

PURPOSE

- The intent of this plan is to develop a strategic approach to the orientation, training and development of those directors/members governing the affairs of QBH, INC., as evidence of our commitment to being a learning organization.
- The focus shall be to facilitate those directors'/members' governance by keeping them informed about the issues, practices and trends that impact the direction and quality of health care delivery.

BOARD ORIENTATION

- The CEO and Board Chair shall develop and maintain a current Board Director/Member Activities Binder that shall include at least the following:
 - Company Mission and Vision Statements, Goals and Objectives and Strategic Plan
 - Governing Board Bylaws and Board Policies
 - Clinical Services Plan, including information on populations served
 - Quality System Plans (including QM, Safety/RM, Infection Control and Utilization Management)
 - Board Member Position Description, CEO Job Description
 - Company Organizational Chart and Narrative
 - Roster of Board Directors/Members, including addresses and phone numbers
 - Roster of key Administrative contacts with phone numbers
 - Educational Calendar and External Education Forms
 - List of Board quality indicators, if applicable
 - Board Meeting Agenda Calendar
 - Financial audit, Annual Budget and Monthly Budget Reports
 - References for applicable law and regulations that apply to QBH, Inc. operations
- The CEO and Board Chair or designees shall review each of the documents in the Binder with the new Board director/member, particularly emphasizing the relevance of each document to the Board director's/member's duties and responsibilities.
- The CEO shall discuss the services/ programs offered by the organization to facilitate the new director's/member's understanding of the organization's purpose. A physical plant tour may be provided.
- The Board Secretary shall keep a record of each Board Director's/Member's completed orientation. The CEO is responsible to notify the Secretary when the new director's/ member's orientation has been completed.

BOARD DEVELOPMENT

- **Annually Board Self Evaluations** and evaluations of the previous year's educational programs shall be conducted. The information from these evaluations, coupled with health care, Company, community and economic trends, shall be used to develop the educational

curriculum for the next fiscal year. The organization budget shall include allocations appropriate to the educational needs of the Board.

- Board directors/members shall be kept informed about educational opportunities in the following manner:
 - A calendar defining the educational curriculum for the year shall be developed by the CEO and Board Chair or designees and distributed to each Board director/member for placement in their Board Activities Binder a month prior to the beginning of the next fiscal year.
 - The calendar shall contain a minimum of one education program quarterly to be held during a regular Board meeting.
 - Modifications to the curriculum will be noticed at Board meetings as needed.
 - Information regarding external educational opportunities will be distributed at Board meetings.
 - Any Board director/member who attends an external educational option shall provide a brief summary of what was learned to the rest of the Board at the next scheduled Board meeting.
 - Board director/member attendance at external educational offerings for which the organization shall bear expense must have prior approval of the Board.

TRAINING APPROACHES

- A variety of approaches to education shall be utilized to achieve Board development. Approaches may include:
 - Board Retreats, Board training as a part of scheduled Board meetings, Conferences, audio/video tapes, individual learning through reading of periodicals and books.
 - Training may be provided by Board directors/members, key Company staff and leaders, consultants and/or other outside experts.
 - Retreats, if held, shall include Board directors/members, executive management and clinical leaders. Retreat agenda shall include both internal and external issues.
 - Board directors/members may be provided with a subscription to a relevant periodical.

TRAINING TOPICS

- Subject areas of particular relevance to Board director/member functioning include:
 - Quality system development
 - Health care reform
 - Health care economics
 - Community expectations
 - Customer service/public relations
 - Company relationships
 - Legal issues in health care and mental health
 - Budget/strategic planning process/Addictions programs/services/trends

DOCUMENTATION

- The Board Secretary shall keep a log of each Board director's/member's participation in educational activities.

- It will be the Board director's/member's responsibility to inform the relevant Secretary of any external education he/she attends, using the form established for that purpose (copies included in Board Activities Binder).

EVALUATION PROCESS

- **Annually** an evaluation of the Boards' Orientation and Development Plan and the previous year's program offerings shall occur.
- The CEO shall be responsible to distribute the evaluation forms and to aggregate the results for presentation at the next meeting of each Board.
- The results and any Board recommendations shall be considered in the formulation of the educational calendar for the ensuing fiscal year.

EVALUATION

- The plan is reviewed and revised, if necessary, by the CEO at least annually, (every twelve months +/- 30 days), and submitted to the Clinical Committee and the Board for review and approval.

FORMS:

- Board Self Evaluation Form
- Board Evaluation Aggregate Form

RISK MANAGEMENT

IDENTIFICATION OF LOSS EXPOSURES

- Quality Behavioral Health, Inc. is committed to the ongoing identification, analysis and evaluation of loss exposure (risks) and the selection of the most advantageous method of preventing and, if an event occurs, treating it. This process involves a four-step process:
 - Risk identification
 - Risk analysis
 - Risk prevention and intervention
 - Risk control (e.g., internal control, external control)
 - Risk financing (e.g., cost associated with insurances)
 - Evaluation of risk prevention and intervention strategies, including performance improvement measures and, if needed, projects
 - Reporting of results of prevention/intervention actions to leadership
- Additionally, QBH practices risk management by identifying, addressing, preventing, and monitoring situations that could result in:
 - Injury and liability
 - Financial loss
 - Regulatory non-compliance

GENERAL SCOPE OF COMPANY RISK

- Risk management is woven throughout the entire organizational structure of QBH. All Board of Directors members, executives, managers, staff and volunteers are charged with risk management responsibilities under the direction of the Chief Executive Officer who is responsible for integrating all components of the risk management program.
 - The Clinical Committee addresses risk management during one meeting per quarter and whenever deemed necessary. This team activity focuses on:
 - Developing formal and informal mechanisms for risk identification and review of pertinent safety and quality information.
 - Developing policies and procedures in key areas of risk management interest, such as informed consent, confidentiality, fraud and abuse and adverse incidents.
 - Promoting compliance with applicable laws and regulations such as the Health Insurance Portability and Accountability Act (HIPAA) and accrediting organization requirements, such as The Joint Commission (JC).

GOVERNANCE AND MANAGEMENT OF RISK

RISK IDENTIFICATION

- Governance and Management risk are key areas of risk with respect to employment, contracting and virtually all areas of organizational operation.

RISK ANALYSIS

- Governance is the highest level of responsibility with respect to risk. It is essential for the Board of Directors to oversee that risk management practices and procedures are in place to manage potential risk that could impact the well-being of QBH. This activity must be monitored, evaluated and reported to the Board of Directors regularly with a comprehensive written report

annually.

RISK PREVENTION AND INTERVENTION

- Risk control (e.g., internal control, external control)
 - There are many ways that QBH can have internal control with respect to risk management. The greatest internal control is having an exemplary understanding and practice of standards as established by JC. These standards are the primary way that comprehensive systems are put in place that will ultimately lead to risk management.
 - External means of displacing risk in the area of internal control includes insuring risk through insurances such as Directors' and Officers' Liability Coverage. This allows QBH to displace risk that could lead to significant financial exposure through legal costs, settlements and damages. It is essential that QBH understand and secure the best insurance coverage possible in order to limit risk.
- Risk financing (e.g. cost associated with insurances)
 - This cost should be developed appropriately using Generally Accepted Accounting Principles (GAAP) in addition to any cost mandates that are imposed by legal contracts. The resources to carry these costs may be reflected in direct service charges to third party payers.

EVALUATION OF RISK PREVENTION AND INTERVENTION STRATEGIES

- The most appropriate means of evaluating this risk is to systematically review the following:
 - Develop formal and informal mechanisms for risk identification and review of pertinent safety and quality information. These may include Incident Reports, grievances, binding arbitration cases, consumer rights complaints, etc.
 - Develop policies and procedures in key areas of risk management interest, such as informed consent, confidentiality, media management, fraud and abuse and adverse incidents. The type of policies that would ultimately impact risk is the Governing By-Laws, Personnel Policies, policies addressing JC Standards, etc.
 - Promote compliance with applicable laws and regulations such as the Health Insurance Portability and Accountability Act (HIPAA) and accrediting organization requirements, such as the JC. The compliance with laws and regulations is best completed by consistent education and legal counsel.

FINANCIAL RISK

RISK IDENTIFICATION

- Financial risk is not always easy to identify. Therefore, appropriate internal controls and financial third-party audits are essential. Risk areas include, but may not be limited to, fraud, embezzlement, catastrophic revenue loss, legal costs, settlements and awarded damages.

RISK ANALYSIS

- QBH has financial risk like any other for-profit or non-profit organization, large or small. Therefore, strong policies, procedures and practices must be in place. The Board of Directors and the Clinical Committee drive these activities. Each group should support and challenge the other.
- The insurance package of QBH is reviewed by the CEO and Board annually to assess its adequacy to protect QBH's assets. The review includes adequacy in at least the following areas:
 - Property coverage
 - Liability coverage such as

- Indemnity coverage
- Workmen's Comp coverage
- Malpractice coverage

RISK PREVENTION AND INTERVENTION

- Risk control (e.g., internal control, external control)
 - The internal risk control consists of carefully drafted governing by-laws and fiscal policies and procedures. The internal controls begin here and are monitored by an annual audit by a Certified Public Accountant retained by the Board of Directors and assisted by the Deputy Director of Operations.
 - External control begins by managing any aspect of fiscal risk as is possible. This should be done in cooperation with the Board of Directors and CEO in conjunction with QBH insurance vendor. A variety of insurance products can be purchased which will protect many aspects of financial risk (e.g., error and omission, lost revenue, workmen's compensation, etc.)
- Risk financing (e.g., cost associated with insurances)
 - This cost should be developed appropriately using Generally Accepted Accounting Principles (GAAP) in addition to any cost mandates that are imposed by legal contracts. The resources to carry these costs may be reflected in direct service charges to third party payers.

EVALUATION OF RISK PREVENTION AND INTERVENTION STRATEGIES

- The most appropriate means of evaluating this risk is to systematically review the following:
 - Develop formal and informal mechanisms for risk identification and review of pertinent quality improvement information. These may include but not limited to exit interviews, Incident Reports, pharmacy reports, no-show reports and productivity reports. All such data has a direct impact on financial risk.
 - Develop policies and procedures in key areas of risk management interest, such as informed consent, confidentiality, fraud and abuse and adverse incidents. Key financial risk management policies that impact financial risk are the Accounting Policies and Procedures, Personnel Policies and Procedures, Governing By-Laws.
 - Promote compliance with applicable laws and regulations such as the Health Insurance Portability and Accountability Act (HIPAA), COBRA, IRISA, and accrediting organization requirements, such as the JC. The compliance with laws and regulations is best completed by consistent education, accounting audits and legal counsel.

HEALTH AND SAFETY RISK

RISK IDENTIFICATION

- Health and safety risks will be identified by the Clinical Committee from safety and quality reports, recipient rights reports, incidents, financial reports, etc.

RISK ANALYSIS

- Health and Safety Risk Management involves monitoring the data that becomes available from the above-mentioned data sources. Each entity and data source will represent prospective and retrospective outcomes which will speak to areas of health and safety risk.

RISK PREVENTION AND INTERVENTION

- Risk control (e.g., internal control, external control)
 - The internal controls include complying with infection control and safety practices of QBH, leadership placing a high priority on these areas and conveying that to staff and consumers, promoting proactive efforts to maintaining safety and health, and responding quickly to any breaches in these areas.
 - External controls include staying compliant with required inspections in safety, fire and health arenas with quick response to any deficiencies, staying informed of changes in law or practice related to these areas, and continuously maintaining satisfactory licensing and accreditation status.
- Risk financing (e.g., cost associated with insurances)
 - Maintenance of indemnity insurance, workman's comp insurance, providing sufficient health insurance options for staff, enforcing sick leave policies help to maintain cost controls.

EVALUATION OF RISK PREVENTION AND INTERVENTION STRATEGIES

- Develop formal and informal mechanisms for risk identification and review of pertinent safety and quality improvement information. These may include but are not limited to exit interviews, Incident Reports, safety reports, HR reports. All such data has a direct impact on financial risk.
- Develop policies and procedures in key area of risk management interest, such as informed consent, confidentiality, fraud and abuse and adverse incidents. Key financial risk management policies that impact financial risk are the Accounting Policies and Procedures, Personnel Policies and Procedures, Governing By-Laws.
- Promote compliance with applicable laws and regulations such as the hand washing and infection control practices, safety guidelines, COBRA, ERISA, and accrediting organization requirements, such as the JC. The compliance with laws and regulations is best completed by consistent education, accounting audits and legal counsel.

CONSUMER PROTECTION

RISK IDENTIFICATION

- Monitoring of grievances and appeals of consumers, satisfaction survey results, Incident Reports and sentinel event data, and clinical outcomes data help QBH identify risks to consumers.

Risk Analysis

- Data listed above should be monitored for any negative trends that give direction for correction or improvement in policies or practices.

RISK PREVENTION AND INTERVENTION

- Risk control (e.g., internal control, external control)
 - Internal controls include having well defined policies and related training associated with consumer rights, accurate and timely identification and address of consumer risk and needs, sustaining state of the art safety practices in the areas of service delivery and facilities/grounds maintenance, compliance with HIPAA regulations and consumer rights, maintaining consumer advocacy services, involving families, and keeping consumers involved in their care decisions.
 - External controls include community involvement of staff as advocates and educators about mental health consumers and their needs, steadfast efforts at care coordination with outside agencies involved in a consumer's care, compliance with regulatory and accreditation standards that promote a consumer focus, and being vocal about legislative action to promote the well-being of consumers.

- Risk financing (e.g., cost associated with insurances)
 - Adequate insurance coverage for QBH, its facilities and liabilities is important to reducing costs associated with consumer protection.

EVALUATION OF RISK PREVENTION AND INTERVENTION STRATEGIES

- Develop formal and informal mechanisms for risk identification and review of pertinent quality improvement information. These may include but are not limited to consumer feedback, Incident Reports, safety reports, no-show reports and productivity reports. All such data has a direct impact on financial risk.
- Develop policies and procedures in key area of risk management interest, such as informed consent, confidentiality, fraud and abuse and adverse incidents. Key financial risk management policies that impact financial risk are the Accounting Policies and Procedures, Personnel Policies and Procedures, Consumer Rights and Advocacy Policies, HIPAA Policies.
- Promote compliance with applicable laws and regulations such as the Health Insurance Portability and Accountability Act (HIPAA), OSHA and ADA regulations, and accrediting organization requirements, such as the JC. The compliance with laws and regulations is best completed by consistent education, accounting audits and legal counsel.

PROFESSIONAL RISK

Risk Identification

- Monitoring of staff performance, compliance with codes of ethical practice, Incident Reports, HR reports, staff satisfaction survey results, and morale of staff give critical insights into professional risk issues.

RISK ANALYSIS

- Analysis of the aforementioned data, particularly being attentive to trends, will give insights into areas of risk that are either being effectively or ineffectively managed.

RISK PREVENTION AND INTERVENTION

- Risk control (e.g., internal control, external control)
 - Maintaining state of the art personnel policies, emphasizing continuous training, providing ongoing supervision, complying with privileging laws and DES guidelines, recognizing outstanding performance, promptly attending to staff grievances, leadership consciousness to staff morale and having an open-door policy, providing resources staff need to effectively and efficiently perform their jobs are important internal controls to manage Professional Risk.
 - External controls include utilization of external sources (e.g., NPDB, data generated by licensing boards) in credentialing and privileging activities, and staying competitive with regional pay and benefit data, tapping local, state and federal training opportunities to keep staff's practices current.
- Risk financing (e.g., cost associated with insurances)
 - Providing and/or requiring staff to maintain Professional Liability Insurance is critical to maintaining costs related to Professional Risk.

EVALUATION OF RISK PREVENTION AND INTERVENTION STRATEGIES

- Develop formal and informal mechanisms for risk identification and review of pertinent quality improvement information. These may include but not limited to exit interviews, Incident Reports, HR reports, productivity reports, staff satisfaction surveys, turnover rates. All such data has a direct impact on financial risk.

- Develop policies and procedures in key area of risk management interest, such as personnel policies, professional and Company codes of ethics, practice guidelines for service delivery, staff grievance procedures.
- Promote compliance with applicable laws and regulations such as the Health Insurance Portability and Accountability Act (HIPAA), COBRA, ERISA, HealthCare Quality Improvement Act, DES and ADA regulations, OSHA guidelines, and accrediting organization requirements, such as the JC. The compliance with laws and regulations is best completed by consistent education, attention to staff needs, and legal counsel.

LEGAL AND STATUTORY RISK

RISK IDENTIFICATION

- Monitoring of results from licensing/certification surveys, feedback from various state agencies to which QBH is accountable, accreditation survey results, findings of billing practices monitoring, any legal sanctions to QBH provide insight into QBH's Legal and Statutory Risk.

RISK ANALYSIS

- Careful analysis for negative trends or serious incidents related to the areas listed in above will help QBH identify areas of actual or potential risk.

RISK PREVENTION AND INTERVENTION

- Risk control (e.g., internal control, external control)
 - Internal controls that can help limit risk include, but not exclusively, maintaining and enforcing a clear-cut fraud policy, ongoing monitoring of billing and accounting practices, enforcing adherence to Recipient Rights policies, staying informed of changes and promptly developing policy and training related to all aspects of legal and regulatory requirements, promptly correcting any deficiencies noted by licensing/certifying agencies and other agencies to which QBH must adhere of a legal or regulatory nature, maintaining a positive relationship with law enforcement personnel.
 - External controls include seeking advice and guidance as needed when regulatory or statutory changes occur for prompt and complete compliance, being involved in committees of regulatory and legislative bodies to have a voice and stay informed.
- Risk financing (e.g., cost associated with insurances)
 - Maintaining liability and indemnity insurance can help minimize financial risk in this area. Maintaining or requiring staff to maintain professional liability insurance policies.

EVALUATION OF RISK PREVENTION AND INTERVENTION STRATEGIES

- Develop formal and informal mechanisms for risk identification and review of pertinent quality improvement information. These may include but not limited to external survey results, incident reports. All such data has a direct impact on risk.
- Develop policies and procedures in key area of risk management interest, such as informed consent, confidentiality, fraud and abuse and adverse incidents. Key risk management policies that impact legal and statutory risk are the Accounting Policies and Procedures, Personnel Policies and Procedures, Governing By-Laws, Codes of Ethics.
- Promote compliance with applicable laws and regulations such as the Health Insurance Portability and Accountability Act (HIPAA), licensing and certifying agencies, DES and ADA, Recipient Rights legislation, OSHA and CDC guidelines, and accrediting organization requirements, such as the JC. The compliance with laws and regulations is best completed by consistent education, community involvement, accounting audits and legal counsel.

SPECIFIC FOCUS ON RISK EXPOSURES FOR 2022

- Based upon analysis of areas of risk exposure for the industry for the past year, the following areas will be the focus of specific analysis, interventions and monitoring for this year:

RISK: HIGH INCIDENCE OF THEFT AND VANDALISM IN AREAS WHERE QBH PROGRAMS RESIDE

- The following actions are being initiated due to the rise in theft and vandalism, particularly related to vehicles and grounds:
 - 24-hour uniformed grounds security patrol all properties
 - Demolish unused buildings in/near parking lots
 - Periodic repeat of training on personal safety measures with staff
- A monitor to assess effectiveness has been established that will look at the incidence of theft/vandalism to see if these actions are effectively controlling this risk; reporting will occur quarterly.

SYSTEM EVALUATION

- The Clinical Committee will address Risk Management at least *quarterly* and as needed to review results of RM monitors and to assess progress with the RM Plan Objectives for the calendar year.
- An *annual summary* of the RM Plan will be presented at the Committee by the CEO and data will be analyzed by the Committee to determine what the high-risk areas of special focus are for the following calendar year.
- A summary including the areas of focus for the coming year will be presented by the CEO to the Board *annually*.

PLAN EVALUATION

- The plan is reviewed by the CEO at least annually, with interim reporting of progress points quarterly to the Clinical Committee and the Board; updating of the plan occurs as needed. The plan is reviewed and approved by the Clinical Committee and the Board annually.

FORMS:

None

POLICY: CONTRACT MANAGEMENT

QBH, Inc. shall monitor the performance of agencies/personnel delivering contracted services.

