STRATEGIC PLAN

310 Board Plan

MENTAL HEALTH CENTER
OF NORTH CENTRAL ALABAMA, INC.
Fiscal Year 2025-2026

Received by Board 9-18-25
President Judy M. Thomas

MENTAL HEALTH CENTER OF NORTH CENTRAL ALABAMA, INC.
STRATEGIC PLAN 2025-2026

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Purposes of the Strategic Plan

1. To provide direction and guidance for the leadership of the Mental Health Center, including the Board of Directors.

2. To define the Mental Health Center to our various constituencies, including purchasers of service and regulatory groups.

3. To serve as a guiding tool for employees of the Mental Health Center.

THE STRATEGIC PLAN
REVIEW

This document will be reviewed at least annually.

Board Review: Judy M. Thomas 9/18/25
President / Date

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I. WHO WE ARE

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A. Our Corporate Status

1. The Mental Health Center of North Central Alabama (MHCNCA) is a public, non-profit corporation, incorporated under Act 310 of the Alabama Legislature.

2. We are a PUBLIC organization. The MHCNCA is incorporated for a public purpose, to serve a public need. (Most non-profit organizations are privately incorporated, e.g., churches, advocacy organizations, fraternal organizations, etc.) We are considered quasi-governmental since we are established by local governmental entities: Lawrence County, Limestone County, Morgan County, City of Athens, City of Decatur, City of Hartselle, and City of Moulton.

3. We are a NON-PROFIT organization. That is, the MHCNCA is incorporated for charitable and beneficial purposes without the intent of making profits to be distributed to its owners or shareholders.

4. We are a Corporation. While we are a public, service agency, we are none-the-less a corporate entity. We have a corporate legal status and we operate as a business.

5. We are a local organization. We are governed and operated by a locally appointed Board of Directors. We belong to the community of North Central Alabama. We are not a state agency.

The Board of Directors: Twenty-one directors are appointed by the local governmental bodies previously listed. They are volunteers who are charged with the legal responsibility to oversee the MHCNCA. The Board employs an Chief Executive Officer who is responsible for the operations of the MHCNCA. The Board meets every 3rd Thursday at 12:00 p.m.

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B. Our Mission

The Mental Health Center of North Central Alabama is committed to providing the highest quality treatment, education, and assistance to people affected by mental health and substance use issues.

C. Our Vision

Our vision is to be **the** provider of choice for community mental health. The foundation of our vision is customer satisfaction, responsiveness, accessibility, quality of care, expertise, adaptability and innovation.

D. Our Customers

We are here for our customers and we cannot exist without them. Therefore, we focus our philosophy, our structure, and our resources on them. While it can be quite difficult to manage increasingly limited resources to help an increasingly complex market of customers, we are committed to that task. Even if we cannot satisfy all of the needs and wishes of our customers, we will do what we can.

Types of Customers:

Our customers are of four types: clients, constituents, competitors and co-workers.

1. *Clients*: Clients are **the** ultimate customer, and the reason we are here. Their well-being is the primary focus of our efforts.

2. *Constituents*: Constituents can be individuals or groups who play a vital role in our activities, and who have the ability to affect our operations.

3. *Competitors*: Competitors are other providers who serve the same markets we serve. We treat competitors with courtesy and respect.

4. *Co-workers*: Co-workers are internal customers to one another. Our co-workers deserve the same consideration we extend to our external customers. We will give quality services or products to one another.

Targeted Customers: Purchasers of Services (Prioritized)

The MHCNCA seeks customers who want to purchase services that are consistent with our organization, mission, and vision. These purchasers make services possible, where otherwise

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there might be no services. Purchasers of services, therefore, are the critical link between community needs and the ability of the MHCNCA to meet those needs. The prioritization of these critical customers is as follows:

- Large volume contract purchasers. Examples: Medicaid, Alabama Department of Mental Health, business, Medicare, and industry.

- Agencies and organizations with critical masses of persons needing services who have purchasers for those services and who can be served at the agency's site. Examples: schools and nursing homes.

- Key individual referral sources. Examples: physicians and businesses that contract with the MHCNCA.

