 56 transports and Marshall County had 43 transports. We received the new 15 passenger van that was ordered and we can now transport our day program individuals in Marshall County. This will save ~$3K per month in transportation costs.

- Jackson Place & Creekside Hospital – Will be meeting with DMH staff tomorrow to explore options to potentially add new beds for deaf individuals at our Woodville location. We will also be conducting training at Creekside Hospital in order to get them set up as a Designated Mental Health Facility, so they can accept and be paid to treat involuntarily committed individuals.

- FY24 Audit meeting – The audit numbers should be finalized in the next couple of weeks. Since we need those final numbers as soon as possible for the CCBHC cost report, I would like for us to have a quick virtual meeting on December 10th at 5:30 to discuss and approve the audit.

- Certified Community Behavioral Health Clinic (CCBHC) – We are currently developing our Community Needs Assessment and our CMS Cost Report. We had the kickoff meeting with our consultant on 11/15 to get the cost report process underway. DMH recently released guidelines describing the deliverables for July 1, 2025 CCBHC Demonstration Entry (attached).

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

Board of Directors Work Session
December 9, 2024

MINUTES

Board members elected not to conduct a monthly meeting during December, but were in agreement to hold a brief work session tonight to review and discuss the FY24 Financial Audit. This was due to the final audit numbers being needed as soon as possible for development of the CCBHC cost report.

Present: Joe Huotari (Virtual)
Jo-Anne Hutton
John David Jordan (Virtual)
David Kennamer, President (Virtual)
Bill Kirkpatrick
Lucien Reed
Jane Seltzer, Secretary (Virtual)

Absent: Victor Manning, Treasurer
Hannah Nixon, Vice-President

Staff: Myron Gargis, Executive Director
Cammy Holland, Business Manager
Shelly Pierce, Executive Coordinator

Other: Joella Bogle, CPA, MDA Professional Group, PC

FY24 Audit Report – Joella Bogle, CPA

Joella Bogle, CPA, presented the audit findings for the fiscal year October 1, 2023 through September 30, 2024. The FY24 Audit Report indicated an unmodified opinion and full compliance with all state and federal requirements. Total operating revenue for the year ended September 30, 2024, was $10,199,106, with total operating expenses of $10,467,616. When combined with non-operating revenue, this resulted in an increase in net position of $1,097,251.

Following presentation of the FY24 Financial Audit, a recommendation was made to include an item on the agenda for the January 21, 2025, Board meeting for the Board's acceptance of the FY24 Financial Audit. Hard copies of the audit will be distributed to all Board members at the January meeting.

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

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

MOUNTAIN LAKES BEHAVIORAL HEALTHCARE
PROGRAM SUMMARY
FOR THE MONTH ENDED DECEMBER 31, 2024

PROGRAM	BUDGETED REVENUE	ACTUAL REVENUE	BUDGETED EXPENSES	ACTUAL EXPENSES	Budget vs Actual Revenues $ Variance	Budget vs Actual Revenues % Variance	Budget vs Actual Expenses $ Variance	Budget vs Actual Expenses % Variance	BUDGETED OPERATING INCOME	ACTUAL OPERATING INCOME	DEPRECIATION EXPENSE	NET INCOME (LOSS)	Variance -/+ 5% Comments
1000 Administration	45,665	11,998	45,665	(1,917)	(33,667)	-280.61%	(33,667)	-280.61%	0	13,915	13,915	0	
1500 Region 1 Project	15,202	15,202	15,202	15,202	(0)	0.00%	0	0.00%	0	(0)	0	0	
2110 Marshall County MHC	290,083	340,823	283,134	281,192	50,741	14.89%	377	0.13%	6,948	59,632	2,320	57,312	
2210 Jackson County MHC	216,409	244,845	217,899	215,641	28,436	0	632	0.29%	(1,490)	29,204	2,890	26,315	
2300 Geriatrics	32,950	34,695	31,039	32,176	1,745	5.03%	1,136	3.53%	1,911	2,519	0	2,519	
2400 Behavioral Health Unit (BHU)	20,058	20,000	20,058	20,000	(58)	0.00%	(58)	0.00%	0	0	0	0	
2610 Dogwood Apartments	5,679	6,601	4,395	3,085	921	13.96%	(522)	-16.92%	1,284	3,515	788	2,727	
2620 EBP Supportive Housing	13,726	14,126	13,724	14,114	400	2.83%	390	2.76%	2	13	0	13	Budget is divided equally over 12 months. Actual is based on the activity during the month
2640 Dutton Facilities	83,014	117,434	89,611	102,468	34,420	29.31%	17,889	17.46%	(6,597)	14,966	5,031	9,935	
2650 Jackson Place	36,767	37,948	34,406	33,218	1,181	3.11%	501	1.51%	2,361	4,730	1,690	3,041	
2651 Marshall Place	20,945	22,013	27,051	27,286	1,068	4.85%	622	2.28%	(6,105)	(5,273)	386	(5,659)	
3030 Substance Use	110,317	92,222	110,840	121,079	(18,095)	-19.62%	17,445	14.41%	(523)	(28,857)	7,206	(36,062)	
3060 Prevention	30,908	17,776	30,002	27,591	(13,131)	-73.87%	(2,411)	-8.74%	906	(9,814)	0	(9,814)	Budget is divided equally over 12 months. Actual is based on the activity during the month
	921,724	975,684	923,027	891,134	53,960		2,332		(1,303)	84,550	34,226	50,325	

MOUNTAIN LAKES BEHAVIORAL HEALTHCARE
PROGRAM SUMMARY
FOR THE THREE MONTHS ENDED DECEMBER 31, 2024

PROGRAM	BUDGETED REVENUE	ACTUAL REVENUE	BUDGETED EXPENSES	ACTUAL EXPENSES	Budget vs Actual Revenues $ Variance	Budget vs Actual Revenues % Variance	Budget vs Actual Expenses $ Variance	Budget vs Actual Expenses % Variance	BUDGETED OPERATING INCOME	ACTUAL OPERATING INCOME	DEPRECIATION EXPENSE	NET INCOME (LOSS)	Variance -/+ 5% Comments
1000 Administration	136,995	36,461	136,995	(5,282)	(100,534)	-275.73%	(100,531)	-275.70%	0	41,743	41,746	(3)	
1500 Region 1 Project	45,607	45,607	45,607	45,607	(0)	0.00%	0	0.00%	0	(0)	0	0	
2110 Marshall County MHC	870,248	935,672	849,403	842,749	65,424	6.99%	307	0.04%	20,845	92,922	6,960	85,962	
2210 Jackson County MHC	649,227	625,957	653,696	630,184	(23,269)	(0)	(14,844)	-2.36%	(4,470)	(4,227)	8,669	(12,895)	
2300 Geriatrics	98,850	110,568	93,118	95,672	11,718	10.60%	2,554	2.67%	5,732	14,896	0	14,896	
2400 Behavioral Health Unit (BHU)	60,174	98,275	60,174	98,275	38,101	0.00%	38,101	0.00%	0	0	0	0	
2610 Dogwood Apartments	17,037	18,930	13,186	9,699	1,893	10.00%	(1,123)	-11.58%	3,852	9,231	2,364	6,867	
2620 EBP Supportive Housing	41,179	46,782	41,172	42,661	5,604	11.98%	1,488	3.49%	6	4,122	0	4,122	Budget is divided equally over 12 months. Actual is based on the activity during the month
2640 Dutton Facilities	249,043	345,332	268,832	291,030	96,289	27.88%	37,291	12.81%	(19,790)	54,303	15,094	39,209	
2650 Jackson Place	110,301	121,394	103,219	94,623	11,093	9.14%	(3,528)	-3.73%	7,082	26,771	5,069	21,702	
2651 Marshall Place	62,836	83,781	81,152	78,902	20,945	25.00%	(1,091)	-1.38%	(18,316)	4,879	1,159	3,721	
3030 Substance Use	330,950	333,754	332,519	336,639	2,804	0.84%	25,737	7.65%	(1,569)	(2,885)	21,617	(24,502)	
3060 Prevention	92,723	62,575	90,005	86,662	(30,148)	-48.18%	(3,343)	-3.86%	2,718	(24,087)	0	(24,087)	Budget is divided equally over 12 months. Actual is based on the activity during the month
	2,765,171	2,865,090	2,769,081	2,647,422	99,919		(18,982)		(3,910)	217,668	102,677	114,991	

REVENUE & EXPENSE REPORT FOR THE THREE MONTHS ENDED DECEMBER 31, 2024

		PROGRAM	BUDGET	ACTUAL
Revenue	1500	REGION 1 PROJECT	45,607	45,607
Expense			45,607	45,607
Revenue	2110	MARSHALL COUNTY MHC	870,248	935,672
Expense			849,403	842,749
Revenue	2210	JACKSON COUNTY MHC	649,227	625,957
Expense			653,696	630,184
Revenue	2300	GERIATRICS	98,850	110,568
Expense			93,118	95,672
Revenue	2400	BEHAVIORAL HEALTH UNIT	60,174	98,275
Expense			60,174	98,275
Revenue	2610	DOGWOOD APARTMENTS	17,037	18,930
Expense			13,186	9,699
Revenue	2620	EBP SUPPORTIVE HOUSING	41,179	46,782
Expense			41,172	42,661
Revenue	2640	DUTTON FACILITIES	249,043	345,332
Expense			268,832	291,030
Revenue	2650	JACKSON PLACE	110,301	121,394
Expense			103,219	94,623
Revenue	2651	MARSHALL PLACE	62,836	83,781
Expense			81,152	78,902
Revenue	3030	SUBSTANCE USE	330,950	333,754
Expense			332,519	336,639
Revenue		STR/CURES/SOR (Part of the Substance Use Program)		9,864
Expense				4,974
Revenue	3060	PREVENTION	92,723	62,575
Expense			90,005	86,662

2025 COMPARATIVE INCOME STATEMENT

As of Accounting Period 3

25.00%	FY 2024	FY 2025	$ VARIANCE/YEAR	%
Medicaid	$1,061,042	$1,059,124	($1,918)	-0.18%
% of Budget	29.19%	29.54%		
DMH	$ 1,792,662	$ 1,438,555	$ (354,107)	-24.62%
	31.80%	24.28%		
Medicare	$ 9,694	$ 7,654	$ (2,040)	-26.65%
	30.37%	25.95%		
Self Pay	$ 38,317	$ 25,528	$ (12,789)	-50.10%
	26.76%	23.85%		
Insurance	$ 208,013	$ 125,848	$ (82,165)	-65.29%
	40.85%	20.71%		
Total Operating Revenue	$3,396,448	$2,865,090	$ (531,358)	-18.55%
	31.79%	25.86%		
Salary	$ 1,914,918	$ 1,640,321	$ (274,597)	-16.74%
	35.43%	26.13%		
Fringe	$ 398,257	$ 314,572	$ (83,685)	-26.60%
	34.54%	26.06%		
Misc Exp-BHU	$ 99,900	$ 98,275	$ (1,625)	-1.65%
	41.50%	40.83%		
Fees Contract Staff	$ 15,525	$ 19,424	$ 3,899	20.07%
	22.85%	12.68%		
Travel	$ 78,739	$ 67,957	$ (10,782)	-15.87%
	33.46%	27.95%		
Total Operating Expenses	$741,907	$2,644,611	$1,902,704	71.95%
	8.03%	24.97%		
Operating Income	$66,101	$220,478	$154,377	70.02%
Depreciation	($27,754)	($105,487)	($77,733)	73.69%
Net Income/(Loss)	**$38,347**	**$114,991**	**$76,644**	

***Does not include Board Investments

2025 COMPARATIVE BALANCE SHEET

As of Accounting Period 3

	FY 2024	FY 2025	$ VARIANCE	%
Current Assets				
Cash	$2,179,725	$979,535	$ (1,200,190)	-122.53%
Total Receivables	$2,017,413	$1,729,420	$ (287,993)	-16.65%
Total Other Current Assets	$2,606,284	$3,430,850	$ 824,566	24.03%
Total Current Assets	**$6,803,422**	**$6,139,806**	**-$663,616**	**-10.81%**
Long Term Assets				
Fixed Assets	$2,335,082	$3,339,634	$ 1,004,552	30.08%
Other Long Term Assets	$7,122,862	$6,837,168	$ (285,694)	-4.18%
Total Long Term Assets	**$9,457,944**	**$10,176,802**	**$ 718,858**	**7.06%**
Total Assets	**$16,261,366**	**$16,316,608**	**$ 55,242**	**0.34%**
Liabilities				
Current Liabilities	($638,405)	($591,270)	$ 47,135	-7.97%
Long Term Liabilities	$0	$0	$ -	
Total Liabilities	**($638,405)**	**($591,270)**	**$ 47,135**	**-7.97%**
Net Assets				
Unrestricted Net Assets	($15,012,055)	($15,610,386)	$ (598,331)	3.83%
Net (Income) Loss	($610,906)	($114,951)	$ 495,955	-431.45%
Total Net Assets	**($15,622,961)**	**($15,725,338)**	**$ (102,377)**	**0.65%**
Total Liabilities and Net Assets	**($16,261,366)**	**($16,316,608)**	**($55,242)**	**0.34%**

Mountain Lakes Behavioral Healthcare
Estimated Net Accounts Receivable Aging
As of December 31, 2024

Self Pay

	30	60	90	>90	Total
A/R Balance as of 12/31/24	71,959.19	44,981.67	36,335.18	89,106.68	242,382.72
Adjustment %	94.44%	94.44%	94.44%	94.44%	
Estimated Net Self Pay A/R Balance	**4,000.93**	**2,500.98**	**2,020.24**	**4,954.33**	**13,476.48**

DHR and Probate and JCH

	30	60	90	>90	Total
A/R Balance as of 12/31/24	198.14	58.87	154.12	456.87	868.00
Adjustment %	0.00%	0.00%	0.00%	0.00%	
Estimated Net DHR/Probate A/R Balance	**198.14**	**58.87**	**154.12**	**456.87**	**868.00**

Medicare

	30	60	90	>90	Total
A/R Balance as of 12/31/24	3,210.12	280.53	-	-	3,490.65
Adjustment %	70.00%	70.00%	70.00%	70.00%	
Estimated Net Medicare A/R Balance	**963.04**	**84.16**	**-**	**-**	**1,047.20**

Medicaid

	30	60	90	>90	Total
A/R Balance as of 12/31/24	312,471.44	19,314.45	9,773.62	25,247.61	366,807.12
Adjustment %	31.88%	31.88%	31.88%	31.88%	
Estimated Net Medicaid A/R Balance	**212,855.54**	**13,157.00**	**6,657.79**	**17,198.67**	**249,869.01**