ESTABLISHING CONTRACTS

- The Chief Executive Officer (CEO), or designee, is responsible for the analysis of solicitation and contract documents, contract negotiation, release of basic contract information, interpretation of contract documents and control, and administration from award through contract completion and payment.
- The CEO will review and approve all Company commitments for services including joint venture arrangements, consulting, and contract/service agreements, including any related to student interns and volunteers.
- Upon approval, copies of contracts and agreements will be routed to appropriate departments or managers for initiation of services. Human Resources shall receive a copy of all contracts of individual service providers for the implementation of appropriate HR policies.
- Signed original contract files will be maintained by the CEO or designee. The CEO or designee will maintain a log of all funding contacts and service agreements. Updates will be distributed when changes occur.
- All contracts with individuals or entities that will have access to patient information as a part of contract performance shall also sign and agree to comply with a HIPAA Business Associate Agreement (included within or as an attachment to the contract).

REQUIRED ELEMENTS OF CONTRACTS

- Contracts of personnel providing clinical services shall include a copy of the job description listing the clinical responsibilities of the contract provider that are within the scope of service of the contract provider. Non-clinical contracts shall spell out the expected services to be provided and timeframes for completion of services.
- A statement that the contract provider will deliver services in compliance with Company policy and Joint Commission requirements relevant to the scope of services provided.
- Inclusion of a Business Associate Agreement if the contract provider will have access to consumers' personal health information, in compliance with HIPAA requirements.
- Specification of the term of the contract, how renewal shall occur, and notice that the contract provider's performance will be evaluated at least annually as part of the process of considering contract continuation and renewal. The contract provider shall receive feedback as to the results of evaluations and any conditions that may be required to achieve contract renewal.

- Specification of fees to be received, how they will be received and the frequency with which they will be received.
- All requirements for participation in a Company orientation, contributions to the Quality Management system, and any documentation expectations and timeframes.
- Identification of supervision requirements and who shall provide that supervision, if applicable to the contract.

MAINTAINING CONTRACT PERFORMANCE

- The Billing Department will notify the CEO of any funding contracts that are overdue payment beyond 90 days.
- Human Resources shall monitor for maintenance of current credentialing information for all individual contract service providers through a tickler system. HR may contact the contracted provider directly to obtain any required updated information. A copy shall be maintained in a contract personnel file. The original shall be forwarded to the CEO or designee for inclusion in the official contract file.
- The CEO or designee shall establish a tickler system for any non-personnel related elements of the contract file which will need to be periodically updated and will be responsible for obtaining updates from the contract source for inclusion in the official contract file.
- All contracted services shall be required to be performed in accordance with the terms and conditions of the contract under which service provision is agreed. Performance will be required to be in compliance with Joint Commission and Regulatory Agencies standards/regulations as applicable to the services provided.
- Any failure of a contractor to provide updated information may result in termination of the contract.

ONGOING MONITORING

- The Clinical Committee will be notified of any service-related contract(s) initiated by QBH. The committee will establish appropriate measurements to monitor contract performance. Any of the following methods may be used to provide ongoing monitoring:
 - Direct observation of the provision of care
 - Audits of documentation
 - Audit of incident reports
 - Review of periodic reports submitted by the individual or organization providing services under the contractual agreement

- Review of performance reports based on indicators required by the contract
- Input from staff and from patients
- Review of patient and staff satisfaction studies
- In the event that a contract's performance during ongoing monitoring results in any threat to the quality of services provided, is inconsistent with JC or regulatory standards for that service, or endangers a patient's safety or security, a report will be generated and forwarded to the CEO or designee for review and for determination of the action to be taken.
 - The original of the determination will be kept in the contract file whether or not the contract is terminated or otherwise acted upon. The CEO or designee will forward a copy to the contracting individual or organization.
 - Any actions taken will be included in the summarization of the contract evaluation annually

CONTRACT EVALUATION AND RENEWAL

- The CEO or designee will establish a tickler file for due dates for evaluations and renewals.
 - Two months prior to contract renewal, a contract evaluation form will be sent to a minimum of three staff that is familiar with the contract services activities.
 - Upon return of the evaluations, a composite evaluation will be completed by the CEO or designee and given by the CEO to the Clinical Committee.
 - The Clinical Committee shall also evaluate the service and provide recommendations related to renewal or non-renewal of the contract and of any corrective/improvement requirements that should be attached to any contract renewal.
 - These recommendations should be provided as soon as possible and at least a month before the end of the current contract.
 - ✓ A month before renewal, contracts and evaluation results for contractors that provide clinical/medical services or clinical support services (e.g. lab), shall be forwarded to the committee by the CEO or designee for their review and recommendations.
 - ✓ The CEO or designee shall consider these recommendations and the evaluation results in his/her decision regarding revision to and/or renewal of the contract.
- Contract evaluation, using meaningful qualitative and quantitative information sources, shall include, minimally, evaluation of contract performance, including expectations of the

services as spelled out in JC standards, state or federal regulations, HIPAA compliance, and any events/practices that compromised patient services quality and/or jeopardized patient safety or security.

- At the time of contract renewal, a copy of the evaluation will be shared with the Contract Service and any improvement activities will be documented.
- The original evaluation will be kept in the contract file by the CEO or designee. If the contract was with an individual, a copy is maintained in their HR file as well.
- Should contract performance at any time not meet contractor expectations, any of the following courses of action may be taken:
 - Increased monitoring of the services/care provided by the contract
 - Provision of consultation or training to the contract provider by the organization
 - Renegotiation of contract terms
 - Termination of the contract
 - Other action as described and agreed to in the contract
- When QBH anticipates that it may alter or terminate a contractual agreement, planning occurs to provide that care, treatment and services are not adversely affected.

EVALUATION:

- Annually the CEO shall review and, if needed, revise this policy and submit it to the Clinical Committee for review and approval.

RELATED POLICIES/FORMS:

Contract Files
Contract Tickler File
Contract Evaluation Policies
Contract Evaluation Form
Governing Board Bylaws
Business Associate Agreement
Relevant HIPAA related policies

PHILOSOPHY

- Quality Behavioral Health, Inc. believes it is their obligation to promote access and remove barriers for:
 - The consumers it serves so that their quality of life can be enhanced by the recovery-based treatment offered;
 - Personnel to be able to work free of any discrimination in the workplace and in employment practices; and
 - Other stakeholders by meeting the legal and regulatory requirements of such a service agency and to meet the expectations of referral sources, liaising providers, payers, the community, and accrediting bodies.
- Quality Behavioral Health provides services to those individuals, including handicapped individuals, who meet the intake criteria.
 - In order to maximize benefits of the program however, all consumers must be able to fully participate, both physically and mentally.
 - The consumer must grant Quality Behavioral Health permission to render treatment and must display overall ability and agreement to work within the physical and therapeutic environment.

BARRIERS IDENTIFIED

ASSESSING FOR BARRIERS

- QBH leaders and staff are encouraged to continually be sensitive to identifying the existence of actual or potential barriers to accessibility in the physical environment, in attitudes that prevail, in financial resources, in employment practices, in communication, in technology, in transportation options for consumers, and/or any other barriers of which they become aware.
- Any barrier or potential barrier may be reported to the Chief Executive Officer (CEO) and/or any member of the Clinical Committee at any time.
- Annually, near the end of the fiscal year (in August or September), the Clinical Committee agendas a specific time to review success with achievement of accessibility goals of that year, to formally assess what barriers currently exist, and to strategize on goals to rectify or minimize those barriers during the forthcoming year.
- Various tools are used to assist in identifying actual or potential barriers, including:
 - As part of the safety/health inspections conducted by the Safety Officer during the year, one priority is to watch for potential barriers that may exist in the architectural and physical environments.
 - Data is extracted from staff and consumer satisfaction surveys that reflect the actual or potential presence of barriers, particularly in attitudes, communication, resources and the overall environment of care and workplace.
 - Feedback from various external stakeholders (regulatory, accreditation, referral and provider sources, focus groups, etc.) that addresses barriers in any area are given

- attention.
- Information from any other annual reports that implicate accessibility issues.
 - Other information that may come to the attention of the CEO, staff or Clinical Committee through the year from whatever sources.

DOCUMENTING BARRIERS

- Any barriers, actual or potential, brought to the attention of the CEO and/or Clinical Committee will be recorded on a *Barrier Log* maintained by the chairperson of the Clinical Committee.
 - Once the CEO is aware of the actual or potential barrier, a determination will be made as to whether the barrier can be addressed immediately or will be addressed within Accessibility Plan Goals for the forthcoming year.
 - The decision, and if action is taken, the action, will be documented on the *Barrier Log* by the Clinical Committee chairperson.
- The *Barrier Log* will be reviewed as part of the annual Accessibility Plan review.

GOALS AND ROLL OUT PLAN

- Annually goals will be set that reflect the efforts of QBH to increase access or remove barriers in each of the key areas of access. The key areas of accessibility for which improvements will be considered is any or all of the following in each calendar year:
 - Architectural: building structures, upkeep and repairs, etc.
 - Physical Environment: location or setting characteristics that impede service or outcomes
 - Attitudinal: Presence of a people first attitude, languages used by consumers, degree of customer service delivery, respect for input from consumers/staff/stakeholders, biases in evidence, etc.
 - Financial: resource limitations, resource distribution, etc.
 - Employment: methods, hiring practices, treatment of staff, etc.
 - Communication: adaptations for disabilities, ethnic considerations, open vs. closed door policy, technology access, etc.
 - Transportation: ability of prospective or current consumers to get to services and/or to other services needed during treatment which are not within the scope of QBH's services, etc.
 - Leadership: actions taken to reduce the stigma of MH/SA within the community, efforts to maintain memberships/relationships in community and stakeholder committees or events, local and legislative advocacy efforts, etc.
 - Other barriers that are outside the realm of these listed areas
- Goals stated must be measurable and periodically assessed for progress or the need for a change in strategy if there is no progress, at a minimum annually. All reviews are documented in the Clinical Committee minutes.
- The *Roll-Out Plan* is designed to prioritize barriers being addressed and to identify the methods that will be used to reduce identified barrier goals. The *Roll-Out Plan* must include who does what, how and within what timeframe.

REASONABLE ACCOMMODATION

- All potential employees and existing employees who incur a handicap while working at QBH may request reasonable accommodation of their handicap to be able to fulfill their job responsibilities. Reasonable accommodation means that it is physically and financially feasible to provide the adaption needed to accommodate a handicap and that the adaptation will accomplish the requirement of making it possible for the person to fulfill the responsibilities of their current or prospective job.
- Likewise, any consumer seeking or in treatment who requires reasonable accommodation to participate in treatment may request such accommodation.
 - If accommodation cannot be made, every effort will be made to help the consumer find an alternative source for the treatment needed that can accommodate their need.
 - The CEO is to be notified if such need is identified during the referral or intake process.
 - The CEO will make a determination of whether accommodation can be made or referral to an alternative treatment site is indicated.
 - All referrals will be documented on the *Referral Form* and/or the consumer's case file.
- All requests for workplace accommodation will be reviewed by the CEO and/or the Clinical Committee and a determination of whether reasonable accommodation can be made. All decisions will be captured in Clinical Committee minutes whether a reported decision by the CEO or a decision made by the Committee.

ANALYSIS AND EVALUATION

- The Clinical Committee shall conduct ongoing assessment, planning, deployment, evaluation and analysis to determine if Accessibility Plan Goals for the current year are being successfully met and to identify new needs that need immediate addition and action.
 - All activities related to the Accessibility Plan will be addressed in Clinical Committee minutes.
- Annually a formal evaluation of the Accessibility Plan and related Goals is done with revision of the Plan and/or Goals if indicated.

EVALUATION

- The plan is reviewed and revisions of plan and/or goal, if necessary, by the CEO at least annually and submitted to the Clinical Committee and the Board for review and approval.

FORMS:

- Referral Form (see Clinical Services Section)
- Barrier Log
- Roll Out Form

FUNCTION OF AUDIT

- To establish guidelines for an annual certified audit¹ or evaluation of the accounting system by a qualified independent accountant.
- This evaluation assists QBH to determine if fiscal management practices and accounting methods are reasonable, prudent, and beneficial to QBH.

AUDIT PROCESS

- A certified audit shall be performed annually at the end of QBH's fiscal year. The fiscal year is October 1 to September 31.
 - An independent accountant other than QBH's accountant currently used to do the accounting books will be chosen by the CEO. All accounts will be audited.
 - Results and unusual findings will be addressed by the auditor in a management report which is to be delivered to the CEO.
 - The management report and any necessary corrective actions taken for accounting practices will be reported to the Governing Board.
-
- ¹Certified Audit - an independent review of the accounting and operating procedures conducted by a public accounting firm or qualified individual who expresses an opinion regarding the "fairness and reliability" of the accounting system in adherence to generally accepted accounting principles.

EVALUATION

- The plan is reviewed and revised, if necessary, by the CEO at least annually and submitted to the Clinical Committee and the Board for review and approval.

FORMS:

None

POLICY:BOARD EVALUATION

- It is the practice of Quality Behavioral Health, Inc. Board of Directors to conduct an evaluation of their own individual performance AND the performance of the Board at least annually. The Board shall review the findings of these evaluations to determine areas of continuing education needed and to identify improvement opportunities regarding their performance as individual Board members and as a Board collectively.

PROCEDURES:**BOARD MEMBER SELF EVALUATION**

- In April of each year, every Board member will be provided with the approved evaluation tools by the Secretary of the Board.
- The evaluations will be completed and returned to the Secretary of the Board within twenty working days.
 - The Secretary will tally the responses for each, following the instructions that accompany the approved tool.
 - The completed aggregate form of Board performance will be reviewed by the Board at the next scheduled Board meeting at which time conclusions will be determined regarding:
 - Performance strengths;
 - Aspects of performance to be improved;
 - Performance goals for the upcoming year.
 - Each individual Board member's evaluation shall be reviewed with that member, prior to the next Board meeting, by the Board Chairperson to discuss:
 - Performance strengths;
 - Aspects of performance to be improved;
 - Performance goals for the upcoming year.
 - The Board Chairperson will report back to the Board at the July meeting, when all personal evaluation discussions have been completed, and address any trends noted that should be considered in Board training or collective Board performance goals.
 - The minutes shall reflect the Board's conclusions from the collective evaluation and the decisions of the Board as a result of the conclusions.
 - The evaluation will include, minimally, assessment of these elements:
 - Board duty of care.
 - Board duty of loyalty
 - Board duty of obedience

OPTION1: BOARD COLLECTIVE PERFORMANCE EVALUATION-INDIVIDUALLY COMPLETED

- In July of each year, every Board member will be provided with the approved evaluation tools by the Secretary of the Board.
- The evaluations will be completed and returned to the Secretary of the Board within twenty working days.
 - The Secretary will tally the responses for each, following the instructions that accompany the approved tool.
 - The completed aggregate form of Board performance will be reviewed by the Board at the October Board meeting at which time conclusions will be determined regarding:
 - Performance strengths;
 - Aspects of performance to be improved;
 - Performance goals for the upcoming year.

OPTION 2: BOARD COLLECTIVE PERFORMANCE EVALUATION-COLLECTIVELY COMPLETED

- In October of each year, the Board will be provided with the approved evaluation tools by the Secretary of the Board.
 - The Secretary will tally the responses for each, following the instructions that accompany the approved tool.
 - The completed aggregate form of Board performance will be reviewed by the Board at the October Board meeting at which time conclusions will be determined regarding:
 - Performance strengths;
 - Aspects of performance to be improved;
 - Performance goals for the upcoming year.

EVALUATION:

- At least tri-annually, the effectiveness of the Board Evaluation Policy will be evaluated as part of the strategic planning process, the evaluation process of the quality systems, and/or through formally structured evaluations/surveys, including an annual survey of leadership performance and satisfaction at various stakeholder levels. The Board seriously analyzes information gleaned from this evaluation so that action can be taken to steadily improve the quality and meaningfulness of the Board and the Agency.

FORMS:

- Board Collective Evaluation Tool and Scoring Guidelines
- Board Member Self- Assessment Tool and Scoring Guidelines
- Governing Board Bylaws

CEO EVALUATION

- In the fall of each year the following personnel will be provided with the appropriate *CEO Evaluation* form by the Office Manager. Forms are provided to:
 - Medical Staff
 - Clinical Staff
 - Nursing Staff
 - CEO
 - All Board Members/Directors
 - A random selection of 10 non-clinical support staff
- The evaluation will be completed and returned to the Office Manager within **five business days**.
 - The Office Manager will tally and, where indicated, average the responses by personnel categories on the aggregate form.
 - The completed aggregate form will be reviewed by the Corporate Board at the next scheduled Board meeting at which time conclusions will be determined regarding:
 - Performance strengths;
 - Aspects of performance to be improved;
 - A decision regarding contract renewal and, if renewal is agreed upon;
 - Performance goals for the upcoming contract year.
- At the following scheduled Board meeting these conclusions will be discussed with the CEO and his/her input into upcoming year performance goals will be considered.
- In addition to the evaluation process just described, the Board shall review the following in contract renewal of the CEO:
 - Overall corporate performance versus targeted performance;
 - Individual performance versus target performance as set in current contract;
 - Degree of professional development, accomplishments and opportunities pursued and achieved.
- Agreed upon performance goals and any revisions to the job description will be included with the contract renewal agreement which shall be initiated for signature.

EVALUATION

- The plan is reviewed and revised, if necessary, by the Administrative Assistant at least annually, (every twelve months +/- 30 days), and submitted Clinical Committee and to the Board for review and approval.

FORMS:

CEO Evaluation Forms
Evaluation Aggregate Form

CLINICAL COMMITTEE

- This committee provides a means to empower a leadership team with the responsibility for developing, monitoring, reviewing and modifying clinical services/programs that address the mental health needs of the community.
- It is further the intent that this committee shall monitor the performance of staff and Company systems as they relate to the delivery of those services/programs.
- The overall purpose of the Clinical Committee is:
 - To be the formal structure through which qualified independent practitioner staff is reviewed and recommended for Company-specific clinical privileges.
 - To serve as the primary means for accountability to the Governing Board for the appropriateness of professional performance and ethical conduct of staff and to strive toward a pattern of consumer service/services in QBH that consistently demonstrates quality and efficiency.
 - To provide a means or method by which staff can formulate recommendations for QBH's policy-making and planning processes, and through which such policies and plans are communicated to and observed by each member of the staff.
 - To constitute a mechanism by which educational activities, professional support, and supervision can be provided in the interest of improving consumer service/services, the skills of persons providing health services, and the promotion of the general health of the community.

RESPONSIBILITIES

- To serve as a liaison between the Staff, Administration and the Governing Board.
- To function as QBH's quality and utilization overseers, conducting all required and necessary activities for assessing and improving the effectiveness and efficiency of services provided by QBH as defined in the Quality Measurement and Improvement Plan.
- To account to the Governing Board for the quality and efficiency of consumer service/services rendered to consumers in QBH through regular reports and recommendations.
- To establish a mechanism for, administer and seek compliance with regulatory and accreditation standards related to clinical privileges and clinical staff rights and responsibilities through the development and implementation of appropriate clinical staff policies related to privileging, primary source verification and fair hearing. To recommend to the Governing Board action concerning clinical privileges and, when indicated, corrective action.
- To assist in identifying community mental health needs and in setting appropriate Company goals and implementing programs to meet those needs.
- To collaborate with the Administrative Assistant and Medical Records Staff in maintaining medical records in accordance with Company policy.
- To assist in obtaining and maintaining licensure, certification and accreditation of QBH.

Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

- To exercise the authority granted by this policy as necessary to adequately fulfill the foregoing responsibilities.

MEMBERSHIP AND OFFICERS

- The Clinical Committee shall be comprised of at least three and no more than seven members. The Medical Director/Program Sponsor and Clinical/Program Director must be members. The CEO, if not already eligible in either of the former categories, may be an ex-officio member with a vote.
- The Clinical Committee shall have three officers: a chairperson, vice-chairperson and a secretary. The secretarial role shall be filled by the Quality and Utilization Manager or designee.
- The Chairperson will call, chair and be responsible for the agenda of all general meetings of the committee.
- The CEO shall represent the views, policies, needs, and grievances of the committee to the Governing Board.
- The Vice-Chairperson will fulfill the Chairperson's role in his/her absence or when it is delegated to him/her.
- The Secretary shall see that accurate and complete minutes of all committee meetings are kept, and attend to all correspondence. S/he may or may not be a member of the committee.
- The CEO shall make appointments to fill vacancies in office during the term of service of any officer.

MEETINGS

- Meetings will be held at least monthly as necessary to fulfill its responsibilities.
- All members are expected to attend. Fifty percent of the voting membership shall constitute a quorum for meetings.
- Minutes shall be kept of all findings, proceedings and actions and a report shall be made at each Governing Board meeting of its activities and recommendations.