Our Targeted Categorical Client Populations (Prioritized)

Purchasers of service determine the client populations the MHCNCA serves, since it is they who provide resources to support the services. Those categorical populations also must be consistent with the mission of the organization. They are prioritized:

- Adults with serious mental illnesses
- Children with severe emotional disturbances
- Geriatric adults with serious mental illnesses
- Adults and children with other emotional problems

Situational and Circumstantial Priorities: Without regard to categorical population or purchaser priorities, situational, and circumstantial priorities are as follows:

- Persons in crisis, with a mental health condition, which could result in danger to self or others, or to property
- Persons discharged from a Designated Mental Health Facility (DMHF)
- Persons in acute distress, with a mental health condition, which could lead to psychiatric hospitalization
- Persons with mental health problems that significantly and negatively affect their life functions

When needs assessments reflect a population in need of services, but there are no resources to provide them, the MHCNCA fulfills its mission by actively seeking sponsors to purchase services on behalf of those in need. When persons seek services from the MHCNCA, which for whatever reason we cannot deliver, we refer them to suitable alternatives in the community.

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E. Our Values and Philosophy

A system of care is based on values and beliefs, whether written or implied. The following statements reflect the values and philosophy of our organization. It is important that every employee understands and embodies these values for the organization to fulfill its mission. The centerpiece of our values is quality to the customer.

1. Satisfaction is the hallmark of quality. We believe that satisfaction with services is the best measure of quality. In the absence of more clearly delineated measures of quality, the primary measure will be customer satisfaction.
2. We believe that our first obligation to our customers is to provide quality services today and improved services tomorrow.
3. We believe quality and productivity are essential. It is the quality of our productivity that matters.
4. Quality can be caused and therefore it can be managed. It doesn't just happen; it is built into the design of our products and processes.
5. The best way to ensure quality is to continually improve our processes.
6. In order to stay in business in an increasingly competitive market, we must become more attractive to our customers. Therefore, we will continue to develop and provide services to meet their needs.
7. A key element to successful performance is for every employee to assume responsibility for the mission and performance of the organization.
8. Prevention of errors, rather than correction, is the best way to achieve quality outcomes.
9. The continual improvement of staff knowledge and skills is essential to performance improvement. This will be accomplished through an ongoing process of training.
10. The first job of management is leadership. We will place in management positions those persons who understand the job and can effectively lead.
11. We believe that our staff take pride in their work and want to contribute to improvements in quality and productivity, which comes from having the tools to do their jobs effectively.
12. We will continue to encourage cooperative efforts by eliminating barriers that separate staff.

F. Our Code of Ethics and Standards of Conduct

The organization's ethical standards permeate all official board-approved documents, such as the Strategic Plan, Operations Manual, Personnel Policy Manual, Corporate Compliance Plan, Performance Improvement Plan and Board By-Laws.

We believe that employees and Board members reflect their commitment to the organization's ethical standards through their knowledge and understanding of those documents and in their compliance with the values and principles expressed therein.

The following summary statements are principles upon which all others are based.

1. We believe it is an ethical requirement that all persons associated with the organization comply fully with all laws relevant to our practice.
2. We believe that it is an ethical responsibility of employees and Board members to share a commitment to our organization's mission and goals, its values and principles, and its policies.
3. We believe that all clients, employees, vendors, payers and visitors deserve to be treated with dignity, respect and courtesy.
4. We believe that all employees share the responsibility for the treatment and satisfaction of all Mental Health Center clients while always respecting and protecting their rights.
5. We believe that the organization, through its employees, shall fully inform our clients of their rights and obligations associated with their care, and to inform them of risks and benefits associated with that care.
6. We believe that it is our ethical duty to do everything reasonably possible to serve those in need of our services; therefore if a person requests services, which we cannot provide, or which he/she cannot or will not accept, we will provide referrals to appropriate alternatives.
7. We believe that the provision of care should be of comparable quality regardless of the setting in which that care is provided.
8. We believe that the organization must respect the client's right to confidentiality and to protect against unlawful or unethical disclosure of confidential information.
9. We believe that we should provide only those services and use only those techniques for which we are qualified by education, training and/or experience and our marketing efforts will represent us accordingly.
10. We believe that employees must respect the clients of the Mental Health Center, and therefore will refrain from attempting to impose their own value systems on the clients, and from engaging in any activity that could be construed as exploitation of clients for personal gain.

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11. We believe that employees should always uphold the integrity of the Mental Health Center, their co-workers and payers, by billing honestly, making only truthful representations and refraining from self-serving solicitations.
12. We believe that employees owe a greater allegiance to higher ethical standards than to compromising relationships; therefore, we are all obligated to report any unethical or illegal behavior to a supervisor or other official.
13. We believe that, in many ways, other health care providers and educational institutions are our partners in carrying out our mission and therefore deserve our respect and cooperation.