Insurance

	30	60	90	>90	Total
A/R Balance as of 12/31/24	67,847.49	8,722.53	5,289.65	7,982.09	89,841.76
Adjustment %	51.67%	51.67%	51.67%	51.67%	
Estimated Net Insurance A/R Balance	**32,790.69**	**4,215.60**	**2,556.49**	**3,857.74**	**43,420.52**

ASAIS

	30	60	90	>90	Total
A/R Balance	240,476.51	5,434.32	-	-	245,910.83
Adjustment %	33.00%	33.00%	33.00%	33.00%	
Estimated Net Insurance A/R Balance	**161,119.26**	**3,640.99**	**-**	**-**	**164,760.26**

Total

	30	60	90	>90	Total
A/R Balance as of 12/31/24	696,162.89	78,792.37	51,552.57	122,793.25	949,301.08
Average Adjustment %					
Estimated Net Total A/R Balance	**411,927.61**	**23,657.61**	**11,388.63**	**26,467.62**	**473,441.46**

Other Information

December 2024

Transportation	**Marshall County**	**Jackson County**
Miles driven in month	1,352.00	1,401.00
Number of riders	198	64
Fuel Purchased	345.53	174.28
Average Price/gallon	2.66	2.68
Maintenance	-	
Depreciation	869.78	842.00
Salary	2,302.25	2,390.08
Cost/rider	17.77	53.22

Client Medical Expense	**Dutton**	**Jackson Place**	**Marshall Place**	**Cedar Lodge**	
Pharmacy	2,283.24	76.09	177.30	209.59	
Physician Charges				682.50	
Co-Pays/Deductibles	73.59				
	2,356.83	76.09	177.30	892.09	**3,502.31**

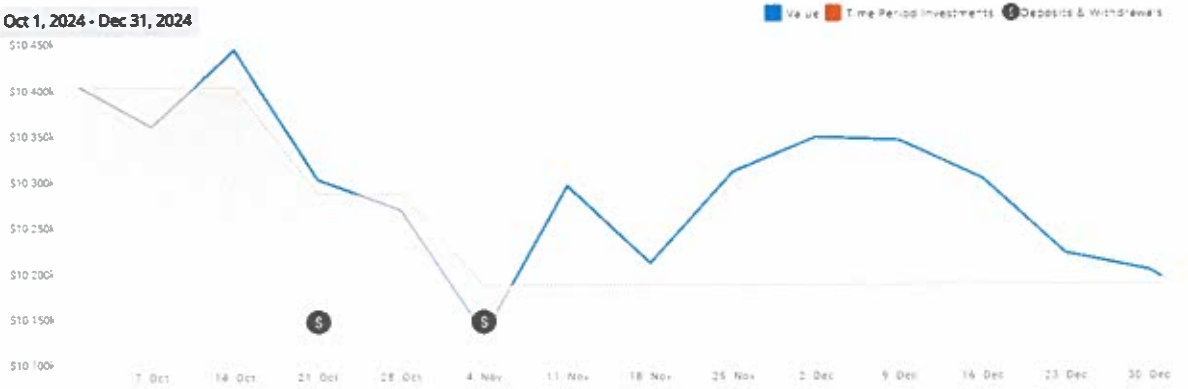
Consumer Housing	**Duplex-Board Inv**
# of Available Units	-
# of Units Rented	2.00
Rental Revenue	800.00

STARTING MARKET VALUE *Oct 1, 2024*	$10,402,990.97
DEPOSIT AND WITHDRAWALS	-$218,182.17
INVESTMENT RETURNS	$8,470.53
TOTAL RETURN	0.08%
ENDING MARKET VALUE *As of Dec 31, 2024, Market Close*	$10,193,279.33

*This total does not include intraday values and may not match Total Value

All | 1 YEAR | YTD | 1 MONTH | CUSTOM

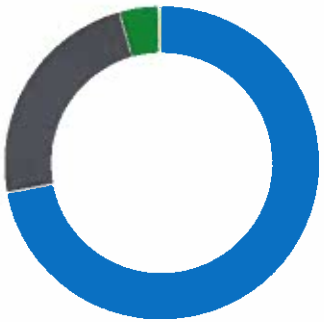
Oct 1, 2024 - Dec 31, 2024



ASSET ALLOCATION

VIEW BY

Broad Asset Class



ASSET	PERCENT
Bonds	72.08%
US Stocks	23.60%
Balanced	3.99%
Others	0.33%

During market hours, values for securities that are priced daily are calculated using prior day's closing price.

MLBH PERSONNEL REPORT

1/21/2025

NEW HIRES

FT	Nicolette Manns	Care Coordinator	11/27/2024	Jail Services
FT	Melody Briscoe	Outpatient Therapist	12/10/2024	MCMHC
FT	Jimmie Boatwright	Outpatient Therapist	1/2/2025	MCMHC
PRN	Kimberly Smith	School-Based Therapist	1/14/2025	Both Counties
FT	Kylie Evans	Outpatient Therapist	1/14/2025	JCMHC
FT	Timothy Phillips	Life Skills Specialist	1/15/2025	Dutton Group Homes
PRN	Wanda Castleberry	Life Skills Specialist	1/15/2025	Dutton Group Homes

SEPARATIONS (VOLUNTARY)

DOH	Alexis Parker	Outpatient Therapist	*11/25/2024*	MCMHC
5/15/2023		*Resignation Reason*	*another job closer to home*	
DOH	Courtney Hawkins	Intake Coordinator (PT)	*1/9/2025*	JCMHC
10/22/2024		*Resignation Reason*	*private practice*	

SEPARATIONS (INVOLUNTARY)

DOH	FT	Perris Hobbs	Intake Coordinator	12/13/2024 JCMHC
2/13/2023				5 productivity misses
DOH	FT	Cody Darnell	Life Skills Specialist	12/19/2024 Substance Use
11/17/2023				personal issues
DOH	FT	Franklin Hardin	Life Skills Specialist	12/13/2024 JCMHC
11/6/2024				excessive med errors

NEW POSITIONS ADDED

TRANSFERS

PROMOTIONS

NOTE: Intern Billy Gilbert began on 11/25/24 at the MCMHC
NOTE: Intern Jackie Brewster began on 01/07/25 with Jail-Based Services

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

MLBH PERSONNEL REPORT

CURRENT OPEN POSITIONS

JP LSS FT (1) PRN (2)

MC Therapeutic Mentor PT (1)

JC Therapeutic Mentor PT (1)

LSS FT SU (1)

Intake Coord. FT JC (1)

MP LSS FT (1)

SU LSS FT (1)

Board Report
JAN 2025

Items Completed from last reports:

-Windows 11 V24H2 Upgrade done.
-Dell computer firmware do auto update rig done.
-Test new Epson scanner operability done.
-Order more fax cards for new copiers done
-Bunch of end of year computers / users /etc. cleanup done.
-Lots of Firmware / software patches / updates done.
-Dutton Video Cam's done.

New Items / Continued:

-Upgrade Phone system Processors and firmware. Waiting.
-Install IP Phones and switches at New Sboro location. Waiting.
-ATT phone service renewal Waiting.
-Bunch of CCBHC changes / additions in Avatar.
-Bunch of other CCBHC Prep / Cost forecasting.
-Connect new fax cards in copiers.
-Bunch of prep work for Phone system processor upgrades.
-Bunch of prep work for Sboro IP Phone installation.
-Cedar Auto Attendant finalize config change the correct way.
-Servers cleanup / optimize / remove / reduce resources.
-Start prep work / conservations for Msoft 365 / Azure Cloud services
-Lots of Avatar patches to install.

Clinical Services Report

January 2025

State Opioid Response (SOR) Grant Services

In 2017, DMH was awarded a State Targeted Response (STR) grant by SAMHSA. This funding, enabled by the 21st Century Cures Act, was based on Alabama's opioid overdose death rate and unmet need for opioid addiction treatment. This grant was developed to improve access to treatment for opioid use disorders; expand access to medications approved by the FDA for treatment of opioid use disorders (OUD); improve retention in care for individuals who have been diagnosed with OUDs; reduce stigma, improve public awareness of Alabama's opioid misuse and addiction crisis and of treatment options available; increase the availability of Naloxone in unserved areas of the state with high overdose death rates; and implement prevention services aimed at preventing the onset and reducing the progression of prescription drug misuse at the community level. Mountain Lakes was awarded a contract to provide prevention and treatment services to address this crisis. Over the years, the grant has evolved and the name was changed to State Opioid Response (SOR).

Since then, MLBHC has partnered with community providers and pharmacies to increase access to Medication Assisted Treatment (MAT) for those with opioid, stimulant, and alcohol use disorders. MAT has been a controversial treatment option with the common misconception that one is "substituting one drug for another." However, MAT is an evidence based practice where medications are utilized to relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT is most effective when accompanied by counseling and other services to treat the whole person and support their recovery. MLBHC requires clients enrolled in this program to attend individual counseling and peer counseling groups to maintain eligibility for medical services. Since its inception, this program has served approximately 400 clients.

We have also promoted education and distribution of naloxone, a medication utilized to reverse the effects of opioid in an overdose situation.

MLBHC also participates in the Prevention program with the goal of preventing the onset and reducing the progression of prescription drug misuse and abuse at the community level. Prevention activities include increasing awareness of prescription drug misuse and abuse through media campaigns, education in local schools, prescription takeback events, and community involvement.

MOUNTAIN LAKES
Behavioral Healthcare

Performance Improvement Annual Report for FY 2024

October 1, 2023– September 30, 2024

The Performance Improvement (PI) system of Mountain Lakes Behavioral Healthcare (MLBHC) is designed to monitor all clinical care and services provided by the organization. While all staff actively engage with the PI system as an integral aspect of their professional duties, oversight and management of the PI system are vested in the Leadership and Performance Improvement Committees. The mission of the PI committee is to ensure the provision of high-quality services delivered in a manner aligned with best practices, ultimately leading to effective outcomes in addressing identified challenges. This committee monitors and evaluates the accuracy and appropriateness of all documentation and identifies areas of client care that are in need of improvement. Committee members include the clinical director, executive director, quality assurance coordinator, program directors, program coordinators, records librarians, administrative coordinators, training coordinator, and treatment plan review coordinator.

The PI system also encompasses a continuous process of problem-solving aimed at refining procedures and techniques, coupled with regular assessments of any deficiencies, requisites, and suggestions for quality enhancement arising from visits by the Department of Mental Health (DMH), advocacy visits, and/or other pertinent regulatory, accrediting, or licensing bodies. The committees possess the ad hoc capability to address any issues pertaining to the quality of treatment and services provided.

The PI committee reviewed the defined performance indicators at the frequency specified in the PI plan. The findings and patterns identified by the PI committee were reviewed by the leadership committee and were subsequently presented to the Board of Directors. This annual report delineates the operational dynamics of the PI system throughout the fiscal year. It is disseminated to the Board of Directors, distributed to all staff via email, and made accessible to all personnel through shared files on the server. The ensuing items are comprehensively addressed in this report for FY 2024:

- Outcome of Deficiencies Addressed
- Administrative Reviews
- Substance Use Program Utilization Data
- SBMH Outcomes
- Significant Events
- Adverse Incidents
- Consumer Satisfaction
- Consumer and Family Satisfaction Survey Results
- Hospital Utilization
- Utilization Review
- Community Residential Service Utilization
- Clinical Reviews
- Corrective Action Plans
- Process Design Forms

Outcome of Deficiencies Addressed

Advocacy Monitoring

DMH-Advocate visit-Dutton CRF-Lynn Pottratz, DMH Advocate visited this program on 1/2/24. The report noted, "Individuals reported being happy with their living situation. No major issues were reported."

DMH-Advocate visit-Adult Rehabilitative Day Program Jackson County-Lynn Pottratz, DMH Advocate visited this program on 1/2/24. The report noted, "Individuals appeared comfortable around their staff. Interaction was warm and appropriate. No issues were reported."

DMH-Advocate visit-Level 111.5-Clinically Managed High Intensity Residential Program-April 16, 2024. Lynn Pottratz, DMH Advocate spoke with individuals in the cafeteria during lunch, in the hallways, and on the smoking porch. Individuals reported that the program is helping them. When asked about the admission process, individuals reported that it went smoothly. Some individuals shared specific things about the program that had been helpful. The food was reported to be good, and many individuals complemented the accommodations (soft beds etc.). Individuals expressed full knowledge of the rules upon admission to the program. They reported that the rules and expectations are reviewed regularly. No follow up was required by the advocate.

DMH-Advocate visit-Marshall Place 3-Bed CRF-April 16, 2024- Lynn Pottratz, DMH- The report noted "Individuals all report things are going well for them. One individual was excited about an upcoming home visit. The other individual reported that she was also doing well. She said she had some issues but talked to her case manager and got them fixed. Neither individual expressed any concerns." No follow up was required.

DMH-Advocate-visit- Adult Rehabilitative Day Program-May 1, 2024- Lynn Pottratz, DMH Advocate- The report noted, "Individuals reported enjoying RDP. Many individuals related stories about the support they have received from RDP staff. No issues were noted."

DMH-Advocate-visit- Jackson Place-September 24, 2024-Lynn Pottratz- Advocate communicated with individuals through the ASL Interpreter. The report noted, "Individuals appeared comfortable around their staff. Interaction was warm and appropriate. No issues were noted during the visit."

Compliance Review

A SU Contract Compliance Monitoring visit was conducted on September 6, 2023. There were no significant findings and no corrective action plan requested. However, it was recommended that the Compliance monitoring tool be reviewed in its entirety.

A SU Contract Compliance Monitoring visit was conducted on April 29, 2024. There were no significant findings and no corrective action plan requested. However, it was recommended that the Compliance monitoring tool be reviewed in its entirety, with a focus on the documentation section.

Administrative Reviews

Administrative reviews of clinical records are conducted regularly using a checklist to ensure compliance with program standards. The following information is compiled for FY 2024:

FY 2024 ADMINISTRATIVE REVIEWS					
PROGRAM	CASES REVIEWED	Documents Reviewed	Docs with Errors	Total Errors	ANNUAL ERROR RATE
FY 2024 TOTALS	327	38807	211	392	1.0 %

Predominant errors noted during this year's administrative reviews included:

- Clinical issues: Services on the treatment plan that were not provided and State reporting data that was late or missing.
- Documentation errors: Late progress notes and late/missing staffing notes.

The PI Committee identified and addressed emerging trends within the organization. Supervisors proactively devised strategies to enhance clinical documentation across all programs, ensuring adherence to best practices. As part of this initiative, training sessions, supervision, and, when warranted, disciplinary actions were administered accordingly.

It's noteworthy that fewer charts underwent reevaluation again this fiscal year, with a total of 327 charts reviewed in FY 2024, in contrast to 546 reviewed in FY 2023. There were 726 reviewed in FY22.

SU Program Utilization Data

Substance use utilization data is be tracked as a PI quality indicator per Alabama Administrative code.