COMMITTEE FUNCTIONS

- The Clinical Committee shall assume responsibilities for various functions as follows:
 - Consumer Service Management
 - Monitor consumer services and supervise activities to support and enforce quality standards of service, compliance with policies for service, and that consumer service needs are being met;
 - Take appropriate action to correct any deficiencies in the quality of consumer service and the supervision of that service;
 - Approve all policies related to the development and delivery of services by QBH.

Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

- Monitor the appropriateness, process, outcome and consumer/family staff perceptions of special procedures used; establish and approve policy related to special procedures.
- Ethics
 - Oversee development of, evaluate and approve an educational plan for ethical issues;
 - Approve all policies related to ethics; sit as an ethics committee whenever ethical issues arise requiring deliberation.
- Privileging
 - Convene to review and recommend privileges of applicants; forward those recommendations to the Governing Board;
 - Participate in any appeal or hearing as defined in policy.
- Performance Measurement and Improvement
 - Oversee development of, evaluate and approve a PMI Plan annually; approve any forms and/or policies developed to implement the PMI system;
 - Carry out those duties as set forth in the PMI Plan;
 - Coordinate and monitor the activities established by the PMI Plan, to include all system components;
 - Monitor the actions taken when opportunities to improve service and/or correct problems are identified for effectiveness.
- Health and Safety
 - Approve and direct the Health and Safety Program;
 - Take appropriate action on findings from surveillance activities, educational activities, and negative trends;
 - Review and approve health and safety policies at least every three years and any significant changes to policies as they are proposed.
- Risk Management
 - Coordinate, approve and monitor the activities of the Risk Management system;
 - Review and approve risk management policies;
 - Take appropriate action to prevent and/or correct issues resulting from the monitoring of incidents and patterns of occurrence.
- Utilization Management
 - Coordinate, approve and monitor all activities of the Utilization Management process;
 - Review and approve utilization management policies;
 - Monitor the actions taken when opportunities to improve and/or correct problems in the efficient and effective use of resources are identified for effectiveness.
- Peer Review
 - Provide supervision of peer review activities and ongoing education to professional staff members based upon need.

EVALUATION

- The plan is reviewed by the CEO at least annually, with interim reporting of progress points quarterly to the Clinical Committee and the Board; updating of the plan occurs as needed. The plan is reviewed and approved by the Clinical Committee and the Board annually.

FORMS:

Minutes Form

Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

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FORMS:

Minutes Form

Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

INTRODUCTION

The movement toward medication assisted treatment (MAT) programs has a recent history in modern healthcare. The use of alternative models has enhanced the identification of consumers with serious addiction issues, so that numbers have grown. The need for MAT recovery management and stabilization has meant that a larger proportion of local behavioral health budgets has been spent for this purpose. Although cost control has been a factor in the development of alternative programs, these programs also have other objectives, such as improved outcomes, a more effective treatment philosophy and closer integration between addiction treatment, behavioral health services and other community services.

In response to these pressures community behavioral health providers have expanded traditional counseling services to also provide MAT evaluation, stabilization, and management in the outpatient setting.

For a community to effectively care for the consumer, a full range of options from the least restrictive to the most restrictive must be available. That the incidence of behavioral illness and substance abuse in Oakland, Macomb, and Wayne Counties and the Detroit inner city is significant and the community resources are limited merits community attention.

QBH, Inc. established its MAT programs in 2017 as a provider network that offers MAT programming designed to increase accessibility, improve affordability and deliver quality health care within the inner city and to Oakland, Wayne, and Macomb County residents. QBH, Inc., serves as an umbrella organization working with a continuum of community-based social and behavioral health providers to make available a continuum of services to these underserved populations. QBH, Inc., has a specialized focus on substance abuse, which is extremely high in the local and regional populace; providing MAT services was a natural outcome in response to local demand.

Services delivered in the MAT program are designed and implemented based upon accepted evidence-based practices and state-of-the-art models of care. Staff and leadership is held accountable to continually explore new research and expert consensus, stay current on changes in best practices developed by professional groups such as American Psychiatric Association, ASAM, ADA and other bodies who research and publish clinical best practices for various diagnoses and fields of practice, and monitor health-related publications and web resources. Any new information is brought to the Clinical Committee for discussion and analysis as to applicability within QBH's programs.

Medication Assisted Treatment has several specific benefits to both the consumer and the general public.

Methadone is the most effective treatment for opiate addiction. Compared to the other major drug treatment modalities -drug-free outpatient, therapeutic communities, and chemical dependency treatment – methadone is the most rigorously studied and has yielded the best results.

Methadone is effective for HIV/AIDS prevention. MAT reduces the frequency of injecting and of needle sharing. Methadone treatment is also an important point of contact with service providers and supplies an opportunity to teach drug users harm reduction

techniques such as how to prevent HIV/AIDS, hepatitis and other health problems that endanger drug users.

Methadone treatment reduces criminal behavior. Drug-offence arrests decline because MAT consumers reduce or stop buying and using illegal drugs. Arrests for predatory crimes decline because MAT consumers no longer need to finance a costly opiate addiction, and because treatment allows many consumers to stabilize their lives and obtain legitimate employment.

Methadone drastically reduces, and often eliminates, opiate use among addicts.

Treatment Outcome Prospective Study (TOPS) – the largest contemporary controlled study of drug treatment – found that consumers drastically reduced their opiate use while in treatment, with less than 10% using opiate weekly or daily after just three months in treatment. After two or more years, heroin use among MAT consumers declines, on average, to 15% of pre-treatment levels. Often, use of other drugs – including cocaine, sedatives and even alcohol – also declines when an opiate addict enters methadone treatment, even though methadone has no direct pharmacological effect on non-opiate drug craving.

Methadone is cost effective. The cost of MAT (includes such costs as medication, urine testing and physician, nursing, and counselling staff) on an annual basis to maintain a consumer on methadone is estimated to be 8 times less than what the untreated opiate user can cost society (on average \$38,500.00 per year). Criminal activities related to heroin use resulted in social costs that were four times higher than the cost of methadone maintenance treatment (Harwood et al., as cited in NIDA, 1995, 1-47). In addition, for every dollar spent on methadone maintenance treatment, there is a savings to the community of between \$4-\$13 (results of CALDATA study, as Stoller and Bigelow, 1999, 24).

QBH's MAT program is an opportunity to:

- Provide an important component to medical and public health care;
- Develop partnerships and linkages with other service providers and provide consumers/families with a range of service and supports;
- Establish positive, supportive therapeutic relationships with, and learn from people who are dependent on opioids;
- Contribute to an educational and therapeutic process that can lead people who are dependent on opioids to gain a new perspective on themselves and their use of drugs, and make changes in their lives.

POPULATION CHARACTERISTICS

Detroit's inner city and surrounding Wayne and Macomb County areas from which most of QBH's MAT consumers are drawn have become progressively depressed due to the long-standing unhealthy economy of the area. The population of the area has a high incidence of alcohol, IV drug use, and other substance abuse involving all age groups, including the elderly; is very low income with many homeless people, and has a higher than normal risk for HIV and Tb among other infectious diseases contributed to by poverty, poor diet and drug use.

Ethnically the population is very diverse with many sub-cultures residing in the area. Mental health problems and drug addiction are prevalent as a result of many factors; generally the lifestyle in the area is stressed, depressed and frustrated due to difficulty finding and holding jobs, disrupted families, variant lifestyles, and the constant threat of theft, violence and other criminal situations.

HOURS OF SERVICE PROVIDED

MAT services are available at the Troy location central to the populations QBH serves, making access easy; transport is available upon request. Information about the locations and hours of service are available to consumers and prospective consumers on QBH website, in Company Brochures, within the Consumer Handbook, and in postings at various locations in the community.

The QBH Methadone Maintenance Treatment Program provides a confidential and comprehensive community based service, which includes a consumer-centered approach, accessibility, wide range of services and support through integrated community services; medical care, mental health, substance abuse treatment, professional counselling and support and health promotion, disease prevention and education. This is accomplished by:

- Fostering healthy lifestyles by eliminating or reducing the harmful impact of opiates dependencies on individuals/families and the community.
- Emphasizing the mobilization of individuals and communities to promote dependence-free lifestyles. Treatment requires a growing commitment by the individual and society to change attitude, behavior and lifestyle. Treatment is consumer-centered, comprehensive, innovative, evidence based and monitored.
- Providing a full range of services, along with flexibility, to adapt to ever changing needs because of the complex nature of opioid dependency. These services are delivered by qualified and competent professionals guided by a Code of Ethics and adherence to the principle of confidentiality.
- Monitoring service and continuously evaluating to support high standards of quality care and cost effectiveness. It is recognized that a variety of outcome measures are necessary for appropriate evaluation of the services offered.

The following Table provides a succinct description of the program, the hours of service and the types of treatment available within the program.

PROGRAM/ DESCRIPTION	SERVICE HOURS	TREATMENT MODALITIES -FREQUENCY
Outpatient Medication Assisted Treatment	<p>Monday through Saturday from 5 AM to 1 PM</p> <p>Take home on Sunday</p>	<p>Standard services for Outpatient Methadone Treatment.</p> <ul style="list-style-type: none"> • Medical Services on-site or by referral depending upon medical issue • Medication Services • Counseling Services – Individual and Group • Educational Services

		<ul style="list-style-type: none">• Assessment and Treatment Services• Vocational Services, by referral <p>Therapeutic and Didactic Groups – 2 to 4 groups per day. (prior Covid 19)</p> <p>AA/NA – at least weekly, or as consumer treatment plan dictates.</p> <p>Support Groups – varies with consumer need/per treatment plan.</p> <p>Substance screening before Methadone administered.</p> <p>Dosing decreased towards completion (10% every two weeks) to detox consumer from Methadone dependence.</p>
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DESCRIPTION OF TREATMENT MODALITIES

Individual counseling sessions, conducted by therapists and/or psychiatrists, are used to complete the initial assessments, develop and evaluate progress of treatment plan goals and objectives, to discuss appropriate treatment modalities, and to process and problem-solve problems of a short-term nature.

Family counseling sessions, conducted by therapists, are used to assist the consumer's significant others to understand and adapt to the consumer's condition and needs, to understand the benefits and risks of MAT services, to work through their own needs related to the consumer's condition, and/or to address dysfunction within the family unit.

Therapeutic Group counseling/Support groups are led by members of the clinical and nursing staffs and are designed to allow consumer growth, development of social and communication skills, and/or to help the consumer build a support system while evaluating the consumer's progress on goals specific to their personal treatment plan.

Psycho-education sessions, conducted by clinical and nursing staff, are designed to give the consumer needed information for informed decisions about behavior choices, treatment options, benefits and risks of MAT, infectious disease prevention and management, community resources, and to develop healthy recreational, living and coping skills.

Case management is offered to any consumer who is using and/or in need of the coordination of multiple community social and psychiatric services and who is not already case managed through another agency with whom QBH, Inc. staff can cooperate.

Pharmacotherapy, beyond MAT, is used only when treatment and/or recovery maintenance without this intervention is not feasible. Consumers who receive psychopharmacologic services are monitored by the nursing and medical staff on a regular basis for surveillance of treatment effectiveness and of any untoward responses.

Alcohol Anonymous/Narcotics Anonymous is available both in the program and in conjunction with community groups. Consumers are encouraged to find a group that can become part of their support system after discharge.

Spiritual services for consumers of various faiths is available upon request through local pastoral resources. The objective is to assist the consumer in establishing or re-establishing a relationship with a higher power to facilitate recovery.

FEES AND PAYER SOURCES

Almost all of the consumers who receive treatment from QBH are on Medicaid, Medicare or Social Security Disability. Most consumers have little or no personal income.

When a third party payor arrangement does not exist, a sliding fee scale exists for services can be provided to the consumer in an affordable manner, but most consumers have no out-of-pocket/personal payment of services. The fee structure is set in accordance with the MI Department of Community Health.

REFERRAL SOURCES

Referrals for Outpatient MAT services are made in a variety of ways. Persons seeking service may contact QBH, Inc., directly (an 800 number is available), through referral from another community service or health care provider, or through a contract holder. QBH, Inc., has various third-party reimbursement arrangements, and Department of Economic Security contracts. Indigent behavioral health/chemical dependency services are provided through federal and state contracts.

Upon referral the consumer is scheduled for an intake appointment. Transportation is arranged for any consumer who is unable to get to treatment him/herself. The intake staff, medical staff and the primary therapist collaborate to complete the intake and assessments and identify presenting problems. The primary therapist and physician collaborate to determine if the MAT program is appropriate and treatment modalities for the consumer.

The initial and personalized treatment plan are developed between the consumer and therapist. Treatment planning involves the consumer and family or guardian, if appropriate, in designing their personalized treatment plan. Additional input is gathered from supervision of individual therapists by the Clinical Director and staffing of individual cases with the Medical Director and/or Case Manager on an as needed basis.

Discharge occurs when the consumer completes his/her MAT program goals to their satisfaction. Follow-up evaluation is conducted through consumer satisfaction surveys and follow-up telephone calls at intervals post-discharge.

Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

other social agencies working with the consumer. The consumer is considered part of the team as are the consumer's significant others, if appropriate.

Supervision of treatment and services follows the structure outlined on the QBH, Inc., Organizational Chart. As part of the staffs' orientation to their positions, staff are informed of their direct supervisor. The direct supervisor is responsible for ongoing evaluation of the staff s/he supervises with written evaluations at the end of the new-employee orientation period and annually thereafter.

The Medical Director is not responsible for providing direct services other than completing History and Physical Exams, medication management, and psychiatric evaluations, when indicated. The Medical Director, who also serves as Program Sponsor, is responsible for supervision of nursing services and medical practitioners who, based upon privileges granted, provide services to QBH, Inc. consumers; for clinical oversight of all programs; and for the medical-administrative supervisory responsibilities for QBH, Inc. The Medical Director shall review and provide approval of all medically related policies. The CEO shall notify SAMHSA and JC within three weeks of any replacement of the Medical Director.

The Clinical Director is responsible for the overall supervision of therapists and for the clinical and administrative aspects of MAT services.

Therapists (licensed counselors, marriage and family therapists, clinical social workers; and certified addictions counselors) are responsible for the direct provision of counseling and therapeutic intervention services and, with assigned consumers, for the management of the consumer's treatment, discharge planning and follow-up.

A registered nurse provides direct nursing services, as needed, and medication management services to the MAT program and is available for consultation upon request. The RN is under the general supervision of the Medical Director.

The psychologist provides psychological and neuropsychological testing when need is indicated and is available for consultation upon request. The psychologist obtains privileges for services rendered and is under the general supervision of the Medical Director.

The consulting registered dietitian, based upon privileges granted, is available upon request to conduct individual nutritional assessments and nutrition education which is incorporated into the consumer's individual treatment plan when indicated.

Essential to the operation of QBH and, therefore, a vital component to the provision of quality consumer care are the areas of finance and operations. These areas are under the supervision of the CEO. A contracted accountant and a contracted billing firm are responsible for financial aspects of QBH in collaboration with the CEO. The responsibilities include: monitoring of contracts and reporting, tracking and service authorization; analysis of financial policies; budget preparation; billing, collection of revenue; implementation and coordination of the data with the information management system.

The CEO supervises operational services, including human resources management; maintenance of personnel and credential files; safety, quality and utilization services; medical records; transportation services; and clerical staff.

SHARING MAT SERVICES

This table reflects the typical ways in which QBH's MAT services is made known to various populations.

POPULACE	METHODS FOR SHARING SCOPE OF SERVICES
Consumers Served	<ul style="list-style-type: none"> ➤ Consumer Handbook ➤ Brochures ➤ Information about services available is provided to various community agencies the consumer population might utilize ➤ Word of mouth via prior consumers, staff and other healthcare organizations ➤ Part of intake information provided ➤ Web site/newspaper ➤ QBH participation in health care fairs
Families/Support Systems	<ul style="list-style-type: none"> ➤ Part of intake information if family or other support systems are participants ➤ Brochures ➤ Newspaper ads and articles/web site ➤ QBH participation in health care fairs ➤ Information available with various healthcare and community providers
Referral Sources	<ul style="list-style-type: none"> ➤ Shared at professional meetings ➤ Web site and newspaper ads ➤ Brochures provided to common and potential provider sources ➤ Professional forums
Payers and Funding Sources	<ul style="list-style-type: none"> ➤ Information that is required to be provided as part of the contract process ➤ Brochures ➤ Web site ➤ Professional forums
Relevant Stakeholders	<ul style="list-style-type: none"> ➤ QBH participation in community health care fairs ➤ Professional meetings ➤ Brochures in various locations within the community served ➤ Web site/newspaper ads
General Public	<ul style="list-style-type: none"> ➤ Web site/newspaper ads ➤ Community forums ➤ QBH representation at various community meetings/service on boards/task forces/etc. ➤ Brochures in various locations within the community served ➤ QBH participation in community health care fairs

EVALUATION OF PLAN

The MAT Written Plan will be reviewed by the Clinical Committee at least annually and revised as necessary. Revision and approval of the plan will be a collaborative effort on the part of the Clinical Committee, the CEO and the Governing Board. The plan will be presented annually to the Governing Board for approval.

Evaluation and, as appropriate, revision will incorporate relevant findings from PMI data, system reports, and other available data. Consideration will also be given to changing needs and characteristics of the consumers to whom services are being provided, a review of QBH's mission and short- and long-range goals and objectives, a comparison of this Company to other comparable facilities and the result of various surveys.

The intent of review and revision will be to keep the plan reflective of the efforts to improve consumer care, to resolve problems and/or changes in the nature of consumer care and to summarize the current scope of MAT services of QBH.

CEO

Date

Medical Director

Date

Governing Board Chair

Date

COLLECTION OF INFORMATION FROM VARIED SOURCES

- QBH gathers data from customers and other stakeholders, using various methods, to glean information that can improve customer care, impact Company policies, and guide programming decisions.
- All sources from which data is solicited are encouraged to identify any issues, concerns, needs during any treatment sessions, meetings, or other forums available to them.

CONSUMERS

- Consumer meetings provide customers with the opportunity to meet without staff members present, to discuss, evaluate and suggest possible changes in Company policy.
 - Meetings are conducted monthly or more often, if needed/requested.
 - When consumers' actions require decisions by staff, a meeting is held as soon as possible to address the actions and make decisions.
- Consumers' Committee meetings are conducted at least weekly to gain consumer feedback on milieu issues such as appointing designees for conducting AA meetings, suggesting open talk speakers, identifying community events to attend, etc.
 - The CEO meets with the Committee members, reviews their meeting minutes, explores each issue and reports back on findings or decisions.
 - All issues are documented and retained in a binder for future reference.
 - Responses to the Committee are in writing and usually are available to the Committee the same day minutes were received.
- Consumer satisfaction surveys are distributed monthly as a means of expressing both areas of satisfaction and of needed improvement. These are reviewed, aggregated by the Utilization/Quality Manager and reported to the Clinical Committee as scheduled for decision making by the Committee.
- A "speak up" box for acknowledging positive facets of QBH or treatment improvement suggestions is available for consumers to put their comments at any time. This box is emptied and reviewed by the Clinical Committee at least monthly.
- The consumer grievance process is available to all consumers and their families.
- Consumers may address any concerns as part of their treatment sessions and during treatment planning input.

OTHER STAKEHOLDERS

- Families and other stakeholders who come to QBH have access to the "speak up" box in the lobby for acknowledging positive facets of QBH and/or its programs and for submitting improvement suggestions. This box is emptied and reviewed by the Clinical Committee monthly.
- Stakeholders are provided an opportunity to give input and feedback periodically through satisfaction surveys distributed by QBH at least annually.
- Anyone may request a meeting with the CEO to discuss any needs or concerns not being addressed by QBH or its programs.
- Leaders and staff who participate in community, profession and provider meetings regularly seek input from these populaces related to needs, satisfaction or improvement suggestions they may have.

- Regulatory and accrediting bodies come regularly to QBH to evaluate some or all services of QBH and provide useful feedback for improvements that impact decision making.

STAFF

- Staff has access to the leadership at all times to provide input, recommendations and feedback without consequence as part of QBH's open door policy.
- Satisfaction surveys are conducted at least annually, providing a venue for anonymous input and feedback for Company improvement and identification of Company strengths. These are aggregated by the Utilization/Quality Manager and reported to the Clinical Committee as scheduled for analysis and decision-making purposes.
- The "speak up" boxes are available to staff as a venue for input at any time.
- The staff grievance process is available to all staff.
- Staff meetings of the various programs and departments offer an opportunity for staff input and participation in problem solving.
- Staff participation in quality projects provides opportunities for them to be part of data gathering, input and problem solving for improvements.
- Staff is encouraged to provide input during formal supervision and evaluation sessions; these contributions are without consequence to their performance assessments.