Judy M. Thomas
Board President

Lisa Coleman
Chief Executive Officer

The Code of Ethics applies to all employees, board members, students, independent contractors, temporary staff and volunteers.

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G. Our Organizational History

The Mental Health Center has provided mental health services to the people of Lawrence, Limestone and Morgan Counties for more than 57 years. The ongoing interaction and mutual respect between our organization and our community have resulted in continual organizational change in response to shifting community needs, which are frequently defined by the payer. Changes can be characterized in five ways:

- Growth: The MHCNCA has increased service capacity in response to the consistent growth in demands for service by the community. Since our beginnings in 1967 to present day, the number of clients served has increased over 1000%.

- Changes in the revenue stream: Over the years we have evolved from an organization that was wholly dependent on federal grants, through a transition period of being almost totally dependent on state funding, to the current situation of earning a substantial percentage of our revenues through fee-for-service agreements and self-pay.

- Continuity of leadership: In our 57 years, we have had strong continuity of staff leadership and board oversight. During that period, the Mental Health Center has had six Chief Executive Officer. Board Members serve six-year terms.

- Intensive interventions: With the strong emphasis on community care for persons with serious mental illnesses and children with severe emotional disturbances, our base client population has demanded, and we have delivered, more intensive interventions to fewer, more severely disturbed clients. Today over 90% of our clients are those who are seriously impacted by their mental illness. Other categorical client populations that are growing include our Residential programs and Outreach programs.

- Increased competition: The Mental Health Center is in one of the most competitive arenas in the State of Alabama, and we have continued to improve the quality of our services, the efficiency of our delivery system, and the attractiveness of our array of services to thrive in a competitive environment.

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H. A Historical Sketch

- 1967 – The Board was incorporated under the name of The North Central Alabama Mental Health Board, Inc. It was originally incorporated as a private non-profit organization.
- 1968 – The first Executive Director, David Loiry was employed and the Mental Health Center began providing services.
- 1971 – The second Executive Director, Preston Bryant, was employed.
- 1974 – The third Executive Director, James Meherg, was employed.
- 1978 – The fourth Executive Director, Thomas Salter, was employed.
- 1982 – The Mental Health Center changed its corporate status to public non-profit.
- 1996 – The name was changed to The Mental Health Center of North Central Alabama, Inc.
- 1999 – Thomas Salter retired and the fifth Executive Director, Marie Hood was named.
- 2016 – Marie Hood retired and the sixth Executive Director, Lisa S. Coleman was named.

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I. Our Resources

As a public non-profit organization, we have resources for one reason: to carry out our mission to do what we can to provide treatment, education, and assistance to people affected by mental health and substance use problems. Any resources we earn, or are given, must be used to fulfill that mission. We differ from for-profit organizations in that we do not help people in order to generate revenues; we generate revenues in order to help people.

To meet all of the diverse needs of a diffuse and complex market would require an equally diversified and unlimited array of resources. Such a resource pool is not feasible. Our response is to search continually for payer sources to enable us to serve the enormous needs of our community.

The most important resource we have is our people. It is our people who translate tangible, financial resources into customer satisfaction.

The sources of our financial resources are:

- Medicaid
- Medicare
- Commercial Insurance
- Self-Pay
- State Service Grants
- City-County Appropriations
- Federal Funds
- United Way
- Donations
- Miscellaneous

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II. WHAT WE LOOK LIKE

A. Our Concept of Structure

Every organization must have structure to exist. Philosophy and values without structure are scattered and ineffective. If quality to our customers is to be ongoing, it must be built into the structure of the organization.

We have structured our organization in a way that allows us to:

- be consistent with our mission and vision;
- focus on our customers;
- be consistent with our philosophy and values;
- encourage teamwork;
- continually improve our processes, our products, and our services;
- allow all levels of employees to participate in decision-making; and
- have a single point of contact.

B. Steering Team

The responsibility for coordinating and overseeing this complex structure rests with the Steering Team. The Steering Team is comprised of the Chief Executive Officer, Clinical Director, Chief Financial Officer, and Chief Human Resource Officer. Each member is responsible for coordination and oversight functions in his/her respective stream and working within the steering structure to inform and organize for the benefit of the whole organization.