Substance Use Outcomes Measures FY24 (10/1/23-9/30/24)	
1. Reduced Morbidity: (i) Outcome: Abstinence from Drug/Alcohol Use (ii)Measure: Reduction/no change in frequency of use at date of last service compared to date of first service	87%
2. Employment/Education: (i) Outcome: Increased/Retained Employment or Return to/Stay in School. (ii) Measure: Increase in/no change in number of employed or in school at date of last service compared to first service.	72%
3. Crime and Criminal Justice: (i) Outcome: Decreased Criminal Justice Involvement. (ii) Measure: Reduction in/no change in number of arrests in past thirty (30) days from date of first service to date of last service.	91%
4. Stability in Housing: (i) Outcome: Increased Stability in Housing. (ii) Measure: Increase in/no change in number of clients in stable housing situation from date of first service to date of last service.	68%
5. Social Connectedness: (i) Outcome: Increased Social Supports/Social Connectedness. (ii) Measure: Increase/no change in number clients in social/recovery activities from date of first service to date of last service.	84%

Significant Events

The CQI plan was developed by the CCBHC and addresses how the CCBHC will review known significant events including, at a minimum: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving CCBHC services; (4) 30 day hospital re-admissions for psychiatric or substance use reasons; and (5) such other

events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan. This new measure was tracked during FY24. See Appendix A for details.

Hospital Utilization

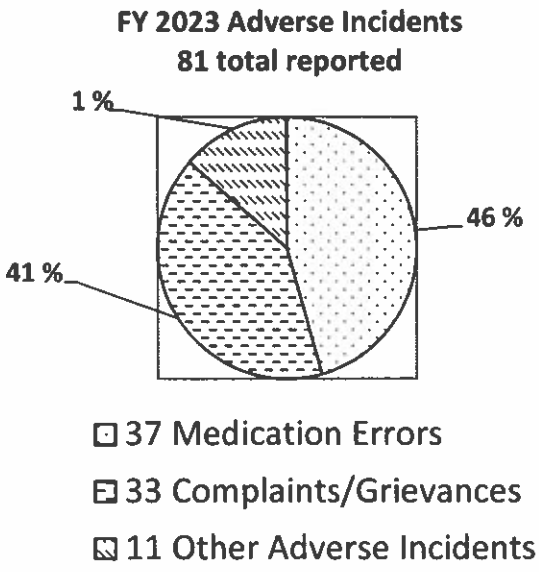
Throughout the year, Mountain Lakes Behavioral Healthcare maintains a vigilant monitoring system for both private and public hospitalizations involving active consumers. A dedicated effort persists in reducing the frequency of consumers admitted to state hospitals from Marshall and Jackson Counties.

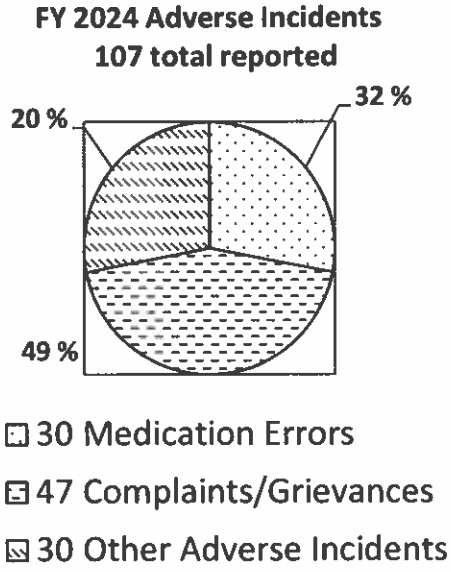
The PI committee conducts a monthly review of a high-risk follow-up report, tracking hospital discharges of active consumers, outpatient commitments, and discharges from state hospitals. To ensure seamless continuity of care, consumers are promptly scheduled for a follow-up appointment within three days of hospital discharge. This process monitors adherence to the three-day criterion for appointment scheduling and follow up on missed appointment.

Mountain Lakes Behavioral Healthcare continued to utilize the contract with the behavioral health unit at Marshall Medical Center North to provide inpatient treatment to indigent clients. A total of 248 bed days were used to provide treatment during FY 2024, up from the 243 bed days in FY 2023. Eighteen Marshall County residents and five Jackson County residents utilized this funding. The full amount of $240,697 was utilized for FY 2024 with the average LOS being 10.8 days.

Adverse Incidents

Adverse incidents are characterized as any event with the potential to jeopardize the safety of either a client or an employee. Such incidents are promptly communicated to the Clinical Director and/or the Quality Assurance (QA) Coordinator. Each quarter, these occurrences underwent thorough examination, and recommendations were formulated to mitigate their recurrence. In cases where deemed necessary, a comprehensive corrective action plan was devised. A total of 107 adverse incidents were reported during the fiscal year 2024, marking an increase from the 81 incidents documented in FY 23. This increase was not particularly notable in medication errors but there was a larger increase in other adverse events, and complaints/grievances.





Consumer Complaints and Grievances

In the fiscal year 2024, a total of forty-seven consumer complaints or grievances were reported, marking an increase from the thirty-three documented in FY 2023. Each of these underwent review by both the PI and Consumer Satisfaction Committees. They were received through diverse channels, including verbal complaints lodged with any agency staff, formal advocacy complaints, as well as through consumer feedback boxes stationed within the outpatient and residential facilities.

Reportable Incidents

In FY 2024, there were 50 incidents reported to the Alabama Department of Mental Health of which 20 were classified as critical incidents. This was slightly higher than the 48 incidents in FY 2023 with 11 critical incidents reported.

	Medication Errors	Other-SU Hospitalization	Alleged Abuse & Neglect/Mistreatment/ Exploitation/Sexual Abuse/Non-consensual sexual contact	Major Client Injury	Discretionary	Su Confidentiality Breach	Law Enforcement Involvement	Suicide Attempt	Total Special Incidents
FY 2024	30	1	15	2	0	0	1	1	50
FY 2023	37	1	6	2	1	1	0	0	48

Medication Errors

In the fiscal year 2024, among the 50 reportable incidents, thirty were identified as medication errors through the Nurse Delegation Program. This represents a decrease from the thirty-seven medication errors reported in FY 2023. No level II or III errors were documented during FY 2024.

As these errors were reported each month, the Nurse Delegation Program promptly initiated measures to address any discernible patterns. Recommendations for procedural adjustments were proposed during PI Committee meetings and subsequently implemented with the collaborative efforts of MAS nurses, MAC workers, and program directors/coordinators. Additionally, ongoing training sessions were conducted for MAC workers in response to identified areas necessitating improvement, ensuring alignment with Nurse Delegation Program guidelines.

Other Reportable Incidents

Of the 50 reportable Incidents, the 20 non-medication errors are described below. This number is higher than last year. (11 in FY 2023)

October 2023- (1) <u>Allegation of Financial Exploitation Jenny's Place</u>: *Consumer reported loss of their wallet containing $60. Other consumers reported seeing a staff member pick up a wallet from the desk in the group home. The investigation was conducted by a DMH trained MLBHC staff and allegation of financial exploitation was unsubstantiated.*

November 2023- (2) Allegations of Neglect Jenny's Place: *Report was made that employee left the shift early on 11/11/23 and arrived late on 11/12/23. Employee did not notify supervisor or other staff. The allegation was investigated by a DMH trained MLBHC staff. Allegation of neglect was substantiated and follow up was reported to DMH. Employee was prohibited from further working in residential programs.*

December 2023- (1) SU-Hospitalization-Cedar Lodge: *Client was admitted to local hospital for testing due to high blood pressure. Was told he could return for SU treatment after being medically cleared.*

January 2024- (1) Major Client Injury- Jenny's Place: *Consumer complained of back pain while visiting PCP. She reported a fall that had occurred previously, date unknown, but did not tell staff. PCP ordered x-ray which revealed compression fracture to vertebrae.*

February 2024- (1) Allegation of Neglect-Cedar Lodge: *Upon client requesting a PRN medication requiring blood pressure monitoring, it was noted that a blood pressure reading was documented at 6:00 a.m., but the client stated it had not occurred. Further questioning revealed two other clients who also stated their BP had not been checked. Investigation was completed and allegation of consumer neglect was substantiated by DMH trained employee. Incident was reported to DMH. Employee resigned employment.*

March 2024- (2) Allegations of Sexual Contact-Veronica House*: Consumer reported they had seen two other consumers at the smoking area have sexual contact and then exchange money. Incident was investigated by DMH certified investigator. The investigation concluded that the sexual contact occurred, but it was consensual. The allegation that money had been exchanged was not substantiated. The consumers were provided further education regarding boundaries, decisions, and safety.*

April 2024 (1) Allegation of Sexual Abuse-Jackson Place: *JP employees reported that clients had stated that another employee had touched a client's intimate parts. The incident was thoroughly investigated by a DMH certified special incident investigator. The investigation was completed and the allegation of sexual abuse was unsubstantiated.*

April 2024 (1) Major Client Injury- Jenny's Place: *Consumer fell out of their bed. 911 was called and consumer was transported to the local hospital. Diagnosis was displaced fracture of left humerus.*

June 2024 (2) Allegations of Non-Consensual Sexual Contact - Dutton Group Homes*: An employee reported that another consumer told them they had witnessed sexual contact between two consumers. Allegation of non-consensual sexual contact was investigated by DMH trained MLBHC staff and unsubstantiated*

June 2024– (4) Allegations of Mistreatment/Verbal Abuse- Dutton Group homes: *Four complaints of verbal abuse and mistreatment by one staff member were recovered from the consumer feedback box. The incident was thoroughly investigated by two DMH trained investigators. Allegations of mistreatment and verbal abuse were substantiated and reported to DMH. Employee was terminated.*

July 2024– (2) Allegation of Neglec- Jenny's Place: *MAC worker administered PRN medications to two consumers without contacting the on-call MAS RN for authorization. Allegation of neglect was reported to DMH, investigated by a trained MLBHC staff, and substantiated. Disciplinary actions were taken.*

September 2024– (1) Law Enforcement Involvement- Jenny's Place: *Consumer became increasingly agitated and threatened to harm "everyone in this house." Program coordinator called 911. Police arrived and consumer was arrested for disorderly conduct. Jail based therapist provided crisis intervention to consumer at the request of jail staff. Jail therapist was informed by jail staff that an order had been submitted by the Jackson County District Court Judge dismissing the client's criminal charge of Failure to Obey a Police Officer as well as a previously filed criminal charge of Harassment. Jail therapist picked consumer up and transported back to Dutton without incident.*

September 2024– (1) Suicide Attempt-Guntersville Outpatient: *Client came in for appointment. After checking in at front desk, he left the premises. Client's collateral, who brought him to the appointment, called and reported he no longer had the medications he had brought to the appointment. It was discovered that consumer went into the clinic bathroom and ingested the contents of his medications. Staff found 5 empty bottles in the trash can. Client's collateral arranged for client to be taken to ER. Therapist followed up with emergency contact the next day who confirmed client had been admitted to MMCN ICU. Client was seen on 10/1/24 for follow up after hospitalization.*

Consumer Satisfaction

Consumer Satisfaction Committee met four times during this fiscal year. Input from consumers was reviewed in order to improve service delivery. There were 147 feedback forms received within FY 2024. This is an increase from 121 feedback forms received within FY 2023.

The feedback received was 33% compliments, 32% complaints, 16% suggestions and 19% comments. The highest percentage of the forms came from the Substance Use treatment facility at 54%. Residential homes provided 39% of the feedback and the remaining 7% came from the outpatient centers. No feedback was received from consumers involved in the Geriatrics program. All Complaints/Grievances were reported to the PI Committee. Complaints and grievances are received through various channels, including verbal complaints, formal advocacy complaints, and Consumer Feedback Boxes.

During the first quarter, a Christmas event was sponsored for the MI and SU residential consumers. Clients from Cedar Lodge, Marshall Place, Jackson Place and Dutton enjoyed a meal along with games. Clients were able to have their picture made with Santa. Filled stockings were distributed to the clients. Clients woke up to presents under the tree Christmas morning.

During the second quarter, the committee reviewed the feedback forms and developed plans for Consumer Appreciation Days in each county.

During the third quarter, the committee members spent time serving the client's lunch on for Consumer Appreciation Days. A Little Something Extra ice cream trucks came to each locations. Clients entered to win gift cards at both locations. Drawings were held and winners were contacted.

During the fourth quarter, feedback forms were reviewed. The committee developed a detailed plan for an event for the Christmas holidays. A date was confirmed and Myron Gargis, Executive Director, approved a budget for this event.

Consumer and Family Satisfaction Survey Results

In accordance with the Performance Improvement Plan, MLBHC participated in the MHSIP consumer and family satisfaction surveys in the month of April 2024. Overall participation and results were very positive. See Appendix B for details.

Community Residential Service and Length of Stay (LOS) Utilization

The PI committee diligently monitors the occupancy rates of each community residential program on a monthly basis, underscoring the agency's commitment to maintaining optimal capacity across all programs. This strategic focus ensures the provision of timely and appropriate services to a larger clientele continuously.

Throughout FY2024, the programs included the Sue Bolt Foster Home, Veronica Foster Home, Jenny's Place Residential Care Home, Crisis Stabilization beds, Dogwood Supervised Apartments, Evidence-Based Supportive Housing Program (EBSHP), Marshall Place, Jackson Place, and Jackson Place Supportive Apartments.

These programs have proven highly effective in facilitating the transition of consumers from hospitals to community-based settings. Such transitions enable consumers to progress through a continuum of residential services tailored to meet their evolving needs. Notably, for FY 2024, these programs collectively achieved an overall average occupancy rate of 94% as seen in the chart below. This was the same as FY 2023.

COMMUNITY RESIDENTIAL SERVICE UTILIZATION MARSHALL AND JACKSON COUNTIES-FY 2023	
Month	**Percent Occupancy**
Oct-23	93%
Nov-23	95%
Dec-23	97%
Jan-24	94%
Feb-24	92%
Mar-24	88%
Apr-24	93%
May-24	88%
Jun-24	88%
Jul-24	89%
Aug-24	89%
Sep-24	98%
FY 2024 Average	94%

Throughout the fiscal year, Jenny's Place had a slightly lower occupancy rate of 88%, compared to the 99% recorded in FY23. This significant decrease is related to the consumer discharges/movement throughout the agency's residential and treatment continuum. Meanwhile, the Crisis Stabilization beds operated at slightly lower than maximum capacity, with a 92% occupancy rate throughout the year.

Priority admission was accorded to individuals discharged from Bryce Hospital or Crisis Stabilization Units, with additional referrals originating directly from the community via AIH/ACT referrals, outpatient therapist referrals, jail, or other community sources.