ANALYSIS AND INTEGRATION INTO BUSINESS PRACTICES

- Data from the various mechanisms listed above is collected and aggregated by the Utilization/Quality Manager and submitted to the Clinical Committee for analysis and decisions relative to any significant issues and/or trends revealed by the data.
- In some instances, the data goes directly to the CEO and/or the Clinical Committee to do analysis and problem solving, or for giving direction to decision making and policy revision.
- Data gathered by other aspects monitored through the quality and utilization systems, many of which include input from various stakeholders, is regularly reported to the Clinical Committee as well and, after analysis, findings may also guide policy, administrative and/or clinical decisions, and program or service changes.
- Leadership takes all input seriously and considers how that input might be used to impact program planning; performance improvement initiatives or measures; strategic, financial and/or resource planning; and/or policy modifications.
- If input indicates that advocacy initiatives are needed, the Clinical Committee will determine how to achieve such advocacy.

LEADERSHIP RESPONSE TO INFORMATION GATHERED

- If the input source is known, the CEO or Utilization/Quality Manager will communicate to the source QBH's appreciation for their input and, if already known, how QBH is responding to their input.
- Whenever possible leadership responses to input generated data is provided in writing. The written response may be:
 - A memo or note to the person(s) who provided the input
 - A formal announcement to staff may be achieved in meetings, via inserts to pay checks, through internal email, a Company letter or newsletter, or a policy change.

- If the response impacts the broader community the response may be via mass media such as the newspaper
- If the response impacts a select stakeholder group(s), a letter or email may be used.
- All leadership responses to information gathered is documented in Clinical Committee and/or Board minutes.

EVALUATION:

- The plan is reviewed and revised, if necessary, by the Quality Manager at least annually, and submitted to the Clinical Committee for review and approval. The Clinical committee submits the policy with changes or recommendations to the Board for review and approval.

FORMS:

“Speak up” Box Form

BOARD, STAFF AND CONTRACTOR'S RESPONSIBILITY

- The Board of Directors of QBH, Inc., Contract Staff and QBH staff, regardless of category, shall exercise full disclosure in their dealings with QBH.
- Board directors and Company staff shall refrain from self-dealing and avoid conflict of interest situations in the performance of their duties, with no intent to use the position at QBH for private gain.
- Any conflict of interest to which a director or staff becomes aware in the course of their work/service shall be reported promptly as defined below.

GUIDELINES

- QBH, INC. SHALL provide guidelines for Board directors and Company staff on action to take if a conflict of interest arises in the conduct of their duties at QBH. It is incumbent upon each director and/or staff member to:
 - Conduct him/herself solely in the interest of QBH without consideration of the interest of any other company, Company, organization or association.
 - Disclose immediately any material, financial or other beneficial interest in any organization or entity providing goods or services to QBH.
 - Refuse any favor or other compensation from a third party that would or conceivably could influence his/her actions in the conduct of his/her duties in behalf of QBH.
 - No Board director or Company staff member or contractor shall participate in any decision for or on behalf of QBH involving his/her own self-interest or the interest of a family member.
 - This prohibition shall further require that such person refrain from discussion and voting thereon.
 - Minutes of all meetings involving any such requirement of non-participation shall accurately reflect adherence to this policy.

THE BOARD - CONFLICT OF INTEREST

- The CEO shall annually send all Board directors a copy of the policy and a *Conflict of Interest Form* that shall be completed and returned to the CEO.
- The CEO shall submit an annual report to the Board(s) concerning any conflicts of interest together with any actions regarding the conflict.
- Any new Board director shall receive the policy and a *Conflict of Interest Form* to be completed as a part of their orientation activities.
- Any time that an agenda item poses a conflict of interest not previously noted by the Board director, they shall at that time convey to the Board the conflict of interest and abstain from any discussion or vote regarding that agenda item.

COMPANY STAFF/CONTRACTORS — CONFLICT RELATED TO JOB RESPONSIBILITY

- Any time that a job responsibility poses a conflict of interest, the employee or contract staff member shall immediately notify their direct supervisor.
- The supervisor shall relieve them of the responsibility to the extent necessary to eliminate the conflict of interest.

- The supervisor shall document the conflict and the action taken and submit the documentation to Human Resources for inclusion in the staff member's personnel file.

COMPANY STAFF — CONFLICT OF INTEREST RELATED TO COMMITTEE AGENDA

- Any time that an agenda item poses a conflict of interest for a participating staff member, that member shall immediately notify the committee chairperson of the conflict.
- The chairperson shall request the member to abstain from any discussion or vote regarding the agenda item.
- Minutes of all meetings involving any such requirement of non-participation shall accurately reflect adherence to this policy.

COMPANY STAFF — OUTSIDE EMPLOYMENT

- Outside employment of full-time staff shall not be permitted if:
 - It is determined that such outside employment is likely to physically or mentally hamper the employee and his/her ability to do the job required.
 - It is likely to reflect discredit on QBH's services or the employee.
 - It is in conflict with one's position as an employee of QBH, Inc.
- Full-time employees are required to notify their direct supervisor of any outside employment.
- Employees shall not engage in private practice activities that potentially conflict with Company goals and objectives.
 - At no time shall a consumer of QBH be transferred as a private consumer of any member of the staff without having been given the opportunity to choose from a list of professionally competent providers within their community.
 - No employee may solicit consumers or staff to promote outside business activity.
- No employee may place or receive phone calls, use equipment or supplies, or otherwise perform any activity related to or in any way connected with the employee's outside employment while on duty at QBH.

VIOLATIONS

- Violation of the provisions of this policy is grounds for discharge or such other disciplinary action as the facts warrant as determined by the CEO.

EVALUATION

- The plan is reviewed and revised, if necessary, by the CEO at least annually, and submitted to the Board for review and approval.

FORMS:

Board Conflict of Interest Form
Personnel Handbook

POLICY: CONTRACT SERVICES MONITORING AND EVALUATION**ONGOING MONITORING**

- The Clinical Committee will be notified of any contract(s) initiated by the organization. The Clinical Committee will establish appropriate measures to monitor contract performance. Any of the following methods may be used to provide ongoing monitoring:
 - Direct observation of the provision of care
 - Audits of documentation
 - Audit of incident reports
 - Review of periodic reports submitted by the individual or organization providing services under the contractual agreement
 - Review of performance reports based on indicators required by the contract
 - Input from staff and from consumers
 - Review of consumer satisfaction studies
- In the event that a contract's performance during ongoing monitoring results in any threat to the quality of services provided, or endanger a consumer's safety or security, a report will be generated and forwarded to the Clinical Committee for review and for determination of the action to be taken. The original of the determination will be kept in the contract file whether or not the contract is terminated or otherwise acted upon. The Human Resources Manager will forward a copy to the contracting individual or organization.
- Any actions taken will be included in the summarization of the contract evaluation annually.

ANNUAL EVALUATION

- The Human Resources Manager will establish a ticker file system to create a reminder of due dates for evaluation. Two months prior to contract renewal, a Contract Evaluation Form will be sent to the Clinical Committee whose members are familiar with the contract service provider's activities. Upon return of the evaluations from each member, a composite evaluation will be completed.
- Contract evaluation shall include minimal evaluation of contract performance, any events/practices that compromised consumer services quality and/or jeopardized consumer safety or security.
- Contract services that are outside the organization's scope of services needing evaluation include, but are not limited to:

Laboratory
Radiology
EKG Services
Hospital Services
Pharmacy Services
Software Program Services
Information Technology Services

QUALITY BEHAVIORAL HEALTH, INC.

CONTRACT SERVICES MONITORING AND EVALUATION – NONSCOPE SERVICES

Dispensing Pump Services
Security Services
Alarm System Services
Pest Control
Grounds Management

- At the time of contract renewal, a copy of the evaluation will be shared with the contract service provider and any improvement activities will be documented. The original evaluation will be kept in the Contract file.
- Should contract performance at any time not meet contractor's expectations, any of the following courses of action may be taken:
 - Increased monitoring of the services/care provided by the contract
 - Provision of consultation or training to the contract provider by the organization
 - Renegotiation of contract terms
 - Termination of the contract
 - Other action as described and agreed to in the contract

EVALUATION:

- This policy will be reviewed annually and revised as needed by the CEO and submitted to the Clinical Committee for review and approval.

RELATED POLICIES/FORMS:

Contract Evaluation Form
Contracts Tickler File
Contract Forms
Contract Files

POLICY: CONTRACT SERVICES MONITORING AND EVALUATION**ONGOING MONITORING**

- The Clinical Committee will be notified of any contract(s) initiated by the organization. The Clinical Committee will establish appropriate measures to monitor contract performance. Any of the following methods may be used to provide ongoing monitoring:
 - Direct observation of the provision of care
 - Audits of documentation
 - Audit of incident reports
 - Review of periodic reports submitted by the individual or organization providing services under the contractual agreement
 - Review of performance reports based on indicators required by the contract
 - Input from staff and from consumers
 - Review of consumer satisfaction studies
- In the event that a contract's performance during ongoing monitoring results in any threat to the quality of services provided, is inconsistent with JC standards for that service, or endangers a consumer's safety or security, a report will be generated and forwarded to the Clinical Committee for review and for determination of the action to be taken. The original of the determination will be kept in the contract file whether or not the contract is terminated or otherwise acted upon. The Human Resources Manager will forward a copy to the contracting individual or organization.
- Any actions taken will be included in the summarization of the Contract Evaluation annually.

ANNUAL EVALUATION

- The Human Resources Manager will establish a ticker file system to create a reminder of due dates for evaluation. Two months prior to contract renewal, a Contract Evaluation Form will be sent to Clinical Committee staff that is familiar with the contract services provider's activities. Upon return of each member's evaluation, a composite evaluation will be completed.
- Contract evaluation, using meaningful qualitative and quantitative information sources, shall include minimal evaluation of contract performance, including expectations of the services as spelled out in JC standards and/any events/practices that compromised consumer services quality and/or jeopardized consumer safety or security.
- Contract Services, as applicable, needing evaluation include but are not limited to:

Dietitian
Psychologist(s)
Physician(s)
Pharmacist
Therapists
Physician Assistant
Psychiatric Nurse Practitioner

Volunteers

- At the time of contract renewal, a copy of the evaluation will be shared with the contract provider and any improvement activities will be documented. The original evaluation service will be kept in the Contract file.
- Should contract performance at any time not meet contractor expectations, any of the following courses of action may be taken:
 - Increased monitoring of the services/care provided by the contract
 - Provision of consultation or training to the contract provider by the organization
 - Renegotiation of contract terms
 - Termination of the contract
 - Other action as described and agreed to in the contract
- When the organization anticipates that it may alter or terminate a contractual agreement, planning occurs to provide that care, treatment and services are not adversely affected.

EVALUATION:

- This policy will be reviewed annually and revised as needed by the CEO and submitted to the Clinical Committee for review and approval.

RELATED POLICIES/FORMS:

Contract Evaluation Form
Contracts Tickler File
Contract Forms
Contract Files

AGENCY CORPORATE COMPLIANCE GUIDELINES

- QBH is dedicated to delivery of behavioral health care in an environment characterized by strict adherence to the highest standard of accountability for administration, clinical, business, marketing and financial management.
- Leadership is fully committed to the need to prevent and detect fraud, fiscal mismanagement and misappropriation of funds and thus has developed a formal corporate compliance process to maintain ongoing monitoring and conformance with all legal and regulatory requirements.
- The program is dedicated to:
 - Prevention of wrong doing, whether intentional or unintentional
 - Stressing immediate reporting and investigation of questionable activities and practices without consequences to the reporting party
 - Timely correction of any situation which puts QBH, its leadership or staff, funding sources or consumers at risk.

PROGRAM OVERSIGHT

- The CEO has delegated overall responsibility for the Corporate Compliance program to the Clinical Director, which entails.
 - The formal written designation of a Corporate Compliance Officer.
 - Monitoring QBH's Corporate Compliance program for compliance.
 - Providing periodic scheduled reports to the CEO on matters pertaining to the program.

CORPORATE COMPLIANCE OFFICER (CCO) AUTHORITY AND DUTIES

- In performance of his/her duties, the CCO shall have direct and unimpeded access to the Clinical Director, CEO, QBH's accountant, and QBH's legal counsel for matters pertaining to corporate compliance.
- The CCO shall be responsible to:
 - Chair QBH's Corporate Compliance team
 - Serve as the primary contact for all corporate compliance issues
 - Schedule team meetings, report on team activities and make recommendations to the CEO and Clinical Director as required
 - Develop, implement and monitor, on a consistent and regular basis, QBH's Corporate Compliance Plan, including internal and external monitoring, auditing, investigative and reporting processes, procedures and systems
 - Prepare, submit and present periodic clear communication to QBH's leadership for Corporate Compliance, including the Clinical Director, CEO and Board for compliance oversight
 - Coordinate development of QBH's formal Corporate Compliance Plan.
 - Schedule, coordinate and monitor regular and periodic reviews of risk areas by competent persons external to QBH. Reviews will:
 - Be conducted so as to ensure ongoing conformance with billing, accounting and collection regulations of the federal government and other "third party" funding sources
 - Augment QBH's annual audit of its accounting system
 - Provide an additional internal measure to ensure conformance with billing and coding policies and practices that can withstand the scrutiny of any regulatory audit or examination.

COMPENSATION REVIEW COMMITTEE

- The CCO shall convene this committee at least once a year; members are assigned by the CEO.
- The committee shall review the compensation packages of all key staff and specifically those staff who have potential to exercise “substantial control” over QBH’s policies, procedures and operations.
- Results of the review will be retained by the Clinical Director who will, in consultation with the CEO, determine appropriate corrective action, if required.

REPORTS

- An annual report is submitted by the CCO to the Clinical Director and CEO which shall include minimally:
 - A summary of all allegations, investigations and/or complaints processed in the preceding twelve months in conjunction with the Corporate Compliance program
 - A complete description of all corrective action(s) taken
 - Any recommendations for changes to QBH’s policies and procedures.

EVALUATION

- The plan is reviewed by the CEO at least annually, (every twelve months +/- 30 days), with interim reporting of progress points quarterly to the Clinical Committee and the Board; updating of the plan occurs as needed. The plan is reviewed and approved by the Clinical Committee and the Board annually.

FORMS:

Appointment as Corporate Compliance Officer Memorandum

DEFINITIONS

- Cultural diversity: The ethnic, racial, religious, age and gender, sexual orientation, language, socio-economic status variances, or regional variations of a population. This may include such areas as spiritual beliefs, holidays, dietary regulations or preferences, clothing, attitudes toward impairments, language, and how and when to use interpreters that will require modified service delivery, consideration of the diversities in treatment plans, personnel training, and increased satisfaction of consumers and other stakeholders.
- Cultural competency: Education and skill development that allows an individual to demonstrate competence in working and communicating effectively with diverse populations.
- Cultural sensitivity: The act of being aware of and/or finding out the cultural orientation of a consumer and responding to that in interaction and communication, service planning and service methods selected.

CULTURAL DIVERSITY INITIATIVES**PERSONNEL**

- The recruitment process of QBH shall not permit discriminatory practices. Staff that represent, and/or demonstrate competency and experience in working with the cultural characteristics of the populations served by QBH, Inc. shall be sought in the recruitment and hiring processes.
- The Governing Body and senior leaders of QBH will attempt to include representatives within their membership from the primary cultures served.
- Staffs shall receive orientation and at least annual training to support the development and maintenance of competence in understanding, communicating and treating the diverse populations served by QBH and to better understand and relate to the diverse staff with which they work. This training and associated competence will be documented in each staff's personnel file. Minimally, training will address cultural, age, gender, sexual orientation, spiritual beliefs, socioeconomic status, and language will be addressed. Also to be considered will be varying views of consumer groups treated on health, wellness, disability and its causes, and the influence of culture on choice of service outcomes and methods.
- Work schedule adjustments to allow for celebration of specific holidays of a staff based on their religious or cultural orientation will be accommodated whenever possible.
- Periodically staff satisfaction surveys are issued to gain feedback on this and other areas of satisfaction.

CONSUMERS

- Clinical decisions and treatment activities will consider and respect the diverse ethnic, cultural and spiritual traditions and values of the populations served as well as the consumer's sexual orientation and socio-economic status. This will be reflected in the individualized treatment planned for each consumer and will be considered in the design and implementation of services/programs offered.
- Printed materials will be available in the language of the primary populations served; if printed material is not available, interpreter services will be arranged.
- As much as possible, service locations will be strategically placed in the communities where the populations served by QBH live to facilitate easier access to services.

- Service hours will be developed and/or modified to adjust to the needs of the populations served to accommodate greater accessibility.
- Periodically, consumers' satisfaction with QBH's respect for their cultural traditions and values within the treatment process will be assessed and analyzed for improvement opportunities.
- Services are the same regardless of the socioeconomic status of the consumer being served.
- For purposes of privacy and respect, units are gender specific.
- Services may be adapted to accommodate a consumer's physical or age-related abilities and interests.
- Spiritual beliefs are supported as long as they are not contradictory to the consumer's recovery and well-being.
- Printed materials and electronic media shall not use any language that implies bias or stigmatization.

OTHER STAKEHOLDERS

- QBH attempts to identify community resources and services that can accommodate the cultural diversity of populations served by QBH.
- When necessary, QBH will advocate for the needs of a consumer who is finding it difficult to receive a service needed because of cultural diversity issues.
- Forums, community sessions or other outreach may be offered to draw out consumers with specific culturally diverse characteristics within the counties QBH serves to provide information and to learn about their unique needs and concerns.

COMPETENCY

- Competence in the areas of cultural sensitivity and diversity shall be evaluated during the initial and annual competency assessment for all staff. While some elements apply to all positions, specific aspects of competency may vary depending on the job responsibilities of the staff member.

PLAN REVIEW

- The CEO reviews and, if necessary, revises this plan at least annually to ascertain:
 - Changes in population characteristics that may indicate modification of cultural diversity initiatives
 - If any satisfaction data has indications of improvements needed to better accommodate cultural diversity of staff and consumers
 - If there are new or changed aspects to be addressed with stakeholders
 - If there are any other concerns or issues that have surfaced relative to cultural diversity and Company initiatives to address these are needed or should be modified.
- The CEO is responsible to see that any changes are made, approved at Clinical Committee level and forwarded to the Board for their approval.
- The HR Manager is responsible to arrange for any training or training adjustments needed based upon plan modifications.

RELATED POLICIES/FORMS:

Personnel Handbook

ETHICAL GOVERNANCE PRACTICES

- The Board of Directors shall be bound to the ethical practices as set forth in the Code of Ethics of QBH and by those ethical guidelines specific to being a Board member as committed by their annual signature on the *Board Code of Ethics Form* and completion of the *Conflict-of-Interest Form*.
- Board members set the bar for ethical standards in the performance of their duties. They shall:
 - Remain actively involved and informed in Company decisions, practices and performance results.
 - Hold the CEO, other leadership and staff accountable to ethical practices in their job performance and oversee that appropriate disciplinary action is taken if ethical breaches occur.
 - Remove immediately any Board member who is verified to have violated QBH's and/or the Board's code of ethics.
 - Comply with legal, regulatory and accreditation requirements in the performance of their duties as Board members and hold QBH's personnel to the same requirements as relates to their roles in QBH.
 - Maintain confidentiality with respect to all Company, staff or consumer information shared at Board meetings, special meetings or by other means of access.
 - Maintain bylaws governing responsibilities and activities as a Board.
 - Remember that they represent QBH in their external and internal interactions and behave accordingly.
 - Hold other Board members, leadership and staff of QBH accountable to ethical practices.
 - Abide by all elements of the *Board Code of Ethics*.

EVALUATION

- The plan is reviewed by the CEO at least annually and submitted to the Board for review and approval.

FORMS:

Board Code of Ethics Form
Conflict of Interest Form

**BYLAWS OF
QUALITY BEHAVIORAL HEALTH, INC.**

**ARTICLE I
DEFINITIONS**

The following definitions shall apply in the interpretation of these Bylaws:

- 1.01 "Articles" means the Articles of Incorporation of the Corporation as the same may be amended, from time to time, on file with the Michigan Corporation Commission.
- 1.02 "Administration" means the management of the Corporation headed by the Chief Executive Officer.
- 1.03 "Board" means the Governing Board of Directors of the Corporation.
- 1.04 "Chair" means the Chairperson of the Governing Board.
- 1.05 "Corporation" means Quality Behavioral Health, Inc., a not-for-profit corporation.
- 1.06 "Director" means member of the Governing Board.
- 1.07 "Clinical Staff" means the medical and clinical staff of the Company.
- 1.08 "Company" means any health care institution operated by the Corporation.