Specific oversight functions of the Steering Team include:

- Strategic Planning
- General direction and oversight to work groups
- Resource allocation
- Utilization of resources and monitoring of service effectiveness
- Compliance with laws and standards which affect the organization's ability to function (including Alabama Department of MH – Service Delivery Manuals, contracts, and applicable local, state and federal laws and regulations)
- The organization's Corporate Compliance Plan (The Steering Team serves as the Corporate Compliance Team)

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C. Family Involvement and – Client Needs (Input and Feedback for Needs Assessment)

Our ability to achieve our mission depends on how well we assess the needs of the community in which we operate. Responding effectively to the needs of those who are affected by mental health and substance use issues requires that those people become involved in an integral way in the planning and performance of all relevant functions. Clients and their families are built into the heart of our operations.

- Treatment and Care: Clients and their families participate actively with their clinical staff in the planning process of their treatment and care. Treatment goals are their goals, and the process is driven by their needs as evidenced by the Person Centered Treatment Approach.

- Satisfaction Surveys: Survey forms are mailed to a sample group of clients from each program on a monthly basis with self-addressed, stamped envelopes for ease of return. Responses are reviewed and reported monthly. Reports are submitted to staff, the Board of Directors, and others as requested. Appropriate follow-up actions are taken.

- Client and Family Feedback Survey: As a part of the Quality Assurance Performance Improvement process, Client and Family Feedback Surveys are mailed each month to those clients whose records are reviewed by the team. Returned surveys are reviewed by the Clinical Director for needed follow-up and performance improvement or other team action. The Mental Health Center of North Central Alabama, Inc. believes that it is important to get input from the families of our clients, as well as the clients themselves.

- We also participate in the Mental Health Statistics Improvement Program (MHSIP) which was developed by the Alabama Department of Mental Health to improve the quality of decision making for all mental health stakeholders through guidance and technical assistance on the design, structure, content, and use of mental health information systems. MHSIP provides uniform, comparable statistical information about mental health services to enable broad-based research on systems of care and models for service delivery. MHSIP is the only program in the Nation focusing on the need for and development of data standards for high-quality statistical information on mental health services. Feedback from the MHSIP surveys and the Client and Family Feedback Survey has led to changes to our Client and Family Handbook and changes in the treatment process to involve the family more in client services when applicable.

- Advisory Councils: Advisory Councils coincide with constituency groups, representatives of consumers, family members, agency heads, and other stakeholders. The Advisory Council is geared toward educating the public and is comprised of consumers, family members of

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consumers, local advocacy groups, and other community organizations. MHC representatives / leaders in mental illness, geriatric, and children's programs provide overview of services and center performance. These cross-agency meetings allow for feedback in developing / changing services to our recipients, thus giving us a more in-depth assessment of the needs of the community. This concentrated organizational effort has allowed us to assess the needs of the community more efficiently and implement new services more quickly. The council members are approved by the Board of Directors; they provide customer input and feedback for the respective service units. The Human Rights Committee serves in an advisory capacity on client rights – related issues.

- Quest Prevention Services spends a considerable amount of time collaborating with local and state agencies. They work to prevent underage pregnancy, alcohol misuse, and abuse with a focus on underage drinking and prescription abuse. The staff also is often called upon to speak to local agencies to share their knowledge of these important prevention issues.

- Child and Adolescent Services: Child and Adolescent staff in all three counties participate in local Children's Policy Councils to insure the needs of this population are being met. Staff often collaborates with DHR and local school systems to assist with the needs of children.

- Staff Input: Each program location shall have mechanisms to solicit staff input for improving policies and procedure, client care, processes, and quality improvement practices.

- The MHCNCA Board of Directors: The Board of Directors is comprised of citizens who are appointed by the city and county governments to represent the interests of the broad community and to oversee the operation of the MHCNCA. All Board members participate actively in carrying out the mission of the organization.

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III. WHERE WE ARE GOING

A. The Planning Process

Planning is an ongoing process of gathering information, interacting with customers, establishing goals, implementing services, reviewing performance data, making corrections and redirecting when needed. The Steering Team is responsible for guiding the Strategic Planning process, subject to the approval of the Board of Directors.

The planning process begins in the 2nd quarter of each year, when the Steering Team assimilates stakeholder's feedback and internal information to formulate direction and priorities. During this time, The Steering Team reviews input information from available sources, including staff from both vertical and horizontal teams, advisory councils, community planning groups, the knowledge and assumptions of the Steering Team members, the Board of Directors, formal and informal consumer feedback, and payer demands and expectations. It is with this knowledge base that the Steering Team reviews the organizational mission, vision, customers, values and philosophy. This information is then used to establish the Focus Areas and identify Strategic Goals for the upcoming year.