Both foster homes, Sue Bolt and Veronica House, maintained an average occupancy rate of 91% throughout the fiscal year. The Supportive Housing program experienced a decrease, with an overall average occupancy rate of 76% in FY24, compared to 99% in FY23. This resulted from continuing increases in housing expenses with no corresponding increase in funding.

Jackson Place experienced an increase in occupancy, with an overall occupancy rate of 92% compared to 82% in FY23. Staffing challenges continued to be a factor. There was also an increase for Jackson Place Supportive Apartments which reported an average occupancy rate of 75% compared to the 59% from FY23.

Marshall Place saw a decrease in occupancy, with openings throughout the year which resulted in an average occupancy rate of 71%, compared to the 100% of FY23. Meanwhile, the Supervised Apartments saw a slightly lower average occupancy rate of 75% throughout the fiscal year compared to the 85% for FY23.

Utilization Review

Throughout FY 2024, the PI Committee reviewed all findings received from the Utilization Review (UR) monitor, encompassing all Mental Illness (MI) residential programs and Substance Use (SU) levels of care.

Program directors/coordinators and the clinical director reviewed a representative sample of charts from all certified programs, evaluating the appropriateness of admissions relative to published admission criteria. The outcomes of these reviews were systematically reviewed by both the PI and Leadership committees on a quarterly basis.

In all the programs reviewed, with one exception, the documentation supported how the established admission criteria were met and the services provided were adequate to address the needs of the clients. In SA Level I.0 Outpatient treatment there was insufficient documentation to support why the assessed severity of illness warranted that level of care.

Clinical Reviews

Clinical reviews, as required by Alabama Administrative Code, are conducted to determine if a case is being properly managed. The clinical review assesses if: 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. Annually, the clinical director or an assigned representative compiles an aggregate review of clinical findings. This comprehensive assessment aims to analyze emerging trends and patterns, facilitating the

identification of areas requiring improvement based on the findings. This crucial review is documented in Appendix C for reference and further analysis.

Corrective Action Plans

The corrective action plan serves as a mechanism for addressing identified issues that cannot be promptly resolved. Once scrutinized by the Leadership Committee, the plan is entrusted to the appropriate staff for the development and execution of corrective measures. The Leadership Committee conducts monthly reviews to identify patterns or trends in problems and assesses the effectiveness of corrective actions when applicable.

In FY 24, a Corrective Action Plan was developed to address a trend where many of the required Child and Adolescent Needs and Strengths (CANS) assessments were not being completed within the required time frame. The Corrective Action Plan was implemented and monitored by the PI Committee which resulted in a significant improvement.

The Corrective Action Plan is being systematically monitored on a weekly basis to ensure compliance with this DMH requirement. This consistent oversight underscored the commitment to maintaining compliance and quality standards across the organization's service delivery processes.

Process Design Form

The process design form is utilized whenever the agency makes major changes involving new or modified processes. This form helps ensure that processes are designed well and in a collaborative and interdisciplinary manner, as specified in the performance improvement plan. No process designs were utilized in FY 24.

APPENDIX A:

Significant Events Statistics
Performance Improvement Annual Report
FY 2024

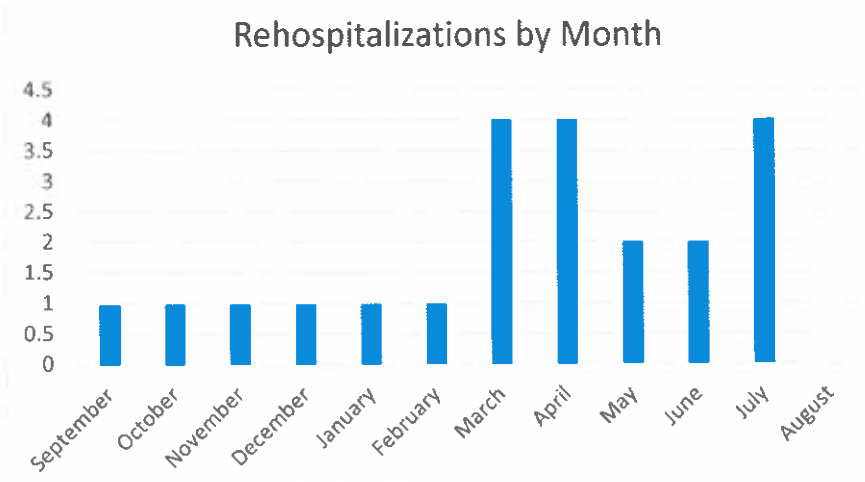
APPENDIX A:
Significant Events Statistics

Significant Event	Number	Gender		Race/Ethnicity		Age			
		% Female	% Male	%White	%Other	<18	18-34	35-54	55+
Suicide Attempts	19	79%	21%	95%	5% >one race	58%	37%	5%	0%
Rehospitalizations	17	53%	47%	N/A	N/A				
Nonfatal Overdose	4	50%	50%	50%	50% Hispanic	75%	25%	0%	0%
Death by Suicide	3	33%	67%	67%	33% Am Indian	33%	0%	67%	0%
Death by Accidental OD	2	0%	100%	100%		0%	0%	100%	0%

Statistics for Persons Receiving Services 10/1/2023 to 9/30/2024 (Total 3,839)

White	85%
Hispanic	6%
Black/African American	6%
More than One Race Reported	2%
American Indian	Less than 1%
Asian	Less than 1%
Native Hawaiian/Pacific Islndr	Less than 1%
Other	Less than 1%
Female	56%
Male	44%

0-4	0%
05-17	41%
18-34	24%
35-54	23%
55and Over	16%

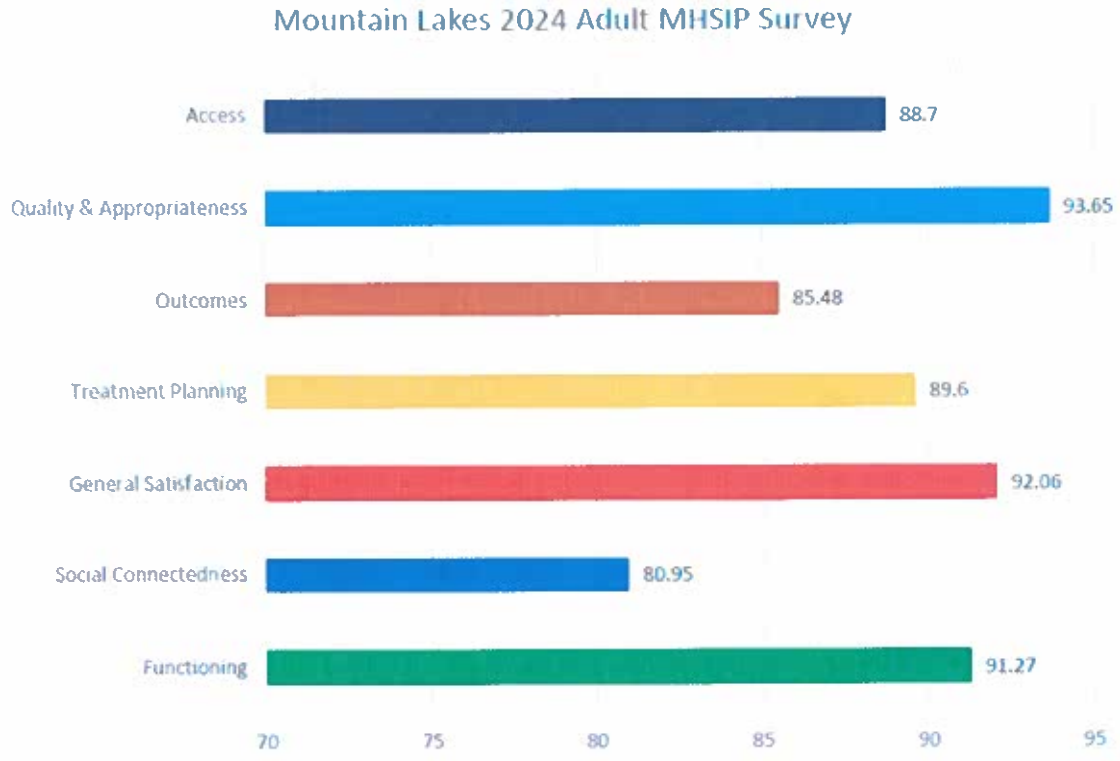


APPENDIX B:

2024 State and National Comparative Results for Adult MHSIP and Youth Family Surveys
Performance Improvement Annual Report
FY 2024

APPENDIX B:

Mountain Lakes 2024 Adult MHSIP Survey Results with State and National Comparisons

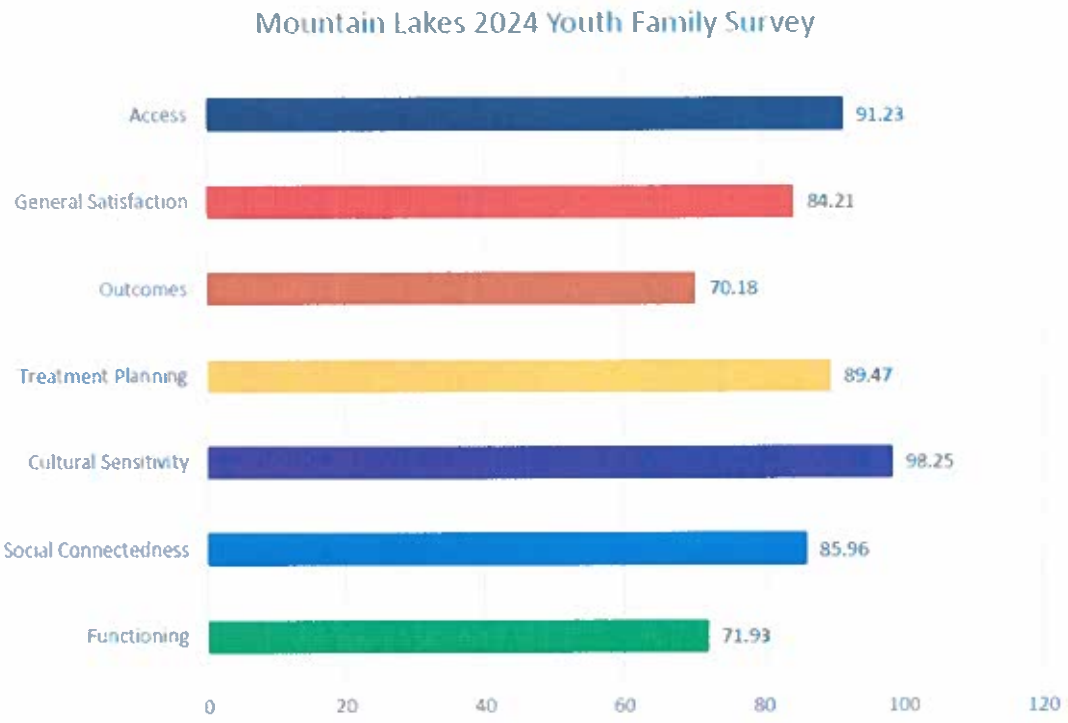


2024 Adult Consumer Satisfaction Survey Results	2024 Mountain Lakes % Positive	2024 State % Positive	2023 Mountain Lakes % Positive	2022 Mountain Lakes % Positive	*2022 US % Positive
1. Reporting Positively About Access	89%	87%	80%	88%	87%
2. Reporting Positively About Quality and Appropriateness	94%	89%	98%	93%	89%
3. Reporting Positively About Outcomes	85%	81%	85%	85%	78%
4. Reporting Positively About Participation in Treatment Planning	90%	82%	92%	93%	85%
5. Reporting Positively About General Satisfaction	92%	86%	90%	94%	88%
6. Social Connectedness	81%	78%	76%	79%	74%
7. Functioning	91%	81%	88%	85%	75%

*Most Recent US Results Available

ADMH
Division of Mental Health and Substance Use Services
Office of Quality Improvement and Risk Management
November 18, 2024

APPENDIX B (cont.):
Mountain Lakes 2024 Youth MHSIP Survey Results with State and National Comparisons



2024 Youth Family Consumer Satisfaction Survey Results	2024 Mountain Lakes % Positive	2024 State % Positive	2023 Mountain Lakes % Positive	2022 Mountain Lakes % Positive	*2022 US % Positive
1. Reporting Positively About Access	91%	85%	69%	87%	87%
2. Reporting Positively About General Satisfaction	84%	84%	86%	87%	86%
3. Reporting Positively About Outcomes	70%	71%	67%	75%	71%
4. Reporting Positively About Participation in Treatment Planning	89%	85%	74%	80%	88%
5. Reporting Positively About Cultural Sensitivity of Staff	98%	93%	95%	93%	94%
6. Social Connectedness	86%	82%	83%	82%	86%
7. Functioning	72%	71%	65%	73%	71%

*Most Recent US Results Available

ADMH
Division of Mental Health and Substance Use Services
Office of Quality Improvement and Risk Management
November 18, 2024

APPENDIX C:

Aggregate Review of Clinical Review Findings
Performance Improvement Annual Report
FY 2024

APPENDIX C:
Aggregate Review of Clinical Review Findings
FY 2024 (OCTOBER 2023– SEPTEMBER 2024)

	CLINICAL REVIEWS FY 2024							
Month	**TPRs**	**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**
Oct	556	1	8	0	33	0	0	**42**
Nov	588	0	0	1	18	0	0	**19**
Dec	563	0	1	1	16	0	0	**18**
Jan	567	0	5	0	37	0	0	**42**
Feb	463	0	5	0	37	0	0	**42**
Mar	464	0	3	0	33	0	0	**36**
Apr	212	0	1	1	10	0	0	**12**
May	12	0	0	0	0	0	0	**0**
June	85	0	2	0	3	0	0	**5**
July	357	0	2	0	20	0	0	**22**
Aug	358	0	4	1	10	0	0	**15**
Sept	370	0	1	0	1	0	0	**2**
YTD	**4595**	**1**	**32**	**4**	**218**	**0**	**0**	**255**

The results of the clinical reviews are discussed in PI meetings on a monthly basis. Monthly reports break down the numbers by program so that each program director can note any trends specific to their program. As evidenced in the chart above, 4,595 treatment plan reviews were conducted during FY 2024. All charts reviewed were selected for clinical reviews. For FY 2024, a total of 255 errors were noted out of the 4,595 charts that underwent a clinical review which results in a 6 % error rate. The overall numbers were lower than the previous year (17% for FY 2023). The most significant trends were documentation did not relate to the treatment plan and/or address progress, and treatment plans not timely. Workforce issues continued to contribute to these errors and the ability to see clients was affected.

Mountain Lakes Behavioral Healthcare shares tips for managing holiday stress

SPECIAL TO THE REPORTER

The holiday season is often a time of joy, connection, and celebration. However, for many individuals, this time of year can also bring significant stress, anxiety, and even feelings of loneliness. Mountain Lakes Behavioral Healthcare is reminding residents of Jackson and Marshall Counties that mental health should remain a priority during the holidays, and simple strategies can make a big difference in navigating this busy season.