**ARTICLE II
CORPORATE OFFICE**

- 2.01 Known Place of Business. The addresses of the MAT Program Administrative offices are 1059 Wendale Troy, MI 48083. The Corporation may have such other offices either within or without the State of Michigan as the Board may designate or as the business of the Corporation may require from time to time.
- 2.02 Change of Place of Business. The Board may, from time to time, change the Corporation's known place of business or its statutory agent by filing a statement with the Michigan Corporation Commission in the manner provided by law.

**ARTICLE III
BOARD OF DIRECTORS**

- 3.01 Designation and Classification. The affairs of the Corporation shall be managed by a Board of Directors. The Board of Directors shall consist of a minimum of two (2), but not to exceed seven (7), regular members selected from the residents of the service area that meet qualifications set forth:

- 3.01-1 Has professional expertise that is beneficial to the Company and the Board's duties; is professionally and culturally competent.
 - 3.01-2 Resides and/or works in the community (e.g., Oakland County) of the population served.
 - 3.01-3 Represents one of the cultures served by the Company.
 - 3.01-4 Other characteristics as may from time to time be decided by the Board as reflected in official Board minutes.
- 3.02 **Term of Regular Directors.** Regular Directors shall serve a term of three (3) years and shall be elected in such a manner as to serve staggered terms. After serving a term, a regular Director shall be eligible for re-election or reappointment to the Board.
- 3.03 **Ex-Officio Members.** The ex-officio members of the Board shall be the Medical Director/MAT Program Sponsor and the Clinical/MAT Program Director. Ex-officio Directors shall serve so long as they hold the designated position which is the basis for ex-officio membership. Directors may not serve as elected officers of the Corporation unless they are also owners in the Corporation. Ex-officio Directors must personally attend meetings of the Board and may not delegate attendance to any other person.
- 3.04 **Resignation.** Any Director may resign at any time. Resignations are effective upon acceptance by the Board.
- 3.05 **Removal.** A Director may be removed from office as a Director, without cause, by majority vote of Directors. Ex-officio Directors may only be removed by their removal from the designated position which is the basis of ex-officio membership.
- 3.06 **Vacancies.** The Board of Directors shall fill vacancies occurring between annual elections for the unexpired term of the elected members causing such vacancy.

ARTICLE IV POWERS AND DUTIES

- 4.01 **General Responsibilities.** The Board shall have general responsibility for management of the affairs of the Corporation. The Board may, in accordance with the Articles and Bylaws:
- 4.01-1 Establish policy, maintain safe, quality consumer care, and provide for institutional management and planning. Oversee the development and operation of a sound safety program and effective quality management program for the Company.
 - 4.01-2 Control and manage the property and business of the Corporation. Require an annual financial audit from a qualified external source. Use other external advisors as needed.

- 4.01-3 Take reasonable measures to achieve and maintain licensure and accreditation of the Company.
- 4.01.4 Enter into written contracts, loans, other financial matters extending beyond their own terms of office. Determine if there will be and any amounts thereof of expense reimbursement. Stock ownership does not apply to this corporation.
- 4.01-5 Elect from their own membership and appoint from their own membership or otherwise, officers of the Corporation.
- 4.01-6 Fill vacancies on the Board.
- 4.01-7 Cause the Clinical Staff to conduct an annual review of its written plan.
- 4.01-8 Cause the Clinical Staff to establish a process of Performance Measurement and Improvement Management and review the standards and implementation of such process from time to time.
- 4.01-9 Require the Clinical Staff to provide the Board with written reports of Clinical care evaluation on a regular basis at such time or times as the Board elects.
- 4.01-10 Cause the Clinical Staff to establish and follow procedures providing due process of law in dealing with Independent Professional Staff privileges.
- 4.01-11 Subject to the remaining provisions of these Bylaws, act in the capacity of final decision-maker as to the granting or terminating of Independent Professional Staff privileges.
- 4.01-12 Development of agenda and development and distribution of meeting materials which may be delegated to the Board President and CEO.
- 4.01-13 Assign to the President and CEO the responsibility to organize whatever resources are necessary for governance development and management.
- 4.01-14 Establish the Chief Executive Officer's compensation on an annual basis which shall be based upon review of Company performance versus target, individual performance versus target, and professional development, accomplishments and opportunities achieved. At each evaluation new performance goals shall be determined.
- 4.01.15 Develop and annually review an executive leadership succession plan.
- 4.01.16 Require an annual review of Company and Board policies.
- 4.01.17 Require an annual Evaluation of board performance collectively and individually.
- 4.01.18 Require an annual written and signed conflict of interest declaration and code of conduct declaration from each Board member.

- 4.02 **Annual and Regular Meetings.** Regular meetings of the Board may, but need not be, held on a fixed day of each month as the Board may, from time to time, select. If a fixed meeting is selected, no additional notice of any regular meeting of the Board is required. The Board shall meet at least four (4) times in each fiscal year. The Board shall designate one of its regular meetings as the annual meeting.
- 4.03 **Special Meetings.** Special meetings of the Board may be held at any time and at any place upon the call of the Chair and shall be called upon the written request of any two (2) Directors. Special meetings of the Board may be conducted telephonically at the election of the Chair.
- 4.04 **Notice of Special Meetings.** Each Director is entitled to written notice by facsimile transmission or ordinary mail, postage prepaid and mailed to the Director's last address on file with the Corporation, no later than three (3) days prior to the date of any special meeting. Notice of any special meeting may be waived, in writing, by all Directors before, during, or after any special meeting and notice shall be conclusively deemed to have been waived by any Director who is actually present at the meeting.
- 4.05 **Action Without a Meeting.** Any action required or committed to be taken by the Board of Directors may be taken without meeting if all members shall individually or collectively consent in writing to such action. Such consent(s) shall be filed with the Minutes of the proceedings of the Board of Directors and shall have the same force and effect as a unanimous vote of the members. Board of Directors action may be conducted by telephone conference which shall be deemed to constitute a meeting and Minutes shall be recorded of such meeting.
- 4.06 **Quorum.** At any meeting of the Board, a majority of the elected Directors shall constitute a Quorum. In the absence of a quorum, the meeting shall be adjourned until a quorum is present. Participation of a member by conference telephone shall be considered attendance at the meeting.
- 4.07 **Attendance.** Each Director is expected to attend every regular and special Board meeting in its entirety. Absence by a regular Director from any three (3) regular meetings in any single elected term shall constitute a resignation by such Director from the Board and create a vacancy. However, if an absence is excused by action of the Board of Directors and entered into the Minutes, that absence shall not count as one of the three (3) absences referred to above.
- 4.08 **Minutes.** All activities of the Board of Directors will be maintained in written Minutes.
- 4.09 **Confidentiality.** Certain matters of the Board, its consumers and/or staff will be confidential, including but not limited to personnel matters; records or matters exempt by law from public inspection and disclosure such as QM issues,

consumer issues and records; deliberations and negotiations regarding issues, projects or services that, if disclosed, would impact the Company's competitive position; other matters as may from time to time be deemed confidential by the Board. Board members shall maintain such matters as confidential during and after their service on the Governing Board.

ARTICLE V OFFICERS OF THE CORPORATION

5.01 Officers. The Corporation shall have elected and appointed officers.

5.01-1 Elected Officers. The elected officers of the Corporation are the Chair, Vice Chair, and the Secretary/Treasurer.

5.01-2 Appointed Officers. The appointed officers of the Corporation are such other officers as the Board may deem necessary.

5.02 Election and Tenure.

5.02-1 Qualifications. Elected officers of the Corporation shall be selected from the regular Directors. Elections shall be conducted by secret ballot at the annual meeting. Appointed officers may be selected from within or without the membership of the Corporation. At least one officer elected shall have served on the Board for a minimum of one (1) year.

5.02-2 Term. Except in the case of resignation or removal, each elected officer holds office for a term of one (1) year and until a successor is elected and qualified. An officer's term commences at the first regular or special meeting after the officer's election.

5.03 Resignation and Removal.

5.03-1 Resignation. Any officer may resign at any time by giving written notice to the Chair or to the Secretary/Treasurer. Such resignation (which may or may not be made contingent on formal acceptance) takes effect on the date of receipt or at any later time specified therein.

5.03-2 Removal. Any officer may be removed by the Board (with or without cause) whenever, in the Board's judgment, the best interest of the Corporation will be served thereby. An officer may only be removed upon the vote of a majority of the total number of Directors serving on the Board at the time of the vote. All votes on the removal of an officer shall be conducted by secret ballot.

5.04 Vacancies. A vacancy in any office may be filled by the Board for the unexpired portion of the term.

5.05 Duties of Officers.

- 5.05-1 Chair. The Chair is the principal officer of the Corporation. Subject to the Bylaws, the Chair shall:
- Preside at all meetings of the Board.
 - Sign on behalf of the Corporation any documents or instruments which the Board has authorized to be executed, except where the signing and execution is expressly delegated by the Board or these Bylaws to some other officer or agent.
 - Perform such other duties as are incident to the office of the Chair or are assigned by the Board from time to time.
- 5.05-2 Vice-Chair. Subject to the Articles and Bylaws and the directions of the Chair, the Vice-Chair shall:
- In the absence of the Chair or when, for any reason, the Chair is unable or unwilling to perform his duties, perform the duties of the Chair.
 - Perform such duties as are assigned by the Board or the Chair.
- 5.05-3 Secretary/Treasurer.
- 5.05-3-1 Duties. Subject to the Bylaws the Secretary/Treasurer shall:
- Provide for the keeping of Minutes of all meetings of the Board.
 - Give or cause to be given appropriate notices in accordance with these Bylaws or as required by law.
 - Act as custodian of all corporate records and reports.
 - Keep or cause to be kept a current roster showing the names of the current Directors and their addresses.
 - Keep or cause to be kept correct and accurate accounts of the properties and financial transactions of the Corporation.
 - If required by the Board (and at the expense of the Corporation), give a bond for the faithful discharge of duties in such sum and with such sureties as the Board shall determine.
 - Perform any and all other duties incident to the office of Secretary/Treasurer and such other duties as may be assigned from time to time by the Chair or the Board.

5.05-3-2 Delegation. The Secretary/Treasurer may delegate any duty to any appointed Secretary or to the accountant for the Company. C

5.06 Chief Executive Officer

5.06-1 Appointment. The Board shall select and appoint a qualified and experienced health care administrator (as defined by job description) to serve at the pleasure of the Board as the CEO and to be the Board's direct executive representative in the management of the Company. The CEO shall be given the necessary authority and be held responsible for the management of the Company and all its services subject to the policies enacted by the Board. Except at otherwise provided, the CEO shall be an ex-officio member of all committees and of all organizations that are associated or affiliated with the Corporation. The CEO shall act as the duly authorized representative of the Board in all matters except those in which the Board has formally designated some other person or group to act. The CEO may sign on behalf of the Corporation any documents or instruments which the Board has authorized to be executed.

5.06-2 Executive Compensation. Annually the Board or an assigned sub-committee that does not include members related to the CEO shall determine what will be the CEO's total compensation mix that might include any or all of the following: 1) base pay, 2) incentive plan; 3) benefit plan, and 4) prerequisites.

- Total compensation shall be comparable to market compensation data for functionally comparable positions.
- Terms of compensation arrangements and performance goals for the year shall be written into a contract signed by the CEO and Board President and shall include the approval date, names of Board members who approved the compensation decision and include a summary of data used for the compensation decision.
- The minutes shall reflect any conflict of interest, if any, in the compensation deliberation and decision.
- The Board shall conduct an annual review of the CEO's compensation records.

5.06-3 Authority and Duties. The CEO shall, subject to the directions of the Board:

- The CEO must be professionally and culturally competent.

- The CEO shall appoint a MAT Program Sponsor, who may or may not also be the Medical Director.
- Be responsible for implementing policies established and plans authorized by the Board for the operation of the Company and for advising on the formation of these policies and plans.
- Provide liaison among the Board, the Clinical Staff, and the services of the Company and assist in coordinating the activities of the Company departments with those of the Clinical Staff.
- Send periodic reports to the Board and to the Clinical Staff on the overall activities of the Company, as well as on appropriate federal, state, and local developments that affect the operation of the Company.
- Provide the Board with such staff and administrative support and personnel as they may reasonably require.
- Provide the Company's Clinical Staff with the administrative support and personnel reasonably required to carry out their review, evaluation, and monitoring activities.
- Organize the administrative functions of the Company, delegate duties, and establish formal means of accountability on the part of subordinates.
- Develop and submit to the Board a plan for organization of the Company services and other organizational components, showing lines of authority, responsibility, and interrelationships.
- Be responsible (except as otherwise provided by the Board) for selecting, employing, controlling, and discharging employees and for developing and maintaining personnel policies and practices.
- Establish such Company administrative departments as are necessary, provide for departmental and interdepartmental meetings, and attend or be represented at such meetings.
- Assist the Board in annually reviewing and updating a capital budget and preparing an operating budget showing the expected receipts and expenditures, and supervise the business affairs of the Company to monitor that funds are expended to the best possible advantage.

**ARTICLE VI
BOARD COMMITTEES**

- 6.01 Committees. There shall be no standing committees of the Board, however, the Chair may appoint AD-HOC Committees as deemed necessary.
- 6.02 AD-HOC Committees. The Chair may call for and establish AD-HOC committees when needed. Each committee shall be given a specific task, and its power will be limited to research the formulation of recommendations and presentation to the Board of Directors for action. Each committee will disband upon completion of its duties. The nominating committee shall be an AD-HOC committee, established at least 60 days prior to any scheduled or required elections. The Chair shall appoint a nominating committee of two (2) or more Directors, designating one to be Chair. The nominating committee shall present candidates for Officers of the Board.

ARTICLE VII QUALITY MANAGEMENT

- 7.01 Board Responsibility. The Board shall establish, maintain, support, and exercise oversight of an on-going quality management process that includes specific review, evaluation and monitoring mechanisms to assess, preserve and improve the overall quality and efficiency of consumer care in the Company.
- 7.02 Delegation to Administration and the Clinical Staff.
- 7.02-1 To Administration. The Board delegates to the Administration and holds it accountable for providing the administrative assistance reasonably necessary to support and facilitate the implementation and on-going operation of the Company's quality management process, for implementing the quality management program as it concerns personnel and technical staffs and consumer services, and for analyzing information and acting upon problems involving technical, administrative, and support services and Company policy.
- 7.02-2 To the Clinical Staff. The Board delegates to the Clinical Staff and holds it accountable for conducting specific activities that contribute to the preservation and improvement of the quality and efficiency of consumer care provided by the Company. These activities include:
- o A systematic evaluation of practitioner performance against explicit, predetermined criteria.
 - o On-going monitoring of critical aspects of service and monitoring unexpected clinical occurrences.
 - o Review of utilization of the Company's resources to provide for their proper and timely allocation to consumers in need of them.

- Provision of continuing Clinical education, fashioned in part on the needs identified through the review, evaluation, and monitoring activities and on any new state-of-the-art developments.
- Definition of the clinical privileges which may be appropriately granted within the Company, delineation of clinical privileges for eligible clinical staff commensurate with individual credentials and demonstrated ability and judgment, and participation in assigning consumer care responsibilities to other health care providers consistent with individual qualifications and demonstrated ability.
- Management of clinical affairs, including enforcement of clinical policies and consultation requirements, initiations of disciplinary actions, surveillance over requirements for performance monitoring and for the exercise of newly acquired clinical privileges, and like clinically-oriented activities.
- Development and oversight of a system for continuous service improvement through the initiation of improvement teams whose mission is the improvement of selected critical processes.
- Such other measures as the Board may, after considering the advice of the Clinical Staff and Administration, deem necessary for the preservation and improvement of the quality and efficiency of consumer services.

7.03 **Documentation and Oversight.** The Board of Directors shall require, receive, consider and act upon the findings and recommendations emanating from the activities required by Section 7.02-2. All such findings and recommendations shall be in writing, signed by the persons responsible for conducting the activities, and supported and accompanied by appropriate documentation and rationale upon which the Board of Directors can take informed action, as required or necessary and can exercise effective over-sight of the quality management process. All reports and supporting documentation shall be prepared and distributed to strict compliance with the confidentiality policies and procedures adopted by the Board so as to protect any legally privileged material contained therein from unauthorized disclosure.

ARTICLE VIII CLINICAL STAFF

8.01 **Organization and Hearings**

8.01-1 The Board of Directors shall require the Clinical Staff to convene a Clinical Committee to organize the clinical staff for the purpose of accomplishing its assigned duties. The Board shall consider recommendations of the Clinical Committee and privilege those eligible practitioners who meet the qualifications for privileges as set forth in policy and procedure. Each independent

practitioner shall have the authority to carry out those services delineated in their clinical privileges.

- 8.01-2 The Clinical Committee shall act on behalf of the Clinical Staff and shall serve as the liaison between the Clinical Staff, Administration and the Board of Directors. The Clinical Staff shall define the membership, functions, and meetings of the Clinical Committee.
- 8.01-3 All applicants' requests for clinical privileges shall be in writing and addressed to the Clinical Committee. The application shall contain full information concerning the applicant's education, licensure or certification, practice, previous experience, and any unfavorable history, including at least final outcomes of clinical liability claims. The applicant must specify the clinical privileges being sought with the application. This information shall be verified by the Clinical Committee.
- 8.01-4 All initial privileges shall be for no longer than one (1) year and all re-privileging shall be for no longer than two (2) years, renewable by the Board of Directors upon recommendation of the Clinical Committee. When privileges have been or are proposed to be reduced, altered, suspended, or terminated, the staff member shall be afforded the opportunity of a hearing. Such hearing shall be conducted under procedures adopted by the Clinical Committee and approved by the Board of Directors so as to afford due process and full opportunity for the presentation of all pertinent information. The foregoing procedure shall apply to the termination of privileges for any independent pursuant to an employment agreement, contract or other arrangement with this corporation, unless the express terms thereof provide that privileges shall automatically terminate upon the termination of the employment agreement, contract or arrangement. In the event that the employment agreement, contract, or arrangement is terminated as a result of incompetence or misconduct that poses risk or danger to the well-being of consumers, then the practitioner shall be afforded the opportunity for a hearing.
- 8.01-5 The appointment for Medical Director shall be made by the CEO and approved by the Board of Directors, shall be for two (2) years, and may be renewable without limit. Duties and responsibilities of the Medical Director shall be set forth in a job description or employment agreement. The Medical Director shall be required to maintain qualifications for clinical privileges appropriate to the assignment. The Board shall conduct a timely evaluation of the Medical Director annually.
- 8.01-6 No particular clinical privileges shall be denied on the basis of sex, race, age, creed, color or national origin, or on the basis of any criteria unrelated to the delivery of quality consumer care/service.

8.02 Medical and Clinical Care/Service and Its Evaluation

- 8.02-1 The Board of Directors shall, in the exercise of its overall responsibility, assign to the Clinical Committee reasonable authority for providing appropriate clinical care/service to the Company's consumers. The Clinical Committee shall define the role of each discipline in the diagnosis and care/ service of consumers.
- 8.02-2 Medical doctors with appropriate licensure, qualifications, and clinical privileges at QBH, Inc., shall evaluate, authenticate, and perform medical evaluations.
- 8.02-3 The Medical Director shall monitor the medical care/service and treatment of consumers and shall act as supervisor to the clinical staff and as a consultant to Contract employees.
- 8.02-4 The Clinical Staff shall conduct an ongoing review and appraisal of the quality of clinical care/service rendered in the Company and shall report such activities and their results to the Board, including recommendations regarding quality issues, overall organizational functioning, or any other concerns. These reports shall be submitted in writing to the Board.
- 8.02-5 The Clinical Committee shall make recommendations to the Board concerning:
- o granting of clinical privileges; 3) disciplinary actions; 4) all matters relating to clinical competency; and 5) such specific matters as may be referred to it by the Board.
- 8.02-6 The Clinical Committee shall establish the clinical record requirements for all programs of the Company.
- 8.03 Clinical Policy. There shall be policies and procedures that set forth the process for credentialing, a hearing process and the organization and duties of the Clinical Committee. These shall be recommended by the Clinical Committee, subject to approval by the Board of Directors. If any amendment is required to comply with any federal, state or local law or regulation, or with any standard or requirement of any accrediting body, and if the Clinical Committee fails to enact any such amendment within thirty (30) days (or such longer period as may be prescribed by the Board) after a request from the Board, the Board may enact said amendment and the same shall not be dependent upon the ratification by the Clinical Committee.