During the 3rd quarter of the year, Supervisors and team leaders are briefed on the elements of the planning process, including the Focus Area (s), Planning Assumptions, and tentative organizational goals and financial parameters. Conversely, supervisors and team leaders provide input regarding their resource needs (financial, staff, facilities, information, etc.).

All work groups and teams develop a plan for the upcoming year to ensure that team and unit goals are derivative of and contributory to the organization's goals. Chief Financial Officer coaches administrative units and works with program directors and team leaders regarding budget development.

At the August Board Meeting, the Steering Team reports to the Board of Directors as a checkpoint in the planning process. The Board of Directors will review the work-in-progress. Topics such as presentation of program overviews; review and discussion of needs assessment and planning assumptions; Focus Area(s), goals, and specific initiatives are discussed. The Board gives official "go ahead" to proceed with the planning.

At the end of the fiscal year, the Board of Directors approves the final plan. After approval, the Steering Team disseminates the updated Strategic Plan, including Focus Areas and Identified Goals via the vertical structure of the organizations.

On October 1, the plan is implemented. This process is self-renewing in that input and feedback are constantly being received from customers, staff, Board, advisory councils and others. For example:

1. The combined Advisory Council meets at least two times a year. The minutes of each meeting is circulated to the Steering Team, Board of Directors, and appropriate programs. Recommendations are passed along to appropriate teams and work groups.

2. All PI Teams route their minutes, via intranet / SharePoint, to the Steering Team for the purpose of coordination and oversight. This information feeds into the planning process.

3. Performance and financial reports are broadly circulated and reviewed, and analyzed on a monthly basis by the program directors and the Steering Team.

4. Satisfaction is assessed on an ongoing basis. Examples of the assessment include: audits, feedback, an increase in contracted services, and new contracts with county agencies.

All of these sources are fed into the ongoing planning process and corrections are made in the plan as needed. Any element of the planning process, or of the plan itself, is subject to change as indicated by changes in the environment, payer demands, consumer needs, crisis situations feedback from monitors, or unforeseen opportunities. In such cases, the Steering Team reviews data, decides on an action plan and implements the plan.

B. Our Assumptions, Expectations & Anticipated Needs about the Future

The planning assumptions reflect the information received from such sources as our advisory councils, consumer councils, community constituencies, contractors and other revenue sources, healthcare sector literature, and feedback from client satisfaction surveys. The assumptions reflect the consensus of the Steering Team relative to the future of our organization and become a driving force in our planning.

Assumption #1: We will face strong competition for our traditional markets.

Action Implications:

1. We must know the competition.
2. We must exceed the competition's quality.
3. We must remain financially stable.
4. We must diversify our markets.
5. We must better define who our customers are, and who they should be.
6. We must continually identify and reduce waste.

7. We must network with community providers to meet competition more effectively.

Assumption #2: Money for Mental Health Care will be more difficult to obtain.

Action Implications:

1. We must be more efficient, creative, and innovative in service delivery systems and in use of staff time.
2. We must be willing to divert our resources to act on opportunities.
3. We must be aware of where, how, and if it cost effective, to access resources.

Assumption #3: The mental healthcare system will continue to be payer and quality driven.

Action Implications:

1. Structure the service delivery system around customer needs, while satisfying payer and quality demands.
2. We must have a mechanism to know if we are satisfying our payers and quality.
3. We must educate caregivers and clients regarding the role, benefits, and limitations of their payer and quality services.
4. We must train staff to work in a payer and quality-driven system.
5. We must promote ourselves.

Assumption #4: Desirable employees will be those who are flexible, adaptable, and versatile with marketable skills.

Action Implications:

1. Improve staff skills through targeted training.
2. We must develop leadership skills among staff.
3. We must educate staff about why changes occur, and support them during change.
4. Improve staff retention..

Assumption #5: Based on technological and medical advances, mental health care, as we know it, will continue to evolve.

Action Implications:

1. We will do more research and development to keep abreast of cutting edge technologies.
2. We will put resources into technological and medical advances.
3. We will utilize more non-traditional forms of services.

4. We will explore other funding services, i.e., grants.
5. We will explore different corporate configurations/structures.
6. We will acquire state of the art equipment.

C. Strategic Goals 2025-2026

Goal 1: Ensure customer satisfaction by continuously improving the quality of services provided through strengthening the competency of our staff via education and trainings.

Goal 2: Maintain current and develop new revenue streams to ensure a positive financial outcome.

Goal 3: Acquire, train and retain quality staff.

Goal 4: Continue development and implementation of the Electronic Medical Record (ECHO)

Goal 5: Continue to plan and build the Crisis Residential Unit to be a part of our crisis continuum of care.