Holiday Stress is Real

While the holidays bring opportunities for connection, they can also carry expectations—financial pressures, social obligations, family tensions, and the hustle and bustle of preparations. For some, feelings of grief, isolation, or a lack of connection can make this time particularly difficult.

"It's important to acknowledge that it's okay not to feel cheerful all the time during the holidays," says Dr. Sarah Boxley, Medical Director at Mountain Lakes Behavioral Healthcare. "Taking small, proactive steps can help people manage stress and protect their mental health."

Tips for Reducing Holiday Stress:

• Set Realistic Expectations

Avoid overcommitting to events and activities. Prioritize what matters most and give yourself permission to say "no" when needed. The holidays don't need to be perfect, and simple traditions can be just as meaningful.

• Stick to a Budget

Financial stress can be a significant source of anxiety during the holidays. Plan ahead and set a realistic spending limit. Remember, gifts don't have to be expensive to be meaningful.

• Take Care of Your Physical Health

Maintain regular exercise, eat well, and get plenty of sleep. Even a short daily walk can help improve mood and reduce stress.

• Make Time for Yourself

Schedule moments for self-care, whether it's reading a book, listening to music, or simply enjoying quiet time. Taking a step back to recharge can help you stay grounded.

• Stay Connected

If you're feeling lonely or isolated, reach out to friends, family, or support groups. Volunteering is another great way to connect with others and boost your mood.

• Manage Family Dynamics

Family gatherings can sometimes be challenging. Plan ahead to set healthy boundaries and focus on the positive aspects of being together.

• Seek Professional Help When Needed

If stress, anxiety, or sadness become overwhelming, it may be helpful to talk to a mental health professional. Mountain Lakes Behavioral Healthcare offers support and resources for individuals in need.

You Are Not Alone

Mountain Lakes Behavioral Healthcare remains committed to serving the mental health needs of the community. "The holidays can be tough, but help is available," Dr. Boxley adds. "If you or someone you know is struggling, don't hesitate to reach out for support."

If you need assistance or have concerns about your mental health, contact Mountain Lakes Behavioral Healthcare at (insert contact information) or visit (insert website).

This holiday season, prioritize your well-being and remember that small steps can make a big difference. Together, we can create a healthier, happier season for everyone.

About Mountain Lakes Behavioral Healthcare

Mountain Lakes Behavioral Healthcare provides compassionate and comprehensive mental health services to residents of Jackson and Marshall Counties. Our mission is to enhance the quality of life for individuals and families by offering treatment, support, and resources for mental health and substance use challenges.

This article was provided by Myron Gargis, MLBHC Executive Director

Continuous Quality Improvement
Summary Reports
November 21, 2024

I. Report from Clinical Director, Dianne Simpson:

- **Staff Error Report-** The October report was distributed to the Program Directors/Coordinators.
- **Wall of Fame/Incentive Plan for October 2024**: The following staff achieved the incentive for the month of October. They all exceeded their productivity standard and produced excellent and error free documentation.

Congratulations:

Incentive Plan-

Brand, Kali
Brookshire, Tom
Burks, Julie
Burns, April
Cheek, Brittany
Early-Foster, Alison
Floyd, Jessica
George, Margaret
Headrick, Tina
Kyle, April
McMurrey, Kimberly
Riggins, Jennifer
Rucker, Elizabeth
Strange, Lilly
Vandergriff, Vanessa
Whitten, Brooke
Zurita, Marili

Wall of Fame-

Alford, Lindsay	Marshall
Barrett, Rob	Jackson
Boxley, Sarah	Multiple
Burkhalter, Brittany	Jackson
Campbell, Teana	J. P.
Clonts, Lisa	Marshall
Cooper, Rebecca	Dutton
DeAtley, Joanna	Residential
Dettweiler, Sarah	Jackson
Estes, Ashlee	Marshall
Hanna, Sarah	M. P.
Hardy, Brandon	J. P.
Hayes, Leilani	M. P.
Herring, Belinda	Multiple
Hixon, Ryan	Dutton
Holcombe, Mitzi	Geriatrics
Hughes, Destiny	Dutton
Johnson, Dallas	Jackson
Johnson, Stacey	Marshall
Justice, Desiree	Dutton
Keeper, Christy	Jackson
Kilian, Zachary	Dutton
Knott, Stephanie	Marshall
Malone, Crystal	Marshall
Martin, Stephanie	Marshall
Moore, Leah	Geriatrics
Moses, Mona	Geriatrics
Nichols, Haley	Marshall
Paschal, Nancy	Dutton
Quinn, Lindsey	Marshall
Ritchie, Denise	Marshall
Roberts, Chelsea	Marshall
Robinson, Hannah	Jackson
Sabb, Shaquitta	Jackson
Steed, Tyler	Geriatrics
Stephens, Marie	Marshall
Traweek, Elizebeth	Marshall
Whitley, Amanda	Marshall
Wilson, Billy (Ross)	M. P.
Wilson, Justin	Dutton
Bartke, George	Cedar
Crowell, Robert	Cedar
Kirkland, Jana	Cedar
Ramsey, Katrina	Cedar
Sweatman, Susan	Cedar
Woodham, Cynthia	Cedar

Continuous Quality Improvement
Summary Reports
November 21, 2024

II. Review and approve of October 17, 2024 summary report:

III. Administrative Review Summary/Error Reports for Oct. 2024: (This is the first month of the fiscal year.):

	Cases Reviewed	Docs Reviewed	Docs w/errors	Total Errors	Predominant Errors
TOTAL	26	3048	2	8	Service not provide per TP

MONTHLY ADMIN REVIEW ERROR RATE: 0.3 % YTD ERROR RATE: 0.3 %

A summary report was sent out to the committee for each program containing details of the errors 1for review. The breakdown of reviews done for 6 month reviews and other/transfers were submitted for each program. The predominant errors were service not provide per TP.

IV. State Reporting Data Elements (SRDE) Report for Sept 2024-These errors are reported one month later as they are not received in time to research and compile prior to PI.

Total Errors	Predominant Error Trends
1	None

V. Prevention Activities: 132 Prevention activity sheets were reviewed for October 2024

Direct Services	# Hours billed in Marshall County	# Hours billed in Jackson County
Block- Community	0	0
Block-Environmental	9	56
Block- Information Dissemination	20	46
Block-Education	10	0
Block-Alternatives	0	0
Block-PIDR	18	N/A
SOR-Environmental	34	62
SOR-Community Based Process	7	45
Total	98	209

In October, the Prevention team distributed over 50 informational bags containing resources on safe drug storage, disposal, and Deterra disposal pouches at the Kids n Kin Event, as well as at Grant and Boaz Discount Pharmacies. They conducted educational sessions on opioid and stimulant use for the Jackson County Solid Waste Department and Dutton Group Home. Additionally, they distributed Narcan and Fentanyl test strips, along with detailed usage instructions.

Prevention staff teach Vape Court Classes in Marshall County every Wednesday from 4:00 to 6:00 PM. These classes provide students with four hours of in-depth education on the dangers of vaping. Prevention staff participated in the NACC Community Resource Event, engaging the community with vital information.

Staff also completed drug awareness orientations for all 9th grade students at Section, Woodville, and Arab High Schools. They taught sessions on the dangers of fentanyl at Arab and Woodville High

Schools. They launched the Too Good for Drugs (TGFD) activities with 5th grade students at Boaz Intermediate School.

Prevention and Jackson County staff participated in the Jackson County First Storybook Spooktacular event, where they distributed educational resources to over 1,200 attendees. Finally, they collaborated with the DEA and Jackson County Sheriff's Office for a Drug Take Back event, successfully collecting 130 pounds of unused prescription medications.

VI. Hospital Discharge Follow-up Report for October:

Location	Local	State/CRU	Total
Marshall	13 Active	0	13
Jackson	11 Active	0	11
Geriatrics	0	0	0
Total	24	0	24

Tracking reports of hospital discharges and 72 hour follow-ups for clients in Marshall and Jackson County were sent out to the committee. All appointments, with one exception were kept in Marshall County. Primary therapist the following day confirmed with DHR that the consumer was in foster care in another county, therefore the chart was closed. All appointments, with the exception of two, were kept in Jackson County. Follow up was completed later for both consumers.

VII. Incident Prevention and Management for October: There were two reportable incidents for October. One SU Hospitalization and one unsubstantiated Allegation of Verbal Abuse.

October 13, 2024 (DMH-SU-24 hr rpt Hospitalization) Cedar Lodge

(85-2024) Client reported experiencing abdominal pain. 911 was called and EMS transported client to Huntsville Hospital.

Follow up: Client was admitted to Huntsville Hospital and scheduled for gall bladder surgery.

October 20 (DMH-MI 24 hr rpt Verbal Abuse Sue Bolt House/Veronica House

(86-2024) A staff member at Veronica House overheard another staff person yelling at a consumer to get out of the house and leave them alone.

Follow up: Investigation was conducted on 10/24/24 as an allegation of verbal abuse. Incident was reported to DMH on 10/25/24. Allegation of verbal abuse was unsubstantiated. Follow up reported to DMH. Employee was terminated on 10/28/24 for an unrelated P & P violation.

VIII. Medication Errors for October: There were eight medication errors reported for the month of October. Six documentation errors and two missed doses. It was noted that six of the errors were made by the same MAC worker.

October 3 Cedar Lodge

(87-2024) MAC worker gave Buprenorphine 8mg at 8am but didn't document on front of MAR that med was given. Client verified that he received medication. Documentation error was discovered at 12pm by RN.

What should have happened? Staff should follow NDP guidelines.

Why the difference? Staff did not follow NDP guidelines.

How can a similar event be prevented in the future? Follow NDP procedures and check MAR.

Follow up: Supervision with MAC worker.

October 12 (2 med errors) Cedar Lodge

(88-89-2024) MAC worker gave Meloxicam 15 mg and Methotrexate 2.5 mg, at 6am but didn't document on front of MAR that med was given. Client verified that she received medication. Documentation error was discovered on 10/14/24 at 8:15 am by RN.
What should have happened? Staff should follow NDP guidelines.
Why the difference? Staff did not follow NDP guidelines.
How can a similar event be prevented in the future? Follow NDP procedures and check MAR.
Follow up: Supervision with MAC worker.

October 12 (3 med errors) **Cedar Lodge**

(90-92-2024) MAC worker gave Pantoprazole 40 mg, Tamsulosin 0.4 mg, and Buprenorphine HCL 8mg, at 6am but didn't document on front of MAR that med was given. Client verified that she received medication. Documentation error was discovered on 10/14/24 at 8:15 am by RN.
What should have happened? Staff should follow NDP guidelines.
Why the difference? Staff did not follow NDP guidelines.
How can a similar event be prevented in the future? Follow NDP procedures and check MAR.
Follow up: Supervision with MAC worker.

October 21 (2 med errors) **Jackson Place**

(93-94-2024) Program coordinator discovered that Sertraline HCL 100 mg and Tamsulosin HCL 0.4mg hadn't been given the night before at 8pm. Meds were still in packet. MAC worker signed that meds were given on the MAR.
What should have happened? Staff should follow NDP guidelines.
Why the difference? Staff did not follow NDP guidelines.
How can a similar event be prevented in the future? Follow NDP procedures and check MAR.
Follow up: Supervision with MAC worker.

By Personnel

	MAC	RN	LPN	Pharmacist	Other (explain)
Level 1	8				
Level 2					
Level 3					
TOTAL	0	0	0	0	0

By Division

	MI	SA	TOTAL
Level 1	2	6	8
Level 2			
Level 3			
TOTAL	0	0	0

By Error Type

	Wrong Person	Wrong Med	Wrong Dose	Wrong Route	Wrong Time	Wrong Reason	Wrong Documentation	Missed Dose	Other (explain)
Level 1							6	2	
Level 2									
Level 3									
TOTAL	0	0	0	0	0	0	6	2	0

IX. Consumer Feedback, Complaints, and Grievances: There were 5 complaints reported for October.

October 3 **Marshall Place**

(95-2024) On 10/3/24 consumer feedback form was found in feedback box dated 9/26/24. Consumer stated she likes her home and they treat her well. However, consumer would like a reduction in the expense of living in the group home so that she would have more discretionary funds.
Follow up: Program director spoke with consumer on October 4th and explained the group home charges. Consumer has previously requested the opportunity of getting a job. Due to her conditional release status this would have to be approved by the judge. Several requests have been made to the judge with no response.

October 17 (2 complaints) **Dutton Group Home**

(96-97-2024) Two consumer complaint forms were found in feedback box on 10/17/24 with one dated 10/12/24 and the other not dated. Consumers complained about how other consumers were treating the GH pets.
Follow up: Program coordinator addressed complaint on 10/24/24 and agreed to speak with the two consumers about being gentle with the dogs and to allow them to walk away when they want to.

October 22 **Dutton Group Home**

(98-2024) Consumer complaint form was found in feedback box on 10/22/24 with dated 10/19/24. Consumer asked for more ice trays, thanked MLBHC for a healthy environment to live in and complained that staff had to buy food.
Follow up: Program coordinator addressed complaint on 10/24/24 and stated that they added 12 ice trays (3 for each home) to the upcoming supply run. Consumer states they always have good meals and good food.

October 22 **Guntersville MHC**

(99-2024) Anonymous consumer complaint form was found in feedback box on 10/22/24 dated 10/19/24. Complaint stated "can staff not dress better and clean room."
Follow up: The employee no longer works here.

FY24-Consumer Feedback	Oct Compliments	Oct Suggestions	Oct Complaints/ Grievances	Oct Comments	Oct Total per location
Guntersville	0	0	1	0	1
Scottsboro	0	0	0	0	0
Outreach/Residential	0	4	4	1	9
Cedar Lodge	5	0	0	1	6
Total MTD	5	4	5	2	16
Total YTD	5	4	5	2	16

X. Residential Services Report for October 2024: A monthly report was ran for October.

FACILITY	CAPACITY	TARGETED PT DAYS	ACTUAL PT DAYS	% OCCUPANCY
Jackson Place	3	93	93	100
Marshall Place	3	93	65	70
Jackson Place Sup Apt.	2	62	31	50
Dogwood Apartments	8	248	202	81
Supportive Housing	12	372	248	67
MLBH Residential Care	10	310	267	86
MLBH Crisis Stabilization	2	62	62	100
Foster Homes	26	806	802	100
Totals		**2046**	**1770**	**87**

XI. Treatment Plan Reviews for October 2024:

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	7	0	0	0	0	0	0	0
Jackson	81	0	0	0	1	0	0	1
Marshall	153	0	1	0	2	0	0	3
Substance Abuse	0	0	0	0	0	0	0	0
Residential	0	0	0	0	0	0	0	0
TOTALS	241	0	1	0	3	0	0	4

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 with details of the errors and the staff responsible. The trend was documentation does not relate to TP and/or address progress this month.