ARTICLE IX COMPENSATION

- 9.01 Board members serve in a volunteer capacity. No form of compensation, stock ownership, or other form of compensation is offered to Board members with the exception of reimbursement, when receipts are submitted to the Office Manager, of expenses incurred to carry out Board duties such as attendance at a conference or meeting outside the Company for Board purposes.

ARTICLE X
BYLAWS AND AMENDMENTS

- 10.01 **Review.** These Bylaws shall be reviewed in their entirety to assure reflection of current responsibilities of the Board of Directors to the Company and community, and representation of current philosophy and direction. Review shall occur every three (3) years.
- 10.02 **Amendments.** These Bylaws may be amended or replaced and new Bylaws adopted by a majority vote of the Board Members at any regular or special meeting, provided written notice of this intent has been given by the Secretary/Treasurer to each member at least fourteen (14) days in advance of the meeting.
- 10.03 **Rules and Regulations.** The Board of Directors shall adopt rules and regulations, or policies and procedures as may be necessary to implement more specifically the general principles stated in these Bylaws. Such rules and regulations or policies and procedures shall be considered of equal dignity with these Bylaws.

CEO

Date

Medical Director

Date

Chair, Governing Board of Directors

Date

QUALITY BEHAVIORAL HEALTH, INC.MAT DIRECTIVES

LEADERSHIP: MISSION, PHILOSOPHY AND

COMPANY MISSION

- The mission if Quality Behavioral Health, Inc. is to provide person-centered, holistic service that reflects innovation, best practices, health care equity, and outcome-based performance that is satisfying and cost-effective to consumers, staff, leadership, and other stakeholders.
- To provide service that meets the needs of consumers of diverse ages, ethnicities, and backgrounds.

COMPANY PHILOSOPHY

- The following statements reflect the philosophy of QBH, Inc.:
 - All actions and decisions of QBH are to be driven by our person-centered philosophy that results in services being delivered in a fashion that is appropriate to the individual consumer and in a manner that demonstrates unconditional positive regard.
 - Connected to person-centered service is an understanding that a holistic approach to service is required because consumers typically need healing and attention to many or all the aspects of who they are physically, mentally, emotionally, socially, and spiritually.
 - Each consumer is seen as a person with an illness, not a moral deficiency, who needs support in a loving, caring environment where they can feel safe and encouraged to heal/recover.
- Leadership and staff are expected to conduct themselves and deliver services in a manner that reflects this philosophy.
- Leadership's development of programmatic and service planning is to be guided by this philosophy.
- For our Company's MAT programs and interventions to promote equity, our leadership and staff is committed to helping fix systemic discriminatory practices, address community needs previously overlooked, and take actions aligned with the Company's mission statements.
- QBH's philosophy is communicated to consumers, staff, and other stakeholders through various means:
 - Training
 - Community Outreach
 - Brochures, pamphlets and/or advertisements about QBH and its services
 - Observation of staff's behavior in service delivery that reflects this philosophy
 - Leaders' communications that reveal their commitment to this philosophy internal and external to QBH.

COMPANY VALUES

- Provide, in an integrated manner, the most comprehensive and cost-effective behavioral health and substance abuse services possible to residents of Oakland County, Wayne County and Macomb County, MI, in need of such services, including consideration of special needs and risks for the ethnic populations represented in the geographic area of each program.
- Preservation of the family unit through provision of services in the least restrictive environment possible based upon the consumer's needs and level of support available, involvement of the family directly or through a multi-family approach to aid them in problem-solving issues so as to establish a strong, healthy family unit that is supportive to the consumer's treatment and recovery.
- Provide culturally, socially, and gender sensitive services with equal access regardless of income, race, religion, or disability. Recruitment and retention of bilingual/bicultural staff, staff training on

Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

QUALITY BEHAVIORAL HEALTH, INC.MAT DIRECTIVES

LEADERSHIP: MISSION, PHILOSOPHY AND

- cultural sensitivity and diversity to raise cultural awareness, and to factor culture and gender into treatment and services provided.
- Supportive, non-judgmental service and treatment to consumers with disabilities through accommodation and/or provision of home-based outpatient services if needed.
- Treatment emphasis on helping consumers to become empowered to become the solution to their own problems through learning and skill building.
- Cost effective approaches to service such as brief, solution-focused treatment using cognitive-behavioral strategies in outpatient treatment that fosters time limited and specific problem identification leading to prompt problem identification and resolution.
- Sensitive and timely response to community need for services through advocacy and/or Company development of those services.

LEADERSHIP DIRECTIVES

- The mission, philosophy, and values of QBH are foundational for the Board of Directors and leadership as they guide the various elements of Company operations, as follows:
 - The Board and leadership, through its Clinical Committee, collaborate in review and, as necessary, revision of QBH's mission as part of strategic planning.
 - Direction to the organization is premised on the person-centered service goal and the delivery of service and conduct of operations in a fashion that is cost-effective while sustaining best practices.
 - Service and program planning promotes value through a utilization and performance improvement model that gives regular feedback to leaders for decision making.
 - Provide resources and education for staff through a variety of methods (in house training, community and professional conferences, electronic media, field-related publications, etc.) to assist staff to stay current in their field, acquire updated best practices, learn about new research findings, and keep abreast of professional experts' consensus on field issues.
 - The performance improvement system is structured to provide ongoing feedback relative to the level of achievement of program and service outcomes through structured performance outcome measures and regularly provided summary reports for leadership's analysis.
 - Monitoring and adjusting, as needed, budgets, financial policies and practices, and financial decisions based upon an annual internal audit and performance outcomes data to sustain financial solvency.
 - Managing risk through risk planning; periodic risk assessments; education for managing risk to leaders and staff, both formally and serendipitously, and to consumers as relevant; scheduled surveillance; incident reporting and analysis; sound insurance programs, etc. to reduce and/or eliminate risks to QBH, its staff, and consumers served.
 - Directing and receiving regular reports on performance improvement system activities and results for the purpose of identifying Company excellence, areas for improvement and success of such improvements, determining performance in many categories of service and operations on an ongoing basis.
 - Establishment and implementation of corporate responsibilities through Board Bylaws, Company policies, record-keeping and minutes, a variety of performance measures, leadership evaluation processes and corporate compliance guidelines.

Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

QUALITY BEHAVIORAL HEALTH, INC.MAT DIRECTIVES

LEADERSHIP: MISSION, PHILOSOPHY AND

- Overseeing compliance with all legal requirements of county, state and federal regulatory bodies, service reimbursement bodies, and local legal authorities as relates to QBH's services and programs.
- In addition to annual reviews of various systems and processes of QBH, leadership conducts an annual review of its policies to assess need for revision to reflect current compliance with internal practices; adjustments needed to meet regulatory, external provider and accreditation bodies; changes in best practice guidelines; changes in staff and/or consumer populations; and other indicators. Clinical Committee minutes and, when applicable, Board minutes reflect the conduct of these reviews and, when needed, approval of any revisions or new policies. Additionally, at least annually, the Company informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health care equity.
 - Reviews and/or revisions will be noted in the footer of the policy indicating each date in which leadership reviewed and/or revised a policy, form, manual within the Policy Manual.
 - The Administrative Assistant will notify staff of new or revised policies and make them available in hard copy and electronically; s/he will also maintain the official hardcopy Policy Manual and keep it current.

EVALUATION

- The plan is reviewed by the CEO at least annually, with interim reporting of progress points quarterly to the Clinical Committee and the Board; updating of the plan occurs as needed. The plan is reviewed and approved by the Clinical Committee and the Board annually.

FORMS:

- Budget Historical Comparison Form
- Annual Performance Analysis Summary Form
- Clinical Committee Minutes Form

COMMUNICATION AND SUCCESSION POLICY**LEADERSHIP STRUCTURE**

- QBH, Inc. maintains a hierarchical structure, though an open-door policy exists at each level and among levels.
- See the Diagram of the Organizational Chart for an overview of QBH's structure.
- Leadership, individually and collectively are to provide guidance in operations and practices, to include, but not exclusively:
 - Establishment and at least annual review, during strategic planning, of the mission and direction of QBH
 - Promotion of value in the services and programs of QBH through orientation and training, supervision and evaluation activities, and by personal modeling.
 - Foster achievement of Company and program-specific outcomes through provision of adequate resources, ongoing attention to quality system results, setting of strategic and clinical goals annually, ongoing training of staffs, and application of ASPIRE in all realms of service delivery.
 - Balancing the expectations of care recipients, staffs and other stakeholders through ongoing open communication, satisfaction assessments and other means.
 - Sustaining financial solvency through setting of fiscal goals, ongoing monitoring in inputs and outputs, continuous attention to changes in service reimbursement trends, and Board oversight of the financial picture on a regular basis.
 - Managing of risk through ongoing surveillance and regular assessments of risk, consumer/staff/ stakeholder feedback, operating in compliance with policy and protocols of QBH, regular assessments of the physical, emotional, financial and operational environments of QBH.
 - Ongoing performance improvement, applying the ASPIRE process.
 - Development and implementation of corporate responsibilities through leadership training, accountability through the committee structure, and periodic assessments.
 - Ongoing compliance with all legal and regulatory requirements through both internal and external surveillance and prompt response to any legal or regulatory changes.
 - Annual review of QBH's policies by leadership itself through committee, or through delegation.
 - Ongoing enforcement of health and safety policies through education, surveillance, supervision and disciplinary processes, if needed.
 - Succession planning as set forth in this policy, to be reviewed annually for continuing appropriateness.

LEADERSHIP STRUCTURE, RESPONSIBILITIES AND SUCCESSION**Board of Directors**

- The Board has overall responsibility for governance and operation of QBH. The Board employees and supervises a Chief Executive Officer (CEO) to act on its behalf in providing direction to the operations and functioning of QBH.
- Additionally, the Board may appoint committees from time to time to which it will delegate specific aspects of governance.
- Bylaws further delineate areas of accountability retained by the Board.

COMMUNICATION AND SUCCESSION POLICY

- Board member replacement is also addressed in the Bylaws.
- Board members must be professionally and culturally competent.

Chief Executive Officer

- The CEO is accountable directly to the Board of Directors; specific duties are defined in the CEO's job description.
- The CEO is responsible for overseeing all operations, including day-to-day decisions relative to operation of QBH.
- The CEO functions as the Administrator and also supervises the Medical Director and Clinical Director.
- The Safety Officer, Utilization/Quality Manager, Recipient Rights Advisor and a Program Sponsor (if other than the Medical Director) are appointed and supervised by the CEO as well. A Clinical/Program Director or Manager will be appointed to assist in daily operations.
- The CEO is chairperson of the Clinical Committee and oversees compliance with the committee's duties and responsibilities as reflected in the committee's agenda calendar and documented in committee minutes.
- Ultimate responsibility for staff recruitment and the provision of quality care rests with the CEO.
- In the event that the CEO is unable to fulfill his/her duties, the Board of Directors will temporarily assign the responsibilities of the CEO to the Medical or Clinical Director. The Board of Directors will begin an active search of qualified individuals with the experience, educational qualifications and demeanor suitable to fill the CEO position. QBH employees wishing to apply for this position must submit a resume to the Board of Directors. Qualified individuals will be scheduled for an interview and further background and educational screening will be conducted. The final candidate will receive an offer of employment from the Board of Directors. Upon acceptance of the position the newly appointed CEO will be placed on a one year probationary period and sent to any necessary training to aid in the completion of his/her duties.
- The CEO must be professionally and culturally competent.

Administrator

- This position is accountable to and supervised by the CEO.
- The Administrator is responsible for overseeing and authorizing day-to-day operation of QBH's administrative services.
- This position appoints and supervises the Accountant, Medical Records and the Administrative Assistant/Office Manager.
- Likewise, the Administrator appoints and supervises the Receptionist and Security Officer.
- In the event that the Administrator is unable to fulfill his/her duties, the CEO will temporarily fulfill the duties of the Administrator, or temporarily assign another qualified staff. The CEO will begin an active search of qualified individuals with the experience, educational qualifications and demeanor suitable to fill the Administrator position. QBH employees wishing to apply for this position must submit a resume to the CEO. Qualified individuals will be scheduled for an interview and further background and educational screening will be conducted. The final candidate will receive an offer of employment from the CEO. Upon acceptance of the position the newly appointed Administrator will be placed on a six month probationary period and sent to any necessary training to aid in the completion of his/her duties.

COMMUNICATION AND SUCCESSION POLICY**Medical Director/Program Sponsor**

- This position is available to the Board of Directors and is accountable to them and the CEO for assisting in and overseeing of the delivery of medical and nursing services of QBH; specific duties are delineated in the job description and privileging record.
- The Medical Director/Program Sponsor also collaborates with the Clinical/Program Director in delivery of clinical services.
- The Medical Director/Program Sponsor directly supervises the physicians and Director of Nursing employed or contracted by QBH to deliver services to QBH, Inc. programs.
- The Medical Director is responsible for ALL medical services performed by the program.
- The Medical Director is a member of and participant in the Clinical Committee.
- This position is responsible to participate in multidisciplinary treatment planning, lends medical expertise as needed to other operations of QBH, participates in peer review activities, and interfaces with internal and external customers and providers to interpret services and to facilitate quality consumer service delivery.
- This position participates in the recruitment of physicians and other licensed independent practitioners.
- In the event that the Medical Director/Program Sponsor is unable to fulfill his/her duties, the Board of Directors will temporarily assign another qualified medical staff. The Board of Directors will begin an active search of qualified individuals with the experience, educational qualifications and demeanor suitable to fill the position. QBH privileged physicians wishing to apply for this position must submit a resume to the CEO. Qualified individuals will be scheduled for an interview and further background and educational screening will be conducted. The final candidate will receive an offer of employment from the Board of Directors. Upon acceptance of the position the newly appointed Medical Director/Program Sponsor will be placed on a six month probationary period and sent to any necessary training to aid in the completion of his/her duties.

Nursing Director (DON)

- This position is responsible to and supervised by the Medical Director.
- The DON oversees all nursing services.
- Accountable to plan, manage and evaluate nursing services, assist with clinical support service contracts, provide nursing scheduling, and development and review of nursing protocols and policies.
- This position also provides direct nursing care on an as needed basis.
- The DON participates in the hire of and supervises nursing staff.
- The Nursing Director is a member and participant of the Clinical Committee.
- In the event that the Nursing Director is unable to fulfill his/her duties, the Medical Director will temporarily fulfill the duties of the Nursing Director or temporarily assign another qualified nursing staff. The CEO and Medical Director will begin an active search of qualified individuals with the experience, educational qualifications and demeanor suitable to fill the position. QBH employees wishing to apply for this position must submit a resume to the Medical Director. Qualified individuals will be scheduled for an interview and further background and educational screening will be conducted. The final candidate will receive an offer of employment from the CEO. Upon acceptance of the position the newly appointed Nursing Director will be placed on a six month probationary period and sent to any necessary training to aid in the completion of his/her duties.

COMMUNICATION AND SUCCESSION POLICY**Clinical/Program Director**

- This position is accountable to and appointed by the CEO; the CEO is the supervisor to this position.
- The Clinical/Program Director is responsible for supervision of clinical staff, including Therapists/Counselors, Case Managers and Monitors.
- The Clinical/Program Director monitors services delivered by employed and contracted clinical personnel and coordinates program implementation.
- This position is a member of and participant in the Clinical Committee, lending clinical expertise and assistance with peer review, credentialing and quality review as well as clinical policy development.
- This position participates in the recruitment of clinical staff.
- In the event that the Clinical/Program Director is unable to fulfill his/her duties, the CEO will temporarily assign a qualified staff. The CEO will begin an active search of qualified individuals with the experience, educational qualifications and demeanor suitable to fill the position. QBH employees wishing to apply for this position must submit a resume to the CEO. Qualified individuals will be scheduled for an interview and further background and educational screening will be conducted. The final candidate will receive an offer of employment from the CEO. Upon acceptance of the position the newly appointed Clinical/Program Director will be placed on a six month probationary period and sent to any necessary training to aid in the completion of his/her duties.

Safety Officer

- Appointed and supervised by the CEO, this position oversees the environmental health and safety of QBH with delegated authority to request from medical staff, nursing staff, administrative staff, clinical staff and support service staff clarification re: pertinent reports and follow-up information on problems or actions implemented to resolve identified health, safety and emergency problems.
- This position is given authority to: train on, receive and review and verify all data and reports related to operationalization of the Health, Safety and Emergency Plans and implementation of Joint commission (JC) and regulatory requirements related to these areas.
- Oversees organization, development and implementation of the Health and Safety and Emergency Management Plans. An overview of responsibilities includes:
 - Identification, investigation and follow through on identified problems to make sure that corrective or improvement actions have been appropriately taken.
 - Review related policies and procedures in collaboration with the Clinical Committee.
 - Keep documentation which supports that the intent of the plans is being carried out.
 - Report on safety and infection control issues and the plans as scheduled to the Clinical Committee.
 - Develop, review and provide for education of staff and consumers or families.
 - Act as a resource to staff and management on safety, emergency and infection control issues and federal, state, or local regulations or laws which affect QBH.
- The Safety Officer serves in a consultative role to the following:
 - Security Officer and Receptionist
 - Clinical Committee
 - All staff relative to health, safety and emergency activities.
- This position does not supervise any other levels of staff, but liaisons with all departments and programs as relevant to health, safety and emergency issues.

Utilization and Quality Manager

COMMUNICATION AND SUCCESSION POLICY

- This position is appointed and supervised by the CEO and holds the following authority as delegated by the CEO:
 - Authority and responsibility for directing and supervising the activities and functions of the Performance Improvement-Quality Management Program, and the Utilization Management Program.
 - Authority to request from Performance Improvement Task Forces, medical staff, nursing staff, administrative staff, and support service staff clarification re: pertinent reports and follow-up information on problems or actions implemented to resolve identified problems.
 - Authority to: train on, receive and review and verify all data and reports related to operationalization of the Utilization and Quality Systems and implementation of CARF and regulatory requirements.
- This position develops and oversees implementation of an Company-wide performance improvement-quality management program, and a utilization management program consistent with Company-approved plans and regulatory and standard setting agencies.
- This position also coordinates activities related to preparation for and facilitation of regulatory and JC inspections/surveys/reports. Official Policy and Forms Manuals, Committee Minutes, and Quality Data are maintained current and secure by and in the office of this position.
- Collaborates regularly with the Safety Officer, Clinical Director, Medical Director, Nursing Director and Office Manager/Administrative Assistant
- Serves in a consultative role to the following:
 - Performance Improvement Task Forces
 - Clinical Committee
 - All staff involved in quality and utilization related activities.
- This position does not supervise any other levels of staff, but liaisons with all departments and programs as relevant to utilization and quality performance issues.

NON-LEADERSHIP STRUCTURE AND RESPONSIBILITIES (MEDICAL/CLINICAL)**Physician and Other Licensed Independent Practitioner Staff**

- These positions are supervised by and accountable to the Medical Director.
- This staff is responsible for evaluating consumers' medical/psychiatric condition, implementing needed psychiatric and pharmacologic services, participating in multidisciplinary treatment planning, contributing to peer review, and, upon request, providing medical expertise to the Clinical Committee.
- This staff does not supervise other levels of staff, but liaisons with all departments and programs as relevant to delivery of quality medical services.

Nursing Staff

- Comprised of nurses at various levels of training, this staff is responsible to and supervised by the Nursing Director.
- Nurses are responsible for providing nursing care to consumers using the nursing process. Care may include:
 - Assessments and treatment planning
 - Medication administration and management
 - Monitoring and/or treating physical health issues

COMMUNICATION AND SUCCESSION POLICY

- Therapeutic milieu management, including assisting with group therapy and psycho-education.
- This staff does not supervise other levels of staff, but liaisons with all departments and programs as relevant to delivery of quality nursing services.

Therapists

- This position is supervised by and under the direction of the Clinical Director.
- Therapists are responsible for the provision of clinically necessary and appropriate assessments, therapeutic treatment services, clinical record documentation and other services as designated in their job description or service contract.
- This staff liaison with all departments and programs as relevant to delivery of quality clinical services.
- Therapists assist in directing service provision of Case Managers and Monitors.

Case Managers and Monitors

- These positions are supervised by and under direction of a designated therapist.
- As assigned by the therapist, this staff is responsible to assist in delivery of treatment services, may assist in group or psycho-educational sessions, aids in facilitating a therapeutic milieu and may have specific documentation responsibilities.
- This staff does not supervise other levels of staff, but may liaison with other departments and programs as relevant to their scope of service delivery and as directed by their supervisors.