Goal 6: Continue participation in the Alabama Department of Mental Health Certified Community Behavioral Health Center (CCBHC) Initiative.

Goal 7: Explore options for new office space for the Community Residential Campus / Mapleleaf program personnel.

IV. BOARD INFORMATION

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MENTAL HEALTH CENTER
OF
NORTH CENTRAL ALABAMA, INC.
2025-2026

BOARD OFFICERS

Judy Thomas, President
Crawford King, Vice President
Allee Kitchens, Secretary
Freda Stephenson, Treasurer

BOARD MEMBERS

Blythe Bowman
Marty Fisher
Wanda Fry
John Griffith
Judy Henry
Karen Howell
Kris Long
Nancy McDonald
Lisa Payne
Bert Pippen
Stacy Rose
Jennifer Sittason
Helen Thompson
Henry White
John Whitley

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V. APPENDIX

APPENDIX A: Programs

Decatur – Morgan Counseling Center: Provides outpatient treatment, psychiatric medical services, day treatment, wrap-around services, case management, and education for the seriously mentally ill adults and their families. Participants in this program have often experienced psychiatric hospitalization and are at risk of returning to the hospital without this support.

Moulton – Lawrence Counseling Center: Offers treatment and education for children with severe emotional disturbances and seriously mentally ill adults and their families. The MLCC provides outpatient treatment, psychiatric medical services, day treatment, wrap-around services, case management, and school services. Participants in this program have often experienced psychiatric hospitalization and are at risk of returning to the hospital without this support.

Athens – Limestone Counseling Center: Provides outpatient treatment, psychiatric medical services, day treatment, wrap-around services, case management, and education for the seriously mentally ill adults and their families. Participants in this program have often experienced psychiatric hospitalization and are at risk of returning to the hospital without this support.

Athens – Limestone Youth Counseling: Is an outpatient-counseling clinic offering a wide range of psychiatric and psychological services for children and adolescents with severe emotional disturbance. Other services include in school interventions, wrap-around services, intensive care coordination, peer support and therapeutic mentoring.

Residential Services: Provides residential programs for the seriously mentally ill. The Mental Health Center has a group home in each county that houses a total of 34 individuals. The Community Residential Campus provides housing for 9 individuals. The George Home provides housing for 3 individuals.

Geriatric Services: The program goes on-site into local nursing homes in Morgan, Lawrence, and Limestone Counties to provide assessment, evaluation and therapy for the elderly and their families. It addresses the needs and the mental health problems of this special population.

The Medical Unit: Provides medication evaluations, psychotropic medication prescriptions, and monitoring. Serving the three-county area, this special unit seeks resources for the indigent clients.

Quest Prevention Services: This program provides an array of services including prevention of underage pregnancies, drug, and alcohol misuse and abuse with a focus on underage drinking and prescription use and abuse.

Children's Albany Clinic: Is an outpatient-counseling clinic offering a wide range of psychiatric and psychological services for children and adolescents with severe emotional disturbance. Other services include in school interventions, wrap-around services, intensive care coordination, peer support and therapeutic mentoring.