XII. Form-Policy & Procedure Revisions/Approvals:

Forms-

- **Crisis Recovery Plan-Rev-** The clinical director requested that this form be built into Avatar for staff use. The hard copy form was revised to match what can be built in Avatar. No actual changes were made to the content of the form, just the format. The form was sent out to the committee with no changes noted. The approved form was placed on the server under MLBHC forms>Quality

Measures tab for staff access. Staff will be notified when the form is built and ready to use in Avatar.

- **Utilization Review Form- Rev-** The clinical director revised this hard copy form to add Dogwood supervised apartments and Jackson Place supervised apartments to the list of programs to review. The form was sent out to the committee with no changes noted. The approved form was placed on the server under MLBHC forms> for staff access.
- **Foster Home Monitoring form-Rev-** This form was revised to match the revisions in MI Community Service Contract Service Delivery Manual and the Alabama Administrative Code. The form was sent out to the committee with no changes noted. The approved form was placed on the server under MLBHC forms> for staff access.

P & P: Procedure revisions for PI approval-None

P & P: Board Approved Policy Revisions-None

XIII. Miscellaneous Items:

- **DMH Advocate Visit-Lynn Pottratz-Cedar Lodge Level III.5-November 6, 2024-** Individuals appeared very comfortable around staff. Individuals reported that staff do a good job and are supportive. Consumers were observed to be attentive and engaged in the group session. No issues were noted during the visit.

Continuous Quality Improvement
Summary Reports
December 19, 2024

I. Report from Clinical Director, Dianne Simpson:

- **Staff Error Report**- The November report was distributed to the Program Directors/Coordinators.
- **Wall of Fame/Incentive Plan for November 2024**: The following staff achieved the incentive for the month of November. They all exceeded their productivity standard and produced excellent and error free documentation.

Congratulations:

Incentive Plan-

Brookshire, Tom
Burks, Julie
Burns, April
Malone, Crystal
McMurrey, Kimberly
Strange, Lilly
Whitten, Brooke

Wall of Fame-

Alford, Lindsay	Marshall
Barrett, Rob	Jackson
Boxley, Sarah	Multiple
Brand, Kali	Marshall
Brown, Jennifer	Jackson
Burkhalter, Brittany	Jackson
Cheek, Brittany	Jackson
Clonts, Lisa	Marshall
Cooper, Rebecca	Dutton
DeAtley, Joanna	Residential
Early-Foster, Alison	Marshall
English, Audrey	Jackson
Estes, Ashlee	Marshall
Hanna, Sarah	M. P.
Hardy, Brandon	J. P.
Hayes, Leilani	M. P.
Headrick, Tina	Marshall
Herring, Belinda	Marshall
Hixon, Ryan	Dutton
Holcombe, Mitzi	Geriatrics
Johnson, Dallas	Jackson
Johnson, Stacey	Marshall
Justice, Desiree	Dutton
Keeper, Christy	Marshall
Knott, Stephanie	Marshall
Martin, Stephanie	Marshall
Moore, Leah	Geriatrics
Moses, Mona	Geriatrics
Quinn, Lindsey	Marshall
Riggins, Jennifer	Marshall
Ritchie, Denise	Marshall
Roberts, Chelsea	Marshall
Romero, Kimberly	Marshall
Rucker, Elizabeth	Marshall
Sabb, Shaquitta	Jackson
Steed, Tyler	Geriatrics
Stephens, Marie	Marshall
Travis, Samantha	Dutton
Traweek, Elizebeth	Marshall
Tubbs, Felicia	J. P.
Vandergriff, Vanessa	Marshall
Amanda Whitley	Jackson
Wilson, Justin	Dutton
Zurita, Marili	Marshall
Bartke, George	Cedar
Crowell, Robert	Cedar
Kirkland, Jana	Cedar
Ramsey, Katrina	Cedar
Sweatman, Susan	Cedar
Woodham, Cynthia	Cedar

Review and approve of November 21, 2024 summary report:

III. Administrative Review Summary/Error Reports for Nov. 2024: (Oct MTD 0.3 % YTD 0.3):

	Cases Reviewed	Docs Reviewed	Docs w/errors	Total Errors	Predominant Errors
TOTAL	30	3308	6	9	Service not provide per TP, Late notes

MONTHLY ADMIN REVIEW ERROR RATE: 0.3 % YTD ERROR RATE: 0.3 %

A summary report was sent out 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: service not provide per TP and late notes. The monthly and year to date error rate was the same as last month.

IV. State Reporting Data Elements (SRDE) Report for Oct 2024-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
6	Invalid Diagnosis

Errors occur when clinicians select an incorrect diagnosis classification or omit minor details. The CQI team is actively revising reporting processes to identify and address these errors before submitting the data to the state.

V. Prevention Activities: 145 Prevention activity sheets were reviewed for November 2024

Direct Services	# Hours billed in Marshall County	# Hours billed in Jackson County
Block- Community	0	0
Block-Environmental	12	6
Block- Information Dissemination	40	25
Block-Education	10	28
Block-Alternatives	0	0
Block-PIDR	12	N/A
SOR-Environmental	50	28
SOR-Community Based Process	11	26
Total	135	113

In November, the Mountain Lakes Prevention Staff carried out a variety of initiatives focused on substance use prevention across Marshall and Jackson Counties.

The team facilitated four sessions of the INDEPTH program for students in Marshall County who were caught vaping on school property. Additionally, staff attended Vape Court every Monday to educate students and their guardians about the Vape Court process and the structure of the associated classes.

Prevention staff distributed "Talk They Hear You" materials at Kids N Kin classes in both counties. At the Albertville Head Start Fall Festival, they engaged with parents to highlight the dangers of secondhand vaping and the harmful effects of opioid misuse.

At Arab School, the team conducted a Drug Orientation session for all 9th-grade students. The presentation covered topics including alcohol, tobacco/vaping, marijuana, and fentanyl, aiming to increase awareness about the risks of substance use. Furthermore, staff began implementing the Too Good for Drugs curriculum at Boaz Intermediate and Woodville Elementary. This 10-lesson program, designed for 5th-grade students, focuses on decision-making, goal setting, and the dangers of alcohol, tobacco, and other drugs (ATOD).

The Prevention team also hosted "Remove the Risk" tables at local pharmacies, including Boaz Discount Pharmacy, Brindley Family Pharmacy, Ross Pharmacy, and Brindley Mountain Pharmacy. At these locations, they distributed Deterra bags and educated customers about the safe storage and disposal of medications.

Finally, all staff attended the Tall Cop Training in Jackson County, where they learned about emerging threats associated with new drugs available at gas stations.

VI. Hospital Discharge Follow-up Report for November:

Location	Local	State/CRU	Total
Marshall	10 Active	0	10
Jackson	6 Active	0	6
Geriatrics	0	0	0
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. All appointments were kept in both counties. One concerning trend is that 63% of the hospitalizations were for children/adolescents.

VII. Incident Prevention and Management for November: There were two incidents of client aggression for November.

November 2, 2024 **Jenny's Place**

(100-2024) Consumer started screaming at, grabbing, and shoving other clients. Consumer threw small items as well. Two staff members intervened and redirected the client. One called 911 while the other one continued to work to deescalate the consumer. Consumer willingly went with EMTs to hospital for evaluation.

Follow up: Consumer was admitted to Creekside Psychiatric Hospital 11/3/24.

November 11 **Jenny's Place**

(101-2024) One consumer bumped into another consumer on two occasions. Words were exchanged and the consumer who had been bumped punched the other consumer in the abdomen.

Follow up: The staff met with the consumer who initiated the altercation as he has a history of provoking others. The treatment team are actively seeking additional services for the offending consumer.

VIII. Medication Errors for November: There were three medication errors reported for the month of November. Three missed doses. No trends were noted.

November 12 **Jackson Place**

(102-2024) MAC worker found a missed dose packet of Lamotrigine 200mg at 8pm that should have been given at 8am that day. Staff who found error called RN on call.

What should have happened? Staff should follow NDP guidelines.
Why the difference? Staff did not follow NDP guidelines.
How can a similar event be prevented in the future? Follow NDP procedures and check MAR.
Follow up: Supervision with MAC worker.

November 21 (2 med errors-same med pass) **Jenny's Place**

(103-104-2024) MAC worker went to pass 8pm meds and noticed 12pm meds, Depakote 500 mg and Seroquel 100 mg had not been given. Staff who found error called RN on call.
What should have happened? Staff should follow NDP guidelines.
Why the difference? Staff did not follow NDP guidelines.
How can a similar event be prevented in the future? Follow NDP procedures and check MAR.
Follow up: Supervision with MAC worker.

By Personnel

	MAC	RN	LPN	Pharmacist	Other (explain)
Level 1	3				
Level 2					
Level 3					
TOTAL	3	0	0	0	0

By Division

	MI	SA	TOTAL
Level 1	3	0	3
Level 2			
Level 3			
TOTAL	3	0	3

By Error Type

	Wrong Person	Wrong Med	Wrong Dose	Wrong Route	Wrong Time	Wrong Reason	Wrong Documentation	Missed Dose	Other (explain)
Level 1								3	
Level 2									
Level 3									
TOTAL	0	0	0	0	0	0	0	3	0

IX. Consumer Feedback, Complaints, and Grievances: There was 1 complaint reported for November.

November 15 **Marshall Place**

(105-2024) Consumer complaint form was found in feedback box on 11/15/24 dated 11/14/24. Consumer complained shampoo being tampered with. Consumer had just bought the shampoo and took a shower and it didn't smell the same.
Follow up: Program coordinator discussed with consumer, if shampoo smelled or looked spoiled or ruined. Consumer confirmed just the smell had changed. Ensured it was still usable and not contaminated, consumer confirmed it was still usable. Suggested consumer consistently keep her door shut and affirmed that no one, including staff enters her room while she is not present. Consumer agreed to keep her door shut.

Continuous Quality Improvement
Summary Reports
December 19, 2024

FY25-Consumer Feedback	Nov Compliments	Nov Suggestions	Nov Complaints/ Grievances	Nov Comments	Nov Total per location
Guntersville	0	0	0	0	0
Scottsboro	0	0	0	0	0
Outreach/Residential	0	3	1	1	5
Cedar Lodge	1	0	0	0	1
Total MTD	1	3	1	1	6
Total YTD	6	7	6	3	22

X. Residential Services Report for November 2024: A monthly report was ran for November.

FACILITY	CAPACITY	TARGETED PT DAYS	ACTUAL PT DAYS	% OCCUPANCY
Jackson Place	3	90	90	100
Marshall Place	3	90	90	100
Jackson Place Sup Apt.	2	60	30	50
Dogwood Apartments	8	240	240	100
Supportive Housing	12	360	240	67
MLBH Residential Care	10	300	262	87
MLBH Crisis Stabilization	2	60	60	100
Foster Homes	26	780	780	100
Totals		**1980**	**1792**	**91**

XI. Treatment Plan Reviews for November 2024:

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	33	0	0	0	0	0	0	0
Marshall	51	0	0	0	0	0	0	0
Substance Abuse	0	0	0	0	0	0	0	0
Residential	1	0	0	0	0	0	0	0
TOTALS	93	0	0	0	0	0	0	0

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. No errors were assigned for the month of November.

XII. Form-Policy & Procedure Revisions/Approvals:

Forms-

- **(Adverse) Incident Report-Rev-** The reportable incidents section in the middle of page one was updated to match the changes by DMH beginning 10/1/24. Page two of this form was revised to add clarification regarding when to complete the root cause analysis portion at the top of the page. The following was added above this section "*Was there something the staff could have done to prevent the incident? If so, complete this section.*" For the follow up line this was added, "(*To be completed and forwarded to Incident Management staff within 5 business days)*". The form was sent out to the committee with no changes noted. The approved form was placed on the server under MLBHC forms> for staff access.
- **House Rules-Rev-** As required by the ADMH Mental Illness Contract Billing Manual, the group home house rules were reviewed by consumers, staff, and the Human Rights Committee. The form was sent out to the committee with no changes noted. The approved form was placed on the server under MLBHC forms> for staff access.

P & P: Procedure revisions for CQI approval-None

P & P: Board Approved Policy Revisions-None

XIII. Miscellaneous Items:

- **CQI Plan FY25-** This plan was approved by the board of directors at the November Board meeting and will be the plan for the following fiscal year. The following is a summary of revisions for the FY25 plan:
  - **Plan name changed from Performance Improvement to Continuous Quality Improvement Plan (CQI)**
  - **Changed PI Annual Report to CQI Annual Report**
  - **Changed PI Committee to CQI Committee**
  - **Changed performance improvement to quality improvement.**
  - **Changed PI System to CQI process.**
  - **Added back:**

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

- **Added:**

Quality Measures: The following quality measures will be reviewed: (1) Time to Services (I-SERV); (2) Depression Remission at six months (DEP-REM-6); (3) Preventive Care and Screening: Unhealthy Alcohol Use Screening and Brief Counseling (ASC); (4) Screening for

Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD); (5) Screening for Social Drivers of Health (SDOHC).

- **Added:**

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

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

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

Leadership Committee
November 21, 2024

MINUTES

Present: Lane Black, Myron Gargis, Cammy Holland, Dana McCarley, Shelly Pierce, Erica Player, Katrina Ramsey, Sherneria Rose and Dianne Simpson

Absent: Gerald Privett

I. HR Training Presentation
Due to technical difficulties, the HR Training Presentation for today was postponed until the December meeting.

II. Approve minutes of the October 17, 2024, meeting
Minutes of the October 17, 2024 meeting were distributed to all staff via e-mail. Minutes were approved, as presented.

III. Committee reports for the month

EEG from 10/24/24

In Attendance
Members: Erica Player, Sherneria Rose, Jeremy Burrage, Lane Black, Alexis Parker, Christy Keeper, Kim Coe
Guest: Brooke Whitton and Jaclyn Gilbert
Minutes
Employee Feedback: N/A
Engagement Activity Planning Updates:
Members preparing to step down: Erica Player, Sherneria Rose, Lane Black, Margret George
New chair elected: Christy Keeper
Minutes: Alexis Parker
Otr 1 (FY 2025): Christmas party 12/13 approved by Myron. Party will be held at Jackson County new office during office hours to increase attendance.
Karaoke, prize hunt, painting station, and other activities mentioned.
Catering – Jeremy working on
Lane to set up photo booth
Ask for assistance from other employees if they are willing to help with planning of Christmas party.
Qtr 2 event mentioned of the HAVOC game- Jeremy to look into this
Jeremy to send out employee surveys
Strategic Action Plan Updates

- Invite 1 employee to attend each meeting to gain feedback & seek new ideas.
  - Qtr 1: Brooke Whitten and Jaclyn Gilbert
- Sponsor 1 employee engagement activity each quarter to foster a feeling of community within the organization.
  - Qtr 1: to be Christmas Party
- Sponsor at least 1 activity that enhances professional development.