Recipient Rights Advisor

- This position is hired by, supervised by and accountable to the CEO.
- This position will receive and acknowledge all reports of and may investigate apparent violations of rights and act to resolve disputes relating to apparent violations.
- It is the responsibility of this position to act on behalf of recipients/consumers to obtain a remedy for any apparent violation as well as to endeavor to safeguard the rights guaranteed by the Michigan Mental Health Code (P.A. 258).
- Monitoring that The SUMMARY OF YOUR RIGHTS pamphlet and the Recipient Rights poster are continually displayed in all waiting rooms and group rooms of Quality Behavioral Health, Inc., and Business Office is also a responsibility of the position.
- The position shall ensure that all recipients/consumers, and others who wish to act on their behalf, have access to forms on which to document alleged violations and is responsible to keep complaint forms and self-addressed envelopes available in all waiting rooms and group rooms.
- This position does not supervise other levels of staff, but may liaison with other departments and programs as relevant to the scope of the position and/or as directed by the CEO.

SUPPORT SERVICES**Accountant**

- This position is hired by, supervised by and accountable to the CEO.
- The Accountant is responsible for recording and reporting on all financial interactions of QBH.
- This position assists, as needed, in quality review, budget preparation and financial advisement.

COMMUNICATION AND SUCCESSION POLICY

- The Accountant is responsible for conducting an annual internal audit for QBH and is responsible for all tax related documentation.
- This position does not supervise other levels of staff, but may liaison with other departments and programs as relevant to accounting needs and/or as directed by the CEO.

Medical Records Staff

- This staff is hired by, supervised by and accountable to the CEO.
- Medical Records Staff is responsible for maintaining the integrity of clinical records and overseeing responses to outside requests for consumer information.
- Processing and filing of legal documents and coordinating court-hearing activities for QBH are also responsibilities of this staff.
- Additional responsibilities include transcription services, assistance with report development, and, as needed, administrative support.
- This position does not supervise other levels of staff, but may liaison with other departments and programs as relevant to clinical records management or as directed by the CEO.

Administrative Assistant/Office Manager

- This position is hired by the CEO and is supervised by and accountable to both the CEO and Administrator.
- This position provides administrative, secretarial and business office support functions, including handling of sensitive Company information and confidential staff and consumer information.
- Interfacing with community and other behavioral health service providers and the Board of Directors is also a responsibility of this position.
- The position may be required to assist with marketing and grant writing.
- The Office Manager is responsible for processing, management and maintenance of personnel and credentialing files of QBH's staffs, coordinating staff training calendars, and assisting with human resources issues and projects.
- Data accumulation and records management for quality activities, mandatory committee attendance, supervision requirements, and other critical HR information is a responsibility of this position.
- This staff does not supervise other levels of staff, but liaisons with all departments and programs as relevant to administrative and HR services.

Receptionist

- This position is hired by, supervised by and accountable to the Administrator.
- The Receptionist is to clearly convey consumer respect, courtesy, and compliance with consumer rights as the first person consumers and their families as well as other stakeholders see when they enter QBH.
- This position greets all who enter QBH to facilitate directing them to the location and/or staff with which they need to meet.
- The Receptionist answers all calls coming into QBH, including those inquiring about an intake.
- The Receptionist may assist with data collection for the Quality System as directed.
- The Receptionist does not supervise any staff but may interface will all departments and programs as necessary to fulfill job duties.

COMMUNICATION AND SUCCESSION POLICY**Maintenance Technician**

- This position is responsible to the CEO for performing Company maintenance and grounds duties including repairs, safety checks, grounds maintenance in a fashion compliant with Company safety, security and hazardous materials policies.
- The position assists the Safety Officer in conducting equipment and vehicle inspections and does maintenance as needed or required.
- This position does not supervise other staff, though liaison with all departments and programs occurs as relevant to maintenance and repair activities.

CONTRACTED SUPPORT SERVICES**Billing Services**

- Responsible to the CEO for billing and collections transactions and generation of related reports to QBH.

Transport Services

- Responsible to the CEO for transport of consumers to and from their residences, appointments, Company activities and other activities as requested in a fashion compliant with Company policy.

Housekeeping Service

- Responsible to the CEO for performing Company housekeeping duties including cleaning, washing, following the safety and security procedures and policies of this Company.

Security Officer

- Responsible to the CEO for performing internal and external facility security services, following the safety and security procedures and policies of this Company.

Psychologist

- The psychologist provides psychological testing and a report of findings for any consumer for whom the Medical Director orders such testing.

COMMUNICATION MECHANISMS**Personnel**

- Leadership maintains an open-door policy for communication with staff, encouraging staffs' ideas and feedback.
- The Organizational Chart directs communication channels; initial communication should occur with each staff's direct supervisor. Should communication at this level not be effective, the staff would then go to the supervisor's direct supervisor as directed by the Organizational Chart. This hierarchy is followed until the situation/concern is resolved.

COMMUNICATION AND SUCCESSION POLICY

- Communication necessary to conduct work activities may go up and down the organizational hierarchy or across laterally, as needed.
- No communication in any form is issued to "All Staff" without prior approval of that individual's supervisor.
- Communication formats available to staff include:
 - Face-to-face such as during informal and/or formal supervision
 - Direct telephone contact
 - Voice mail
 - Email
 - Fax
 - Written memos and messages (response should occur timely, even if to simply give notice that a full response will come within 24 hours)
 - Pay check attachments
 - Meetings and meeting minutes
 - Tele-med
 - Policies and procedures
 - Newsletter
 - Requisitions/work orders/purchase orders
 - Internal Company and UPSO mailings
- Communications requiring use of equipment may be limited due to prioritization of use, availability, or Company/program/department protocol.

Consumers

- Consumers are directed to address issues, concerns, and ideas first with their primary service provider. If necessary, the consumer can go to that provider's supervisor. See the Consumer Grievance Policy for more details.
- Leadership seeks consumer input through satisfaction surveys, "speak up" (for feedback and complaints) boxes, community meetings and other formal channels depending upon the need. Leaders willingly communicate with consumers for ideas and feedback directly or via methods listed here.

Other Stakeholders

- Stakeholders are welcome to arrange appointments to speak with leadership staff at any time.
- Leaders are also involved in various community and service provider forums, committees, and meetings where they invite ideas, feedback, and conveyance of needs.
- QBH periodically invites stakeholders to forums and community input sessions held by QBH.
- Company website, newspaper articles, and community service events are also venues for communication with stakeholders.
- Stakeholders are offered satisfaction surveys as a venue for providing feedback to QBH.
- Communication external to QBH by staff must be pre-approved by the staff's supervisor.

TRAINING

- New Board members receive training as part of their orientation to their roles and responsibilities.
- All staff is trained on this policy at hire and whenever any revision occurs.

COMMUNICATION AND SUCCESSION POLICY

- Staff is trained on use of communication equipment according to need and job responsibility.
- Consumers are informed about means they have available for communication as part of their intake and orientation.

EVALUATION

- The plan is reviewed by the CEO at least annually, (every twelve months +/- 30 days), with interim reporting of progress points quarterly to the Clinical Committee and the Board; updating of the plan occurs as needed. The plan is reviewed and approved by the Clinical Committee and the Board annually.

FORMS:

Organizational Chart

Our programs also serve the local communities by providing addiction treatment for community residents and offering jobs for qualified residents. We make every effort to recruit and hire responsible, qualified personnel from the local community.

QBH, INC. leaders and staff are active as representatives, speakers, or planners at professional conferences and as members or leaders in professional and community coalitions, including advisory councils. Such affiliations augment community relations efforts through increased professional education and public awareness, providing an opportunity to exchange information with and counter MAT stigmatization among other treatment professionals. These forums also may present community relations models that can learn from as well. Staff participation on local planning or development bodies helps us contribute to community improvement, particularly in social and health services.

We will plan to participate in national SAMHSA campaigns; for instance, by supporting National Alcohol and Drug Addiction Recovery Month or sponsoring events to emphasize that addiction recovery is possible and facilitating MAT as compassionate and a sound investment.

ESTABLISHING EFFECTIVE MEDIA RELATIONS

Print, broadcast, and Internet media play critical roles in reporting and educating, as well as influencing public opinion. Local and national media differ widely in their portrayals of opioid addiction, MAT, and people addicted to opioids. These differences reflect a combination of factors including journalistic integrity, reporting style and philosophy, political leanings, regional influences, and business considerations. Successful media outreach enhances our programs' image, improves understanding of our programs' mission and methods, and generates supportive public policies. Media outreach can demystify treatment, counteract stigma, and improve fairness of coverage. The CEO is continually watchful of media opportunities and works at building firm relations with key media sources in these service communities.

DEVELOPING POLICIES AND PROCEDURES TO ADDRESS AND RESOLVE COMMUNITY CONCERNs

The best intentions to educate and serve the community are undermined if they are not followed up to resolve problems and concerns about our MAT programs. We have policies in place, and desire to work with local merchants, internal and community security forces and other community groups/resources to help curtail loitering, drug sales, and the diversion of methadone before they prompt community complaints. Staff and security force visibility reminds consumers of the negative effect of loitering and similar behavior and demonstrates to neighbors that the programs actively are committed to community safety and improving quality of life.

Consumers observed loitering will be counseled, and their treatment plan may be revised to address this behavior. Consumers observed in illegal transactions or medication diversion will have progressive discipline and intervention and an opportunity to a fair hearing and treatment before discharge will be considered. Although discharge is counter to the mandates of voluntary treatment, consumers who are unconcerned about the MAT program's larger community acceptance might be better served by a facility equipped to handle their behaviors. Decisions to discharge consumers for loitering shall balance consequences for the individual consumer and public health against the need to maintain a stable program environment and maintain community-based services open to all consumers.

Community representatives are provided with QBH MAT program contact information to report problems involving consumers; however, the program clarifies that they cannot assume a police role. In emergency and criminal matters, the police should be contacted first, not the MAT program. Effective liaison with local law enforcement personnel is critical to OTP relations with the community. Although

police officers are generally supportive, QBH strives to correct any misconceptions police personnel have about MAT programs. Consumers are to be differentiated from people actively using illicit drugs or abusing prescription drugs, and law enforcement personnel are informed about MAT program operations, with the understanding that police and the program share a purpose—addressing substance abuse in the community. Other community problems (e.g., drug sales, unsafe community conditions) identified during staff tours will be reported to law enforcement authorities. Local officers are encouraged to contact the MAT program about problems involving consumers, but in a fashion that protects consumer confidentiality.

DOCUMENTING COMMUNITY CONTACTS AND COMMUNITY RELATIONS ACTIVITIES

QBH, INC. leadership and staff is instructed to document their efforts to establish productive community contacts and resolve community concerns and submit that documentation to the CEO or designee who shall maintain a database and keep it updated. Communications should be logged, and staff participation in community events should be summarized. Letters and communications substantiating community complaints and the program's follow-up shall also be kept on file. Records are kept of staff participation in professional and community conferences, articles published in professional journals, and contributions to local news organizations. Using this information, The Clinical Committee shall, at least semi-annually evaluate community relations efforts. Such reviews can identify organizations excluded from previous efforts or problems requiring revision of program policies or practices.

STATE AND NATIONAL COMMUNITY EDUCATION OPPORTUNITIES

QBH, INC. works with local and state government entities to stay aware of and be involved in the dialog and efforts to promote MAT, improve and disseminate information about opioid addiction, and partner with other national organizations and agencies in public relations and community education efforts. In addition, we will attempt to build on and contribute to national initiatives within our program communities.

As opportunity avails itself, leadership and/or staff may participate in national and regional conferences that bring together treatment providers, policymakers, researchers, and advocates to share knowledge and discuss how to advance national drug policy and expand effective treatment models, including strategies to improve public relations and reduce stigma. Focused training sessions also provide critical information, for example, to explain how to improve current treatment of consumers who are opioid addicted. Other sessions may focus on improving staff attitudes and the treatment system regarding implementation of accreditation.

In 1999, SAMHSA convened expert panels and hearings to examine critical issues affecting the National Treatment Plan Initiative to improve and extend alcohol and drug treatment to all communities and people in need in the United States. This extensive exploration documented widespread stigma and bias and its effect on public support and policy, such as delaying the acknowledgment of addiction as a disease; inhibiting prevention, care, treatment, and research efforts; and diminishing the life opportunities of those stigmatized. This knowledge affirms the value of mass media public health education campaigns, comprehensive community-based health communications, media advocacy, and the application of commercial marketing technologies to programs to change social attitudes.

As government and provider-based organizations mobilize national efforts, consumers in and providers of MAT, along with other interested citizens, have been encouraged to unite and organize, educate health providers and their communities, and actively engage in public relations initiatives and other advocacy efforts that advance knowledge and change attitudes about MAT.

EVALUATION REQUIREMENTS

- QBH'S Governing Board will direct conduct of an evaluation of the Medical Director's performance at least annually prior to contract renewal.
- Because of the scope of the Medical Director's roles and responsibilities, that evaluation shall be a multidisciplinary process, culminating in a Corporate Board appraisal.

Medical Director Job Description

- Has authority over medical and nursing aspects of MAT and retains autonomy to see that medical decisions are individualized to the consumer's needs
- Is responsible for overseeing that all services of the MAT program are compliant with federal regulations at all times
- Is present at the program at sufficient number of hours to enforce regulatory compliance and carry out his/her duties
- Either directly provides required services to consumers or oversees that needed services are provided by appropriately trained and licensed providers

EVALUATION PROCESS

- In JANUARY of each year the following personnel will be provided with the appropriate *Medical Director Evaluation Form* by the CEO or designee:
 - Medical Director
 - All Physicians (staff/contract)
 - CEO
 - All Board Members
 - Clinical Director
 - Nursing staff
- The evaluation will be completed and returned to the CEO or designee within five business days.
- The CEO and Office Manager shall together tally and, where indicated, average the responses by personnel categories on the *Aggregate Form*.
 - The completed *Aggregate Form* will be reviewed by the Board, or a designated ad hoc committee of the Board, at the next scheduled Board meeting at which time conclusions will be determined regarding:
 - Performance strengths
 - Aspects of performance to be improved
 - A decision regarding contract renewal and, if renewal is agreed upon, performance goals, compensation and contract requirements for the upcoming contract year.
- At the following scheduled Board meeting these conclusions will be discussed with the Medical Director and his/her input into upcoming year performance goals will be considered. Agreed upon performance goals and any revisions to the job description will be included with the contract renewal agreement which shall be initiated for signature.
 - The Board may review with the Medical Director, upon request, aggregate and

anonymously the data used to arrive at their decision and to present the Board's decision.

EVALUATION

- This policy is reviewed by the CEO at least annually and submitted to the Clinical Committee and the Board for review and approval annually.

FORMS:

Medical Director Evaluation Forms
Aggregate of Medical Director Evaluations

GENERAL GUIDELINES

Purchases under or equal to \$100 may be made through petty cash or a CEO approved and distributed credit card with Department Manager or Program Director approval can be purchased without the use of a Purchase Requisition. The purchase receipt is submitted to the Accountant within 1 business day of the purchase. The Accountant has the authority to direct return and refund of the purchase within 1 business day after receipt, if in the best interests of the Company, in circumstances where return and refund is an option.

Purchases in excess of \$100 or not made through petty cash or credit cards, require a properly authorized Purchase Requisition.

Authorization authority is demonstrated by the level of signatures on the Purchase Requisition. Based upon the amount of the purchase, the following authorization(s) is required before procurement may be carried out:

- The Department Manager or Program Director must sign off and date all Purchase Requisitions that are between \$0.00 and \$500.99 in value in order for it to be valid. A Supervisor's signature on the Purchase Requisition is only an assurance to the Department Manager or Program Director signing the Purchase Requisition that the purchase is warranted.
- Both the Accountant and the Department Manager or Program Director must sign off and date all Purchase Requisitions between the amounts of \$501.00 to \$2,499.99 in value in order for it to be valid.
- The Chief Executive Officer (CEO) must sign off and date all Purchase Requisitions that are between \$2,500.00 and \$9,999.99 in value in order for it to be valid and acted upon.
- Both the CEO and the Board of Directors designee, with Board approval, must sign off on a Purchase Requisition that is \$10,000 or greater in value in order for it to be approved. The Accountant will first obtain at least 3 bids on expenditures that are over \$10,000 for the CEO and Board to consider and decide upon the procurement source.

Purchase requisition/orders without proper authorization are not valid and may not be used as authority to purchase.

RATIONALE FOR PROCUREMENT GUIDELINES

- To standardize the procurement process throughout the Company.
- To maximize available funds.
- To purchase needed items at the best possible price, quality and delivery.
- To stay within the approved operating budget.
- To assist the procurement function to operate in a manner that adheres to reasonable standards and will withstand an independent audit.

PURCHASE REQUISITION/ORDER PROCESS

The requestor will:

- Complete a Purchase Requisition Form with his/her name, the date of the request, and the assigned Department or Program.
- Note any suggested supplier, vendor or contractors in the space provided on the purchase requisition/order.
- Fill in: the item or service needed, the quantity needed, a detailed description, and the cost of the item, if known. Attach additional information (e.g. pictures, color preferences, etc.) as necessary. Remember to include the mailing/physical address, telephone/fax number, and/or email address/website, as appropriate.
- Indicate any special instructions and the purpose for which the item will be used.
- Check the “urgent” box if this item has to be purchased quickly and provide a brief explanation of this circumstance making it urgent.
- Submit the requisition to his/her immediate supervisor. If the supervisor approves, s/he must sign the requisition and obtain necessary authorization(s) before forwarding the purchase requisition to the Accountant for processing.

If the item being considered for purchase has safety or infection control issues associated with it and the item has never been previously approved by them, then it will have to be reviewed by the Safety Officer and/or Infection Control Coordinator and approved by them, as evidenced by their signature in the designated area of the Purchase Requisition, before the Accountant may move forward to procure the item. The Accountant is responsible to seek this approval when indicated.

The Accountant, or designee, will order or purchase the item in most situations. The date ordered, who ordered the item, and the anticipated date of delivery will be noted on the Purchase Requisition. The requestor may be notified that the order has been placed.

In certain circumstances, the Accountant may suggest that the employee requesting the purchase also order the approved item(s) or service(s), once it has the authorized approval. This will be limited to situations where the requestor has technical knowledge about the item(s) or service(s) or where the requestor will be physically present or proximate to the supplier/contractor and is therefore the most appropriate person overall to make the purchase. Examples of when this would be appropriate are:

- Item inventory that needs to be replenished on an ongoing basis once stock has reached a reorder point.
- The CEO approves the need for services that are provided on a recurring basis by the same vendor such as utilities, in writing, for one Fiscal Year. Vendors are examined at the end of the year by the CEO or designee prior to renewal.

RECEIPT AND ACCEPTANCE

The Accountant, or upon the Accountant's request, the Department Manager or Program Director, as appropriate:

- Inspects all goods received and examines goods for damage.
- Compares the description of goods and quantity to the Purchase Requisition for accuracy.

The inspection date and results are documented on the Purchase Requisition Form.

EVALUATION

This policy is reviewed and revised, if needed, by the CEO on an annual basis. The Policy is approved by the Clinical Committee annually.

FORMS:

Purchase Requisition Form

HANDLING OF SECURITY ISSUES

At determination of a security related incident:

- Staff person witnessing the incident would initiate action, if appropriate, and/or notify the Chief Executive Officer, Administrator or Safety Officer of the problem.
- If necessary, local law enforcement will be contacted to assist.

Authority for security:

- If the situation is deemed to be threatening the safety of consumers, visitors, or staff, any staff person is authorized to take immediate action.
- If the situation is of less severity, the Chief Executive Officer, Administrator or Medical Director will determine actions to be taken.

Managing "celebrities":

- Persons deemed to be "celebrities" or considered to be "very important persons" (VIPs) are to have their identities protected, unless they give permission to be otherwise treated, at all times.
- Confidentiality is to be strictly enforced. If deemed necessary by the Chief Executive Officer, a Jane or John Doe designation may be assigned to the consumer name on the record to protect identity.
- In the event of more than one record, then a number will also be assigned.
- Only the Chief Executive Officer and Administrator will have a list with actual names for the consumer records.

HANDLING MEDIA

Authority to address media:

- If the media is involved as a result of a security incident, only the Chief Executive Officer (CEO), Administrator or Medical Director may give out information.
- If the media contacts QBH for any other reason than a security incident, only the CEO, Administrator or Medical Director may provide information.
- Any staff contacted by the media should share no information, make no judgments, nor offer any personal comments, but immediately refer them to the CEO, Administrator or Medical Director, regardless of the time of day.