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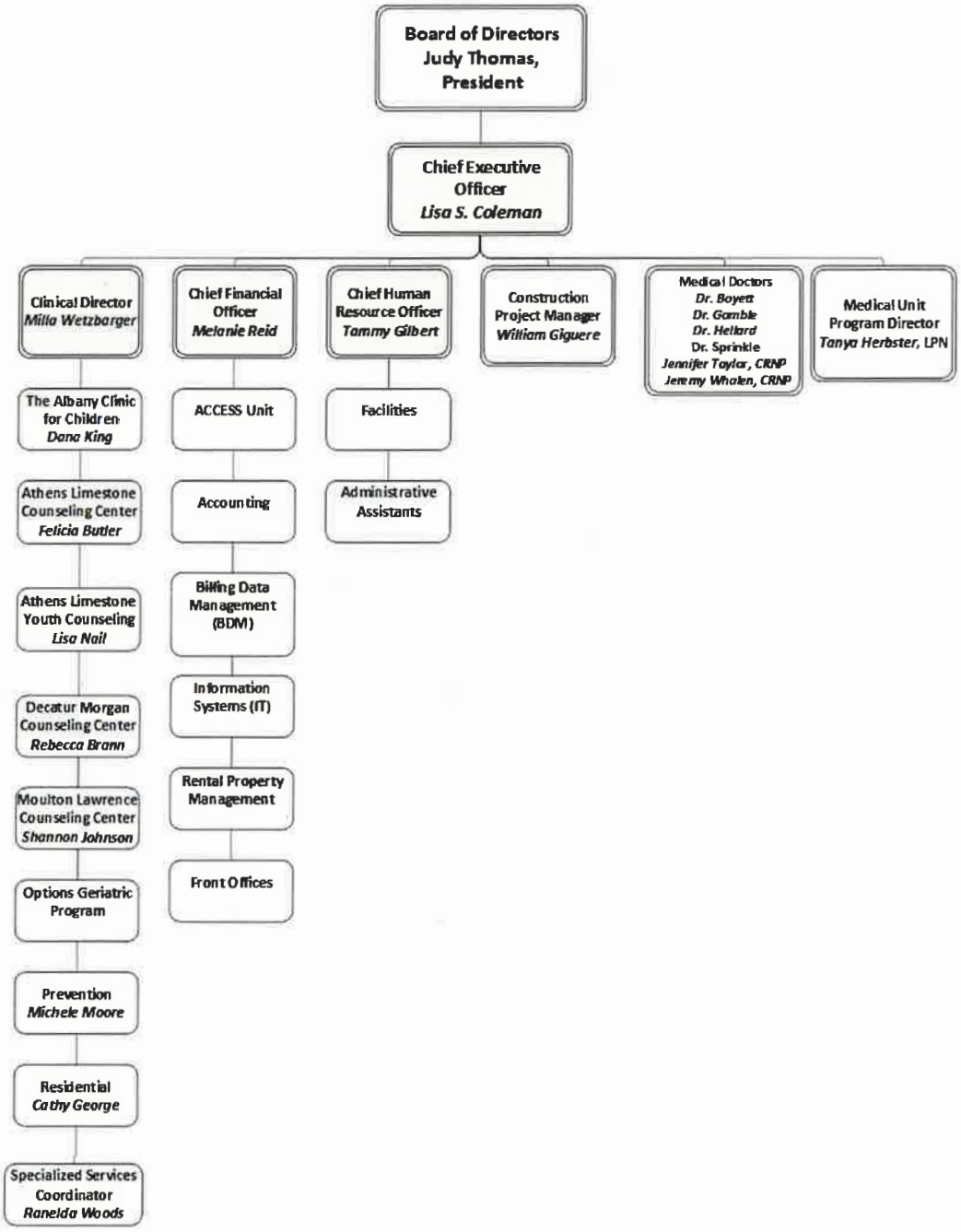
APPENDIX B: Organizational Chart #1

MENTAL HEALTH CENTER OF NORTH CENTRAL ALABAMA, INC.