Next Meeting
TBD

EEG from 11/13/24

In Attendance
Members: Jeremy Burrage via zoom, Ryan Hixon via zoom, Alexis Parker, Christy Keeper, Brooke Whitton and Jaclyn Gilbert

Guest: Miranda Holland, Hannah Bishop, Jessica Floyd, Brianna McDonald, Dallas Johnson
Minutes

Employee Feedback: N/A

Jeremey is compelling and creating survey to send employees. Jeremey will get with Erica to send all user email. Survey will be through survey monkey.

Engagement Activity Planning Updates:

Minutes: Miranda Holland in place of Alexis as she is leaving.
Otr 1 (FY 2025): Recap of HAVOC game, Jeremy to send out survey and update about this being sent out for HAVOC game and employee feedback.
Christmas Party will be Qtr 1 activity. During meeting ideas and brain storming were done. Party will be at the new Scottsboro office on Dec. 13th from 12-4 with food served at 1.
Games, door prizes, crafts, food, decorations and other activities were discussed.

EEG is asking for assistance from other employees if they are willing to help with planning of Christmas party. Accepting donations for gifts, be on the lookout for Christmas CDs to play during the event.

Qtr 2 event mentioned of the HAVOC game- Jeremy to look into this
Guests at meeting to be new EEG members.
Next Meeting will be Nov. 25th from 2pm-3pm to discuss progress from brain storming. Meeting will be via zoom.
Dec 5th Christmas party meeting 3-4:30 at Scottsboro office.
Dec 12th Christmas party meeting 3-4:30 for decoration for the Christmas party at Scottsboro Office.

Strategic Action Plan Updates

- Invite 1 employee to attend each meeting to gain feedback & seek new ideas.
  - Qtr 1: Miranda Holland, Hannah Bishop, Jessica Floyd, Brianna McDonald, Dallas Johnson
- Sponsor 1 employee engagement activity each quarter to foster a feeling of community within the organization.
  - Qtr 1: to be Christmas Party
- Sponsor at least 1 activity that enhances professional development.

Next Meeting
11/25/24 @ Guntersville Conference room, JC staff can attend via zoom if needed.
Meeting before Christmas party 12/5/24 @ 3pm meet at new JC building.

Consumer Satisfaction from 11/8/24

Present: Brittany Cheek, Sarah Hanna, Cammy Holland, Jennifer Riggins, Dianne Simpson and Lily Sparks.
Absent: Hannah Chandler and Elizabeth Rucker

Christmas Event:

The menu was finalized and a food signup sheet started and emailed.
Games/stations were finalized. All supplies and prizes for the games will be provided. A signup sheet for volunteers for games and serving were started and emailed. An email was sent to all users about donations. A monetary donation was given. After we have received all donations from staff, we will take any monetary donations to purchase items needed for prizes and the store for the event.
CSC members will get a list of approximately 5 clients to purchase items for along with an about me page. The budget is $50 per client. This items will be sent to Administration to be delivered to each location on Christmas Eve. Brittany & Lily will keep their gifts at Dutton, Sarah will keep the ones for MP. The CSC decided to include the 2 Jackson Place peer employees/clients in this as well.
Suggestions for prizes and the store included: laundry baskets, collapsible laundry baskets, socks, belts, gift cards to Burger King, Wendy's or McDonalds, movies – (sci-fi, horror), cds, books and number search books.
Discussion of items to have at the event included plenty of plates, water, caffeine free drinks, ice, potholders, serving utensils, etc.

Other Business:

Discussion took place concerning the consumer feedback for the year. Complaints were addressed. Brittany brought up that many of the clients at Dutton ask about streaming options. Brittany & Lily both suggested to consumers to place their suggestion in the feedback box. No suggestions concerning this have been received. Cammy will email Regenia and IT about campus wide streaming options for Dutton and Marshall Place. It was suggested to cancel cable because it is so antiquated and use those savings for streaming services. Some believe

Jackson Place already has streaming abilities. Cammy will also email Regenia about motion solar lights at the smoking shed. Discussion was held that those lights could be in many places at Dutton (solar motion lights)

New Business:

None

Next Meeting

TBA

IV. Program Financial Reports: October, 2024

- YTD net loss of $37,218 (not including Board investments).
- **Marshall Co. OP & OR – Net loss $19,551**
- **Jackson Co. OP & OR – Net loss $30,397**
- **Geriatrics – Net loss $3,036**
- **Residential –**
  - Supervised Apartments – **Net income $1,103**
  - EBP Supportive Housing – **Net income $3,183 (program designed to break even)**
  - Dutton – **Net income $8,756**
  - Jackson Place – **Net income $10,320**
  - Marshall Place – **Net loss $2,362**
- **SU Services – Net loss $1,698**
- **Prevention Services – Net loss $3,536**

V. Reports & Program Updates:

- **Executive Director's Report – Myron Gargis**
  - Myron met with DMH staff yesterday at Creekside Hospital. All are working together to get Creekside certified as a DMHF, which will allow that hospital to get paid for admitting involuntary committed individuals.
  - Renovations are close to completion at the new facility on Hwy 35. The wood and metal awnings still need to be installed and the parking lot needs to be sealed and restriped. Getting the telephone system installed may create a delay, so no definite move in date has been set. Dana and Kellye need to be working on a floor plan to maximize space and a wish list for items that we do not already have.
  - We're moving forward toward CCBHC implementation. Staff are currently working on the needs assessment and the kick off meeting for the costing report was conducted last week.
- **Clinical Director's Report – Dianne Simpson**
  - Julianna Davis, Community Support Specialist, has been accepted to speak at ASADS.
  - Dianne distributed three reports (non-billables, bill nots and mental health consults) to LC members. Supervisors were asked to review these items and continue to monitor each for excessive use.
- **Administrative Services – Cammy Holland**
  - Cammy and Devin are currently working on items for CCBHC.
  - The possibility of requiring consumers to submit for their own Medicare supplement (Humana/Devoted/etc.) reimbursement is being considered.
- **HR Report – Lane Black**
  - Lane reported that turnover for FY24 was a little less than in FY23. He also noted no payments toward unemployment claims, which proves that our attention and diligence to documentation of employee related issues is effective.
  - The listing of current vacant positions was distributed to LC members. Please advise Lane of any discrepancies.
- **Jackson County – Dana McCarley**
  - Several JC staff recently participated in the Storybook Spooktacular with the JC Children's Policy Council.

- Savannah Miller has officially transferred to the position of Adult Peer Specialist. Brooke Whitten will soon begin her graduate internship, with Savannah filling in for her on the JC AIH Team. Savannah has been traveling with Brooke and Tom to meet the JC AIH consumers.
- Courtney Hawkins, part-time JC IC, is on the schedule for two intakes per day.
- The JC ACT Team really worked together in getting a consumer to SU treatment, encouraging him to finish the program and assisting him with temporary housing until a long term solution becomes available.
- Dana recently participated in a Miracle Worker's meeting and also in her first JC Multi-disciplinary Team meeting.
- There is a JC TH is the pipeline to begin in January.
- Renovations to the new Hwy 35 facility are looking great. Dana is already working on a plan for initial work place assignments.
- Staff are working on ideas for support groups/group therapy for biracial kids, foster/adoptive parents, and LGBTQIA+ consumers.
- Life Resource Center wants to partner with the JC MHC on the resource room. They are willing to donate items for any consumers in need.

- **Marshall County OP & OR – Erica Player**
  - The observation room for Parent/Child Observation Therapy is up and running.
  - Four of the consumers on the MC CAIH Team are actively suicidal.
  - Evidence based training will soon be provided to staff members.
  - A finalized version of the PAD form was distributed to LC members.
- **Geriatrics – Dianne Simpson**
  - Geriatrics held their staff meeting and holiday luncheon last week.
  - Education on CCBHC was provided during the staff meeting.
- **Residential – Sherneria Rose**
  - Sherneria noted recently receiving several referrals from outside our catchment area.
  - She is experiencing difficulty in finding nursing home placement for one of the consumers at JP. Any ideas or suggestions for other placement options are welcomed.
- **SA Services – Katrina Ramsey**
  - Brad Bewley recently passed his CRSS exam.
  - Census is currently 24.
  - Cedar is fully staffed at the moment.
  - The advocate recently visited Cedar Lodge, with no findings and a positive report.
  - The possibility of Melissa Blanks, CPS-P, conducting parenting groups at Cedar Lodge is being explored.
  - LC members are invited to the Christmas Luncheon at Cedar Lodge on 12/11/24.

VI. Review of wait times

For October, 2024, the following wait times were reported:

MC Intake	5 days	MC MD/CRNP	14 days
JC Intake	6 days	JC MD/CRNP	10 days
Average	5.5 days	Average	12 days

VII. Unfinished Business

- **None noted**

VIII. New Business

- **None noted**

IX. Adjournment

The Leadership Committee meeting was adjourned at 3:50 p.m.

Leadership Committee
December 19, 2024

MINUTES

Present: Lane Black, Myron Gargis, Cammy Holland, Dana McCarley, Shelly Pierce, Erica Player, Gerald Privett, Katrina Ramsey, Sherneria Rose and Dianne Simpson

Absent: None

I. HR Training Presentation
Lane provided a training presentation titled "Psychological Effects That May Affect Your Management Of Others".

II. Approve minutes of the November 21, 2024, meeting
Minutes of the November 21, 2024 meeting were distributed to all staff via e-mail. Minutes were approved, as presented.

III. Committee reports for the month

Corporate Compliance from 11/21/24

Present: Dana Childs, Myron Gargis, Cammy Holland, Shelly Pierce, Erica Payer, Katrina Ramsey, Sherneria Rose and Dianne Simpson

Absent: None

I. Approval of minutes from May 23, 2024

Minutes of the May 23, 2024, meeting were approved, as presented.

II. Review of Clinical & Financial Controls

The following items of significance were reported since the last meeting:

- **CLINICAL CONTROLS – Dianne Simpson**
  - On May 30, there was an anonymous report of fraud in that an employee was not clocking in and out properly. Following an investigation, it was determined there was no fraud. The anonymous reporter appeared confused on the process for clocking in and out on a shift that spans two days.
  - On May 30, it was reported that a staff member at the Dutton Residential Facility videoed a consumer and shared the video with other staff members. An investigation was conducted, but no proof found that the action occurred. The employee admitted to recording, but reported that it was audio only. Supervision was conducted with the employee involved.
  - On June 3, there was an allegation of verbal abuse toward a consumer at the Dutton Residential Facility. The allegation was investigated and consumer mistreatment was substantiated. The staff member was terminated.
  - On June 17, there was an allegation of staff billing for a service when the consumer was actually participating in a service with another employee. Following investigation, it was determined that the staff member estimated the time of the service that was provided, which did overlap with the time of the other service. This action was noted as a training issue and not a deliberate act of fraud. All employees involved were provided with additional training on the importance of documenting services/billing accurately.
  - On July 8, there was an allegation of an employee falsifying their time card by claiming time not actually worked. The allegation was investigated and substantiated, with the staff member being terminated.
  - On July 30, there was a complaint against a staff member of giving PRN meds without the RN's approval. This action is not in compliance with NDP procedures. The employee admitted providing the medication and documenting RN approval, without actually contacting the RN. A

written warning was issued to the employee, along with suspension. Employee was also required to repeat MAC II training.
    - Dianne reported two current investigations. Those will be reported at the next CCC meeting.
- **FINANCIAL CONTROLS – Cammy Holland**
    - The 401k audit was conducted and finalized since the last CCC meeting.
        - The auditors provided recommendations related to segregation of duties and documentation of the oversight process. Both of these suggestions have been implemented.
    - We are currently waiting on the FY24 Financial Audit to be finalized.
    - Surprise audits were conducted at the Jackson County MHC on July 9 and November 5. Ms. Holland noted:
        - Petty cash was in balance and is being counted daily.
        - Gift cards for the Medicaid Contingency Management Program were accounted for.

III. Identification of any new clinical or financial issues/high risk areas that need to be addressed by the Committee

- None noted

IV. Next meeting

Committee members agreed to meet again in May, 2025. If an issue arises that needs to be addressed before that date, a special meeting can be called at any time.

EEG from 12/9/24

In Attendance

Members: Christy Keeper, Miranda Holland, Jaclyn Gilbert, Bri McDonald, Jeremy Burrage, Dallas Johnson, Jessica Floyd, Ryan Hixon, Brooke Whitten

Guest: Nicolette

3pm-5pm

Employee Feedback:

Jeremy to send out surveys after the first of the year.

Engagement Activity Planning Updates:

Otr 1 (FY 2025) Recap: Myron approved the Christmas Party to be held at the new Jackson County office. Budget approved. Date is 12/13 from 12 - 4. Employee company gifts will be given out during the event. Group went over donations that were given and finalized Itinerary and activities for Christmas party. Members will meet on 12/10 to work on center pieces and 12/12 to decorate for party.

12-1: Stations

1-2: Food

2-3: Games

3-4: gifts

Strategic Action Plan Updates

- Invite 1 employee to attend each meeting to gain feedback & seek new ideas.
    - Nicolette
- Sponsor 1 employee engagement activity each quarter to foster a feeling of community within the organization.
    - Qtr 1: Christmas Party
    - Qtr 2: Havoc Tickets – Jeremy to get more information and arrange tickets.
- Sponsor at least 1 activity that enhances professional development.
    - Tabled for this meeting.

Next Meeting: Dec. 12th @ JC new building to setup for Christmas party.

Human Rights from 12/2/24

In Attendance

Those in attendance were: Marguerite Rollins, Tricia Hopper, Leona Stancil, Sherry Bailey, Katrina Ramsey, and Dianne Simpson.

Not present: Kathleen Rice, Carrie Thomas, and Sherneria Rose

Human Rights Committee

The meeting was called to order at 5:00 pm. at Cedar Lodge. The minutes of the September 16, 2024 meeting were reviewed. Tricia Hopper made a motion to accept them as written. The motion was seconded by Leona Stancil and unanimously approved.

A consumer from the Dutton group home joined the meeting via Go-to-Meeting. The consumer stated that she had been at the home for approximately 6 months. The consumer said she was anxious at first about living in a group home, but her experience had been "awesome." She said, "I found my place here." She stated that she first lived at Jenny's Place, but now at Veronica House. The consumer said that the staff were helpful and she felt she could go to them with anything. She said the food was good, she had opportunities to go shopping, and there were numerous activities for the residents. When asked if she had access to medical care, she stated that she had recently had pneumonia and the staff promptly got her in to see a provider. She said that she made phone calls twice per week to her aunt, and that she also went on passes with her. The consumer said she felt the house rules were fair and had no recommendations for changes.