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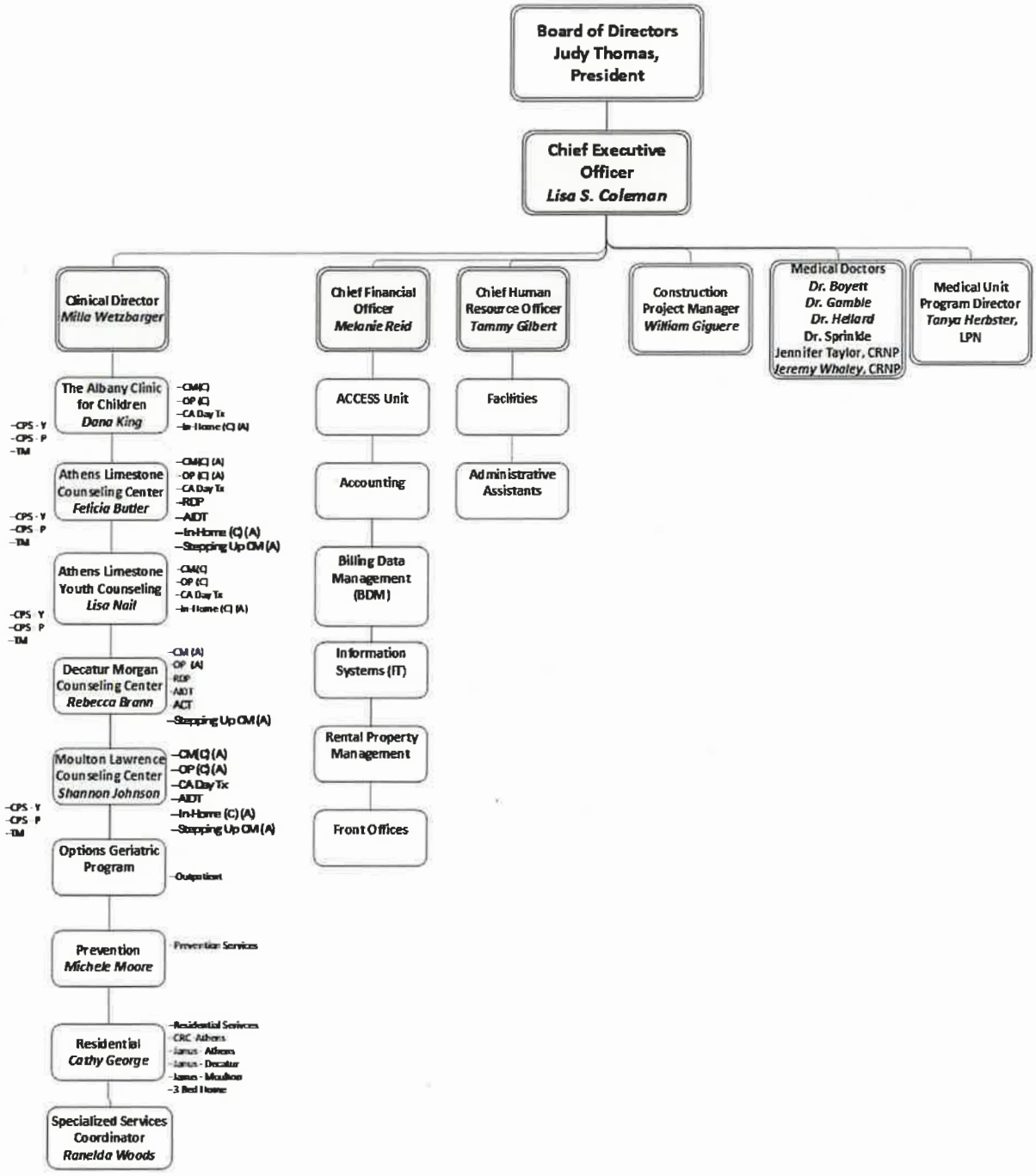
APPENDIX B: Organizational Chart #2

MENTAL HEALTH CENTER OF NORTH CENTRAL ALABAMA, INC.



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APPENDIX C: Standing PI Teams

Billing and Collections Team:

Mission: Assume responsibility for the stability and oversight of the billing and collection process with authority to make changes to improve it.

Function: Monitor billing and collections on an ongoing basis and intervene as necessary; promote training for staff.

Quality Assurance / Performance Improvement Team:

Mission: To develop, implement and monitor a Performance Improvement System that incorporates all required elements of the Performance Improvement section of DMH Standards.

Function: Ensures compliance with Performance Improvement standards of DMH.

Records Improvement Team:

Mission: To assess the stability of the clinical records system and its processes and continually improve them.

Function: Maintain up-to-date record audit manual; train staff in recording; measure records accuracy; continually improve records audit process; approve forms that go into records; oversee entire records system.

SMI Care Team:

Mission: To ensure an effective system of care for SMI adults at risk of entering and being discharged from state hospital systems by coordinating, monitoring and improving services.

Function: Provide effective liaison with state hospitals; ensures contracts compliance; monitors and oversees state hospital census reduction.

HIPAA Task Team:

Mission: To establish, implement, and enforce policies that assure compliance with federal HIPAA Privacy and Security Rules, and the HITECH Act.

Function: To establish compliance standards, policies and procedures for HIPAA and HITECH, to communicate those policies to the Workforce, to conduct scheduled reviews of those policies, to conduct scheduled Risk Analyses to identify and improve areas where there may be risk, and to monitor Workforce compliance with policies.

ECHO Project and EMR Sub-Committees:

Mission: To establish and implement an electronic medical records system, and to monitor and review associated processes allowing continual improvement of the most effective EMR possible.

Function: To identify and implement necessary infrastructure improvements; to identify, review and update processes affected by and associated with an EMR (client care, documentation, scheduling, billing, reporting of data for oversight, reporting of data for meaningful use, and quality measures...); and to train Workforce on those processes.

Stepping Up Initiative Team

Mission: To coordinate all Stepping Up services to ensure consistency in quality and procedures; and to be knowledgeable of all contractual regulations supporting the Stepping Up Initiative and ensure optimum satisfaction of the requirements of the funding constituents.

Function: Develops protocols to ensure that the integrity of the Stepping Up Initiative is adhered to and completed in a timely manner.

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