As required by the Alabama Department of Mental Health Mental Illness Contract Billing Manual, the committee reviewed the group home house rules. The residential staff had recommended the following changes.

- Rule #4, Electronics/Phone Usage- they added "videos/Face Time/audio live streams" to the list of activities not allowed for the protection of other residents' privacy. They also recommended adding "Cell phones should be off and out of sight during medication passes."
- Rule #5- recommended adding "during the following hours: 1:00 PM-7:00 PM on weekdays and 10:00 AM-7:00 PM on weekends" and "Phone usage should not interfere with group home activities" for the use of the house phone.
- Rule #6- Personal Appearance- They recommended adding, "Ensure that your bedroom and bathroom doors are closed when getting dressed and/or attending to personal needs. Avoid exposing yourself when leaving the shower or changing in areas where others may be present."
- Rule #16- Laundry- Staff added "during the designated times as specified by the group home staff."
- Rule # 18- Outings and Visits- Recommendation was to add "All pass requests must be submitted 7 days prior to the outing, with exceptions granted by the program director/coordinator."
- Rule # 19- Visiting hours- Recommended changes in visiting hours to avoid conflicting with medication passes. "Visiting hours are on Wednesday from 3:00pm – 5:00pm and Saturday/Sunday 10:00am – 12:00pm and 3:00 PM-5 PM. Other days and times may be arranged through the program director/coordinator. All visitor requests must be submitted 7 days prior to the visit, with exceptions granted by the program director/coordinator."

The residential staff requested that the Human Rights Committee make a recommendation regarding a consumer's request to have a visitor whom they had never met, or had only met online. This is a safety concern for all residents and staff of the campus. The members reviewed the applicable section of the Alabama Administrative Code Chapter 580-2-20-.04 (4)(x) which states residents have the right, "To have access to and privacy of mail, telephone communications, and visitors for recipients in residential or inpatient settings." It does not address this situation. Leona, who works in an ID/DD group home setting, shared how they had handled this situation. She said that they had a meeting with all parties: the resident, resident's family, group home staff, and the advocate to develop a plan. She recommended that Mountain Lakes consult the consumer advocate as well. After further discussion, Tricia mad a motion, which was seconded by Sherry, and the committee unanimously agreed to make the following recommendations:

- Consult with the consumer advocate on this issue.
- Add to rule # 19: "If a resident makes a request for visitation from a non-family individual with whom they are not familiar and/or met online, this process shall be followed:
    1. The individual will meet with the residential staff in a neutral location.
    2. If the staff are not aware of safety concerns, the visitor may come to the group home for a visit to be supervised by the staff.
    3. If/when the staff approve, they may have unsupervised visitation.
    4. If the residential staff still have safety concerns and do not approve for unsupervised supervision, a Documentation of Rights Restriction will be implemented."

Marguerite shared that 25 of the Dutton Group Home residents and 3 staff recently had participated in a bingo event sponsored by her church. She said the residents thoroughly enjoyed it. She also stated that the staff had expressed how much they enjoyed working at the group home.

The next meeting was scheduled for March 3, 2025 and Marguerite adjourned the meeting at 5:45.

Next Meeting

Monday, March 3, 2025 at 5:00 pm. Location to be Cedar Lodge.

[Meeting adjourned 5:45 pm.]

IV. **Program Financial Reports: October - November, 2024**

- YTD net income of $64,686 (not including Board investments).
- **Marshall Co. OP & OR – Net income $28,651**
- **Jackson Co. OP & OR – Net loss $39,210**
- **Geriatrics – Net income $12,376**
- **Residential –**
  - Supervised Apartments – **Net income $4,139**
  - EBP Supportive Housing – **Net income $4,109 (program designed to break even)**
  - Dutton – **Net income $29,291**
  - Jackson Place – **Net income $18,662**
  - Marshall Place – **Net income $9,380**
- **SU Services – Net income $11,560**
- **Prevention Services – Net loss $14,273**

V. **Reports & Program Updates:**

- **Executive Director's Report – Myron Gargis**
  - We've received notification that the Opioid Treatment Grant has been renewed for the second year.
  - Myron also recently applied for another grant thru DMH, but we've not yet received notification if it was awarded to MLBHC or not.
- **Clinical Director's Report – Dianne Simpson**
  - A meeting was held last week with all individuals involved with School Based Mental Health Coordination. Approximately 25 MLBHC staff and school faculty were in attendance.
  - It was noted in this week's DMH huddle meeting that FEI has been postponed from 1/6/25. A new date has not yet been announced.
  - Several of the recent changes to Medicaid have not been updated for the billing process, so all are working together in an attempt to receive correct payment for these services.
- **Administrative Services – Cammy Holland**
  - The next payroll has a short turnaround time. The pay period ends on 12/25/24 and must be submitted by 12/26/24. Supervisors are asked to advise Cammy if they will be unable to approve timesheets by the deadline and to also encourage staff to get timesheets completed ASAP.
- **HR Report – Lane Black**
  - Leilani Hayes, LSS at MP, utilized MLBHC's Educational Assistance Program and recently received her BS in Psychology.
  - The listing of vacant positons was shared with LC members. Please advise Lane of any discrepancies.
- **Jackson County – Dana McCarley**
  - Erica and Dana have implemented a plan to utilize Shaquitta Sabb and Amanda Whitley to cover Intake responsibilities on a part-time basis until a new JC IC can be hired. Courtney Hawkins, part-time JC IC, will continue providing two intakes per day.
  - A former employee has submitted paperwork for the JC IC position. Pending salary decisions, she could begin in early February.
  - A new JC OP TH will begin on January 2nd. She is excited and eager to join the team.
  - A new SB TH (floater) is in the pipeline and expected to start mid-January.
  - Several staff are reviewing and cleaning up the vacant caseloads left by two former employees. Cases are being closed, as needed, and active cases are being organized to prepare for handoff.

- Emphasis remains on ensuring that staff prioritize billable services over non-billable activities to improve the program's budget. Every effort is being made to maximize service delivery and billing.
- November and December have been difficult months due to high levels of leave, illness, and the holidays. Billing and productivity have been negatively impacted.
- With new employees starting soon, staff are optimistic that once they are trained and fully integrated, billing and productivity will improve, helping to stabilize the budget.

- **Marshall County OP & OR – Erica Player**
  - The behavioral screening process is going smoothly.
  - The PAD form (along with instructions) has been distributed to outreach staff serving adult consumers.
  - One MC intern will be assisting with some CCBHC items (veteran services) and will likely be shadowing with Julianna Davis, Community Outreach Specialist, in the near future.
  - Lisa Clonts, MC AIH TH, is working on her own to explore CBT for psychosis.
  - Staff members are currently working with consumers on crisis plans. The goal is to complete a plan for all consumers.
- **Geriatrics – Gerald Privett**
  - All is going will in the Geriatric Program.
- **Residential – Sherneria Rose**
  - Several former JP staff have been contacted in regard to the possibility of returning to work. One employee will be rehired for DGH, one decided not to return and no response has been received from others.
  - A few individuals have expressed possible interest in working with deaf/hoh consumers, but are not certified in ASL. It was noted that as long as an individual is working toward ASL certification, they can be employed.
- **SA Services – Katrina Ramsey**
  - Census is low (currently 17, with 5 possible admissions tomorrow) due to an outbreak of flu.
  - New Life Methodist Church recently made a generous donation to Cedar Lodge.

VI. Review of wait times

For November, 2024, the following wait times were reported:

MC Intake	5 days	MC MD/CRNP	17 days
JC Intake	6 days	JC MD/CRNP	13 days
Average	5.5 days	Average	15 days

VII. Unfinished Business

- **None noted**

VIII. New Business

- **Update on CCBHC Project–**
  - Myron shared that he, Cammy and Devin are currently working closely with the consultant on the CCBHC Costing Report. The rate needs to be set and submitted by the end of January.
  - Myron compiled a draft listing of new staff positions to be added under CCBHC, which he distributed to all LC members for review and discussion. LC members asked several questions in regard to the listing and explanations were given for many of the new positions.
  - Erica noted that she would begin to develop a draft Org Chart to reflect lines of supervision for the new positions.
  - LC members were encouraged to continue to review and be familiar with the SAMHSA CCBHC Certification Criteria, the CCBHC Implementation Bulletins and the newest Triggering Events Listing.

IX. Adjournment

The Leadership Committee meeting was adjourned at 3:15 p.m.

MOUNTAIN LAKES
Behavioral Healthcare

New Directions

January

Effective January 1, 2025, monthly premiums for LOCAL GOV Medical Insurance will *decrease* to the following amounts.

(MLBHC pays 68% of premium and staff pays 32% of premium)

Ind	**$ 609.00**	**MLBHC**	**$ 414.12**
		Staff	**$ 194.88** ($97.44/pp)
Family	**$1,483.00**	**MLBHC**	**$1,008.44**
		Staff	**$ 474.56** ($237.28/pp)

Personnel Policy Spotlight

4.1.18 Inclement Weather

It is MLBHC's policy that employees make their own decision as to whether to stay home or leave work early in the event that there are severe weather conditions or other uncontrollable circumstances that present concerns for personal safety. Only the Executive Director has the authority to close any MLBHC facility. Employees who take leave for these reasons must use their accrued leave, approved by their Immediate Supervisor or take unpaid leave, which must be approved by the Immediate Supervisor and the Executive Director. This policy applies to both exempt and non-exempt employees.

What's Going On ???

Remaining FY25 Holidays for Full-Time MLBHC Staff

Friday, April 18	Good Friday
Monday, May 26	Memorial Day
Friday, July 4	Independence Day
Monday, September 1	Labor Day

Birthdays

Brad Bewley	Jan 1
Melody Briscoe	Jan 2
Leilani Hayes	Jan 2
Danielle Wilbanks	Jan 4
Shelby Granger	Jan 6
Shelly Pierce	Jan 7
Christy Keeper	Jan 8
Lindsay Alford	Jan 9
Jennifer Riggins	Jan 12
Ryan Hixon	Jan 14
Anna York	Jan 15
Katrina Ramsey	Jan 22
Hannah Robinson	Jan 24
Mark Slade	Jan 28
Dewayne George	Jan 29
Susan Sweatman	Jan 29
Bri McDonald	Jan 30

Anniversaries

Brandon Hardy	1 year
Ivan Taylor	1 year
Haley Nichols	2 years
Leilani Hayes	4 years
Rebecca Cooper	5 years
☺ Loyalty Bonus	$200
Tyler Steed	9 years
Steve Collins	17 years
Julie Burks	19 years
Leah Moore	22 years
Gerald Privett	22 years
Mona Moses	28 years

CPI Training For New Staff

- Tuesday, January 14th
  8:00 am - 11:00 am Admin Office

Staff required to attend
have been notified via email.

~ Monthly Meetings ~

Thursday, January 16th
PI Committee meeting 1:00 pm
Leadership Committee meeting (following PI)
Administrative Office
Quarterly meeting so all attend in person

Tuesday, January 21st
Board meeting 5:30 pm
Administrative Office
(Confirm attendance with Shelly Pierce)

Good Work!

Wall of Fame

Good Work!

November 2024 (I = Incentive)

MC OP & OR
Lindsay Alford
Kali Brand
Julie Burks (I)
Lisa Clonts
Ali Early-Foster
Ashlee Estes
Tina Headrick
Belinda Herring
Stacey Johnson
Christy Keeper
Stephanie Knott
Stephanie Martin
Lindsey Quinn
Jennifer Riggins
Denise Ritchie
Chelsea Roberts
Kimberly Romero
Elizabeth Rucker
Marie Stephens
Elizebeth Traweek
Vanessa Vandergriff
Marili Zurita

Residential
April Burns (I)
Rebecca Cooper
Joanna DeAtley
Sarah Hanna
Brandon Hardy
Leilani Hayes
Ryan Hixon
Desiree Justice
Kimberly McMurrey (I)
Samantha Travis
Felicia Tubbs
Justin Wilson

Multi Programs
Sarah Boxley
Crystal Malone (I)
Lilly Strange (I)

Geriatrics
Mitzi Holcombe
Leah Moore
Mona Moses
Tyler Steed

JC OP & OR
Rob Barrett
Tom Brookshire (I)
Jennifer Brown
Brittany Burkhalter
Brittany Cheek
Audrey English
Dallas Johnson
Shaquitta Sabb
Amanda Whitley
Brooke Whitten (I)

Substance Use
George Bartke
Bob Crowell
Jana Kirkland
Katrina Ramsey
Susan Sweatman
Cindy Woodham

Hello To Our New Employees

MLBHC recently gained two new staff members. **Nicolette Manns** (left), BS, is the Stepping Up Care Coordinator for Marshall County and **Melody Briscoe**, ALC, is a Marshall County Outpatient Therapist.

Family Photos

Amanda Whitley, Therapist for Scottsboro City Schools, with her husband, Wayne, and sons, Alex, Julio, Chris, Mario and Kayden.

Amanda is a first time grandmother and shown in the top photo with her grandson, Milo, who was born on 11/2/24.

MLBHC's Educational Assistance Program

Leilani Hayes utilized the MLBHC Educational Assistance Program and recently received her BS in Psychology.

Leilani has worked for MLBHC since 2021, first serving as a Crisis Counselor for the Alabama Apart Together Grant and then transferring to a LSS position at Marshall Place.

Congratulations Leilani -
We are very proud of you!!!

Newsletter Articles

If you would like to have an article/photo/etc published in New Directions, please e-mail it to Shelly Pierce by the 20th of each month for the next month's publication. Make certain that your submission does not refer to a consumer by name or include any other type of identifying information. If so, you must submit a signed "Informed Consent" specific to each item.

EMPLOYEE spotlight

Vanessa Vandergriff

MC School-based Therapist

ABOUT VANESSA

How long have you been at MLBHC? This time – almost 3 years. I started working at MLBHC while in college. At that time I wasn't sure what I wanted to do – then I decided I wanted to go into counseling. Never looked back.

What is your favorite part of the job? I LOVE my clients.

What do you do for fun? I love to spend time with my family. If we are not at a game or visiting one of the girls, I read or take naps with my fur babies.

What is something unique or interesting about you? I was told I would never be able to have children. God had a different plan.

Do you have kids/family/pets? I have been married to my husband Shane for 25 years. We have 4 amazing girls – Lindsey who is an RN, twins Anna who is majoring in SW at Univ Alabama, Olivia who plays basketball at Lipscomb University, and the baby Mary George who is a Junior at GHS and plays volleyball. We have 4 fur babies Hamlett (cat), Bernie Girl (cat), Susee (rescue from the Fairy Dog Mother) and Louie (Labradoodle)

Do you have a favorite quote or verse? The two things in your life you have total control over are your attitude and your effort – Billy Cox

MLBHC Christmas Party 2024