Media relationships:

- The CEO, Administrator and Medical Director will attempt to sustain contact relationships with local media sources (newspaper, TV, radio) so that, should the situation arise where media coverage or contact is needed, a known entity is available to communicate with.
- Likewise, an established relationship with local media can help to facilitate accurate press releases, publishing of articles about QBH for promotional or informational purposes, and to gain their endorsement and support of the goals of QBH.

SOCIAL MEDIA MANAGEMENT

- Social media includes all forms of electronic formats to interact with other people for social purposes. Such media include, but not exclusively: Facebook, Twitter, LinkedIn, WeChat, internet browser- specific social links, blogs, “texting” for social purposes, message boards, etc.
- Use of these media on QBH property and/or during working hours, whether on or off the property, is not allowed as such activities do not relate to the job or job responsibilities of any staffs and can interfere with one's focus and accountability in fulfilling job responsibilities in a timely, quality fashion.
- If any such sites are deemed beneficial to marketing and promotion of QBH, such posts may be entered and/or modified by the CEO only.
- Use of social media/interaction sites shall not be used to communicate Company, care recipient or their significant others/family, or staff information; nor shall Company owned phones, tablets, I pads, or computers be used to connect to such sites at any time. Violation of this requirement is a federal offense as stipulated in HIPAA statutes.
- Staff may not communicate with potential, current or former patients using these social interaction networks.
- Any phone and electronic media belonging to QBH and/or used in the conduct of one's job at QBH may be searched at any time by the CEO or Safety Officer; privacy settings must be as set forth in Company policy.
- All staff is responsible to immediately report any violation to the CEO or Safety Officer if they become aware of violations of this policy; failure to report, if prior knowledge is validated, will result in the same disciplinary actions as may apply to the actual violator.
- Violations of confidentiality and security using social media, or any other means, by a staff member is grounds for discipline up to and including immediate dismissal. Further, if a HIPAA violation is involved, federal fiscal penalties and/or legal action may also occur.
- See the Technology Plan and Information Management Policy for additional information regarding confidentiality and protection of health information.

EVALUATION

- The plan is reviewed and revised, if necessary, by the CEO at least annually, and submitted to the Clinical Committee and the Board for review and approval.

FORMS:

Social Media Disclaimer Form

STRATEGIC PLANNING ANALYSIS PROCESS

- The strategic plan is viewed as a guide to focus Company efforts, position QBH to take advantage of future opportunities, as well as to counter potential external threats.
- Planning commences with a careful review of the current mission, philosophy and core values; internally and externally generated performance data from the past three years; current demographics of QBH's service area; current relationships with external stakeholders and other valuable information; evaluation of QBH's status in achieving the previous years' goals and objectives; feedback on needs and expectations from customers, staff and various stakeholders through satisfaction surveys and other input mechanisms; adequacy of Company technology to produce efficient operations, effective service delivery, performance improvement and data analysis capabilities.
 - A SWOT process is employed that looks at Company strengths and capabilities; Company weaknesses or improvement needs; internal and externally identified opportunities, particularly financial opportunities, positive features of the current and projected regulatory and/or legislative environment, and service area needs QBH might address; and internal and external threats of a financial nature, degree of competitiveness in the provider environment, the nature of the regulatory and legislative environments, etc.
 - This review provides the foundation for the development of the strategic plan.
- Based upon the priorities set by the leadership as a result of this analysis, corporate goals and objectives are established to act upon and maximize the opportunities and strengths identified and to reduce the actual or potential threats to and weaknesses of QBH and its services.

WRITTEN STRATEGIC PLAN

- The CEO in collaboration with the Clinical Committee and Board members is responsible to develop the written plan.
 - Current and projected financial position of QBH is a serious consideration in developing the plan as this situation will impact what resources are available for allocation of resources needed to support achievement of the plan.
 - The plan sets goals, priorities and an implementation plan (including what is to be done, broken into steps, by whom and by when).
 - The plan may be for one year or multiple years with yearly achievement points, considering QBH's current financial position and financial planning for the future as well as other resources available.

COMMUNICATING THE STRATEGIC PLAN

- The Strategic Plan, once approved, is communicated to staff at staff meetings by the department or program leadership.
- A copy of the plan is posted in the consumer community rooms to avail interested customers of the information.
- The plan is shared with other stakeholders as required per contract agreement or upon request.

EVALUATION

Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

- The plan is reviewed by the CEO at least annually, with interim reporting of progress points quarterly to the Clinical Committee and the Board; updating of the plan occurs as needed. The plan is reviewed and approved by the Clinical Committee and the Board annually.

FORMS:

SWOT Form

Strategic Plan Implementation Form

ANNUAL PERFORMANCE ANALYSIS/OUTCOMES MANAGEMENT REPORT OUTLINE OF CONTENT

INSTRUCTIONS: Complete a review of data for each of the areas listed below to summarize improvements identified and results of efforts (status). Summarize this information (can be by category). Next summarize conclusions about priorities for efforts in the upcoming year that will result in new business/strategic goals, modifications to plans and/or goals/measures, changes in quality monitors, systems changes. Finally, describe how you provide this report, in a meaningful way, to your various stakeholders.

DATA REVIEW -> SUMMARY

- I. Results/progress in achieving business improvement goals for the year
- II. Results of analysis of financial information (quarterly budget variance reports, annual audit findings, P/L statements, historical budget comparison)
 - A. Improvement opportunities identified
 - B. Actions taken to improve - status
- III. Results of analysis of accessibility status reports (access issues and progress toward resolution)
 - A. Improvement opportunities identified
 - B. Actions taken to improve - status (Include Roll Out Plan)
- IV. Results of resource allocation measures (e.g., wait lists, LOS, referral to service, staffing compliance, overtime use, productivity, appropriate admits/discharges)
 - A. Improvement opportunities identified
 - B. Actions taken to improve - status
- V. Results of surveys (staff, consumer, stakeholders)
 - A. Improvement opportunities identified
 - B. Actions taken to improve - status
- VI. Results of HR reports (turnover, staff training/competence, staff evaluations, job description review)
 - A. Improvement opportunities identified
 - B. Actions taken to improve - status
- VII. Review technology reports (results of needs assessment; any deficits in back up, security, confidentiality processes; status of technology goals/improvements)
 - A. Improvement opportunities identified
 - B. Actions taken to improve - status

- VIII. Results from safety and IC reports (drills, inspections, incidents/risks, infection rates)
 - A. Improvement opportunities identified
 - B. Actions taken to improve - status
- IX. Results of Risk Plan objectives
 - A. Improvement opportunities identified
 - B. Actions taken to improve – status
- X. Review state/federal directives, accreditation recommendations, web/conference information related to new field trends presented during the year
 - A. Improvement opportunities identified
 - B. Actions taken to improve - status
- XI. Results from system delivery/outcomes measures (e.g., improvements in functioning, follow up, CGI, other quality process and outcome measurements)
 - A. Improvement opportunities identified
 - B. Actions taken to improve - status

CONCLUSIONS

- I. What improvement directives are indicated for the coming year that will enhance:
 - A. Service effectiveness
 - B. Service efficiency
 - C. Service access
 - D. Increased satisfaction of clients, staff, other stakeholders
 - E. Increase emphasis on mission/core values
 - F. Improve program quality
- II. Communication of this outcomes management report in a meaningful way to
 - A. Consumers
 - B. Staff
 - C. Other stakeholders

BUDGET ADJUSTMENT REQUEST (BAR)

Number: _____ Date: _____

Instructions: This form is to be completed and approved for any projected expenditure that will exceed \$1,000 and was not previously budgeted.

Amount Expected: Capital Improvement _____
Operating Expense _____
Personnel _____

Budget Data:

What expense category is affected? _____

Is actual expense in this category under budget? Yes _____ No _____

Will this expenditure cause the expense category to exceed budget? Yes _____ No _____

If yes,
explain: _____

_____Explanation and Justification (attach supporting data):

_____Approvals:

Preparer _____ Date _____
Executive Director _____ Date _____
Executive Director _____ Date _____
Chairman of the Board _____ Date _____

QUALITY BEHAVIORAL HEALTH, INC.**BUDGET HISTORICAL COMPARISON SHEET**

PROGRAM		Date Prepared	Page __	Of __
Quality Behavioral Health, Inc.		BUDGET PERIOD		
		From:	To:	
751 E Grand Blvd, Detroit, MI 48207				
EXPENDITURE CATEGORY	CURRENT YEAR TOTAL	LAST YEAR TOTAL (Actual)	2 YEARS AGO TOTAL (Actual)	3 YEARS AGO TOTAL (Actual)
Salaries and Wages				
Fringe Benefits				
Client Transportation				
Supplies and Materials				
Contractual (Sub contracts)				
Food Services				
Equipment				
Housing Program				
TOTAL DIRECT EXPENDITURES				
TOTAL				

QUALITY BEHAVIORAL HEALTH, INC.

MINUTES FORM

<input type="checkbox"/> MEETING MINUTES		Page _____ of _____	
Board/Committee/Workgroup:	Date: _____	Time: _____	Location: _____
Meeting Purpose:	Meeting Chair/ Facilitator: _____		Minutes Taken By: _____
Attendees:	Guests: _____		Absent: _____
Next Meeting: Date: _____	Time: _____		Location: _____
Distribution of Minutes: <input type="checkbox"/> Board/Committee Members <input type="checkbox"/> UM/Quality Manager <input type="checkbox"/> CEO <input type="checkbox"/> Administrator <input type="checkbox"/> Medical Director <input type="checkbox"/> Other (specify): _____			
<input type="checkbox"/> Minutes of Last Meeting on _____ Approved		<input type="checkbox"/> Minutes of Last Meeting On _____ Changed and Approved	<input type="checkbox"/> Not Applicable
AGENDA ITEM: Priority: High Time:	DISCUSSION/ ANALYSIS/ FINDINGS:		<p>OUTCOME/ DECISION:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Deferred to (target date): <input type="checkbox"/> Information Only, No Action Required <input type="checkbox"/> Report Accepted <input type="checkbox"/> Motion/ Decision/ Plan Approved as Follows: <p>IMPLEMENTATION:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Issue/ Rpt Referred to (person/group): <input type="checkbox"/> Follow-up Assignment(s) as Follows: (action to be taken/ person responsible/ target date) <input type="checkbox"/> Update/ Status Report Scheduled (date):
AGENDA ITEM: Priority: High Time:	DISCUSSION/ ANALYSIS/ FINDINGS:		<p>OUTCOME/ DECISION:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Deferred to (target date): <input type="checkbox"/> Information Only, No Action Required <input type="checkbox"/> Report Accepted <input type="checkbox"/> Motion/ Decision/ Plan Approved as Follows: <p>IMPLEMENTATION:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Issue/ Rpt Referred to (person/group): <input type="checkbox"/> Follow-up Assignment(s) as Follows: (action to be taken/ person responsible/ target date) <input type="checkbox"/> Update/ Status Report Scheduled (date):
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Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

QUALITY BEHAVIORAL HEALTH, INC.
QBH MEETING MINUTES and/or AGENDA CONTINUATION SHEET

MINUTES FORM

Page _____ of _____

AGENDA ITEM: Priority: High Time:	DISCUSSION/ ANALYSIS/ FINDINGS:	OUTCOME/ DECISION: <input type="checkbox"/> Deferred to (target date): <input type="checkbox"/> Information Only, No Action Required <input type="checkbox"/> Report Accepted <input type="checkbox"/> Motion/ Decision/ Plan Approved as Follows: IMPLEMENTATION: <input type="checkbox"/> Issue/ Rpt Referred to (person/group): <input type="checkbox"/> Follow-up Assignment(s) as Follows: (action to be taken/ person responsible/ target date) <input type="checkbox"/> Update/ Status Report Scheduled (date):
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Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

QBH MEETING MINUTES and/or AGENDA CONTINUATION SHEET

Page _____ of _____

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QUALITY BEHAVIORAL HEALTH, INC.**MINUTES FORM**

		<input type="checkbox"/> Update/ Status Report Scheduled (date):
--	--	--

First Quarter

October

- 1 Approve 20__ Accessibility Plan and Goals
- 2 Approve 20__ Strategic Plan
- 3 Approve 20__ Budget
- 4 PMI Report (see PMI Calendar for items)/System Evaluation/Changes to
- 5 Privileging, if due
- 6 Review Annual RM Plan/Objectives
Evaluation and Set New Objectives
- 7 Approve Technology Plan – New Goals
- 8 Direct Scheduling of Annual External Health and Safety Inspection
- 9 Speak Up Box Results
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20

November

- 1 Review of Safety/IC/Emergency Policies and Forms
- 2 PMI Report /Approve any New Monitors (see PMI Calendar for items)
- 3 Privileging, if due
- 4 Approve RM Plan – New Objectives
- 5 Safety/IC /Emergency Report – Inspections, Drills, etc.
- 6 Billing Audit Results (currently part of PMI report)
- 7 Speak Up Box Results
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
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- 18
- 19
- 20

First Quarter

December

- | | |
|----|--|
| 1 | Review of Consumer Rights Policies/
Forms and Cultural Diversity Plan |
| 2 | PMI Report (see PMI Calendar for items) |
| 3 | Privileging, if due |
| 4 | Fee Structure Review – any changes? |
| 5 | Progress Report on Strategic Plan Goals |
| 6 | Annual External Health and Safety
Inspection Report |
| 7 | Speak Up Box Results |
| 8 | Review/Analysis of Incident Reports for
the Year |
| 9 | Review of Med Use/Prescribing trends |
| 10 | |
| 11 | |
| 12 | |
| 13 | |
| 14 | |
| 15 | |
| 16 | |
| 17 | |
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| 20 | |

Second Quarter

January

- | | |
|----|---|
| 1 | Accessibility Plan Goals - Update |
| 2 | Budget Variance Report |
| 3 | Review of Leadership Policies/Forms |
| 4 | PMI Report (see PMI Calendar for items) |
| 5 | Privileging, if due |
| 6 | Status Report on Strategic Plan Goals |
| 7 | Status Report on Technology Goals |
| 8 | Speak Up Box Results |
| 9 | Review Programs Plan/Scope of Services |
| 10 | |
| 11 | |
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| 17 | |
| 18 | |
| 19 | |
| 20 | |

February

- | | |
|----|--|
| 1 | Review of Clinical Policies/Forms |
| 2 | PMI Report (see PMI Calendar for items) |
| 3 | Privileging, if due |
| 4 | HR Report on Staff Competencies/Review JDs for Revision/New needed |
| 5 | RM Plan Objectives - Update |
| 6 | Safety/IC/Emergency Report – Inspections, Drills, etc. |
| 7 | Billing Audit results (currently in PMI Report) |
| 8 | Speak Up Box Results |
| 9 | |
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Second Quarter

March

- 1** Review of Clinical Policies/Forms cont.
- 2** PMI Report (see PMI Calendar for items)
- 3** Privileging, if due
- 4** Technology Plan Review; Goals - Update
- 5** Status Report on Strategic Plan Goals
- 6** Speak Up Box Results
- 7** Report on Status of Corporate
- 8** _____
- 9** _____
- 10** _____
- 11** _____
- 12** _____
- 13** _____
- 14** _____
- 15** _____
- 16** _____
- 17** _____
- 18** _____
- 19** _____
- 20** _____

Third Quarter

April

- 1 Accessibility Plan Goals - Update
- 2
- 3 Budget Variance Report
- 4 Review of PMI Policies/Forms
- 5 PMI Report (see PMI Calendar for items)
- 6 Privileging, if due
- 7 Speak Up Box Results
- 8 Status Report on Technology Goals
- 9 Analysis and Review of Trends in Formal Complaints with action planning
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20

May

- 1 Review of HR Policies/Forms
- 2 PMI Report (see PMI Calendar for items)
- 3 Privileging, if due
- 4 RM Plan Objectives - Update
- 5 Safety/IC /Emergency Report – Inspections, Drills, etc.
- 6 Billing Audit Report (currently in PMI Report)
- 7 Speak Up Box Results
- 8
- 9
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Third Quarter

June

- | | |
|-----------|--|
| 1 | Review of Info Mgmt. and Technology Policies/Forms |
| 2 | PMI Report |
| 3 | Privileging, if due |
| 4 | Annual Evaluation of Current Contracts – decide re renewal, new contracts needed |
| 5 | Status Report on Strategic Plan Goals |
| 6 | Speak Up Box Results |
| 7 | Review of Incident Report Trends for first half of year |
| 8 | |
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| 20 | |

Fourth Quarter

July

- | | |
|----|---|
| 1 | Accessibility Plan Goals - Update |
| 2 | Budget Variance Report |
| 3 | Schedule for Annual Financial Audit |
| 4 | Review of Leadership Related Policy/Forms |
| 5 | PMI Report (see PMI Calendar for items) |
| 6 | Privileging, if due |
| 7 | Approve Renewal/New Contracts |
| 8 | Request Budget Proposals from Programs |
| 9 | Speak Up Box Results |
| 10 | Status Report on Strategic Plan Goals |
| 11 | Status Report on Technology Plan Goals |
| 12 | _____ |
| 13 | _____ |
| 14 | _____ |
| 15 | _____ |
| 16 | _____ |
| 17 | _____ |
| 18 | _____ |
| 19 | _____ |
| 20 | _____ |

August

- | | |
|----|--|
| 1 | Review of Medication Management, Nursing and Medical Policies/Forms |
| 2 | PMI Report (see PMI Calendar for items) |
| 3 | Privileging, if due |
| 4 | HR Report of All Aspects (see guidelines In HR Policy) |
| 5 | RM Plan Objectives - Update |
| 6 | Safety/IC Report – Inspections, Drills, etc. |
| 7 | Annual Insurance Coverage Review – changes needed? |
| 8 | Approval of Protocols, Standing Orders, OTC Med List (MD must submit after review) |
| 9 | Speak Up Box Results |
| 10 | Billing Audit Results (currently in PMI Report) |
| 11 | _____ |
| 12 | _____ |
| 13 | _____ |
| 14 | _____ |
| 15 | _____ |
| 16 | _____ |
| 17 | _____ |
| 18 | _____ |
| 19 | _____ |
| 20 | _____ |

Fourth Quarter

September

- | | |
|----|---|
| 1 | Accessibility Plan Evaluation – New Goals |
| 2 | Annual Performance Summary Review
(form) |
| 3 | 20__ Staff Training Calendar |
| 4 | Strategic Plan Goals – Update/New Year
Priorities |
| 5 | Results of Annual Financial Audit |
| 6 | PMI Report (see PMI Calendar for items) |
| 7 | Privileging, if due |
| 8 | Annual Evaluation Technology Plan/Goals |
| 9 | Review/Approve Audit Report |
| 10 | Review Proposed Budget then to Board |
| 11 | HR Report on Staff Turnover (comparison
of current year with past three years) |
| 12 | Review of Corporate Compliance Plan -
New Goals |
| 13 | Accountant Input on Proposed Budget |
| 14 | _____ |
| 15 | _____ |
| 16 | _____ |
| 17 | _____ |
| 18 | _____ |
| 19 | _____ |
| 20 | _____ |

MEMORANDUM

From: CEO QUALITY BEHAVIORAL HEALTH

To: Corporate Compliance Officer

Subject: APPOINTMENT AS CORPORATE COMPLIANCE OFFICER

As per our previous discussions, you are hereby appointed as Corporate Compliance Officer (CCO) for Quality Behavioral Health. In the performance of your duties, you will be bound by all applicable state and federal guidelines and will have direct access to the Clinical Director and members of the Quality Behavioral Health Chief Executive Officer as necessary. As CCO, you will be responsible for development, implementation and ongoing monitoring of all policies and procedures to ensure conformance with generally accepted operational and administrative practices regarding corporate compliance. Additionally, you will be responsible for establishing and chairing the organization's Corporate Compliance Team and submitting periodic reports on the team's activities and other corporate compliance activities as required.

Your appointment as CCO is effective _____ and will remain in effect until withdrawn in writing.

Chief Executive Officer

Date:

Donor Address:

Dear donor name

This letter is forwarded to you as an acknowledgement of your recent cash/in-kind donation to Quality Behavioral Health, Inc., which was in the amount of \$ /you have estimated to be worth \$

At this time when our most vulnerable have the fewest resources, words alone cannot convey the deep gratefulness we feel. Please feel confident your contribution will assist in the continuation of quality mental health services provided to our deserving citizens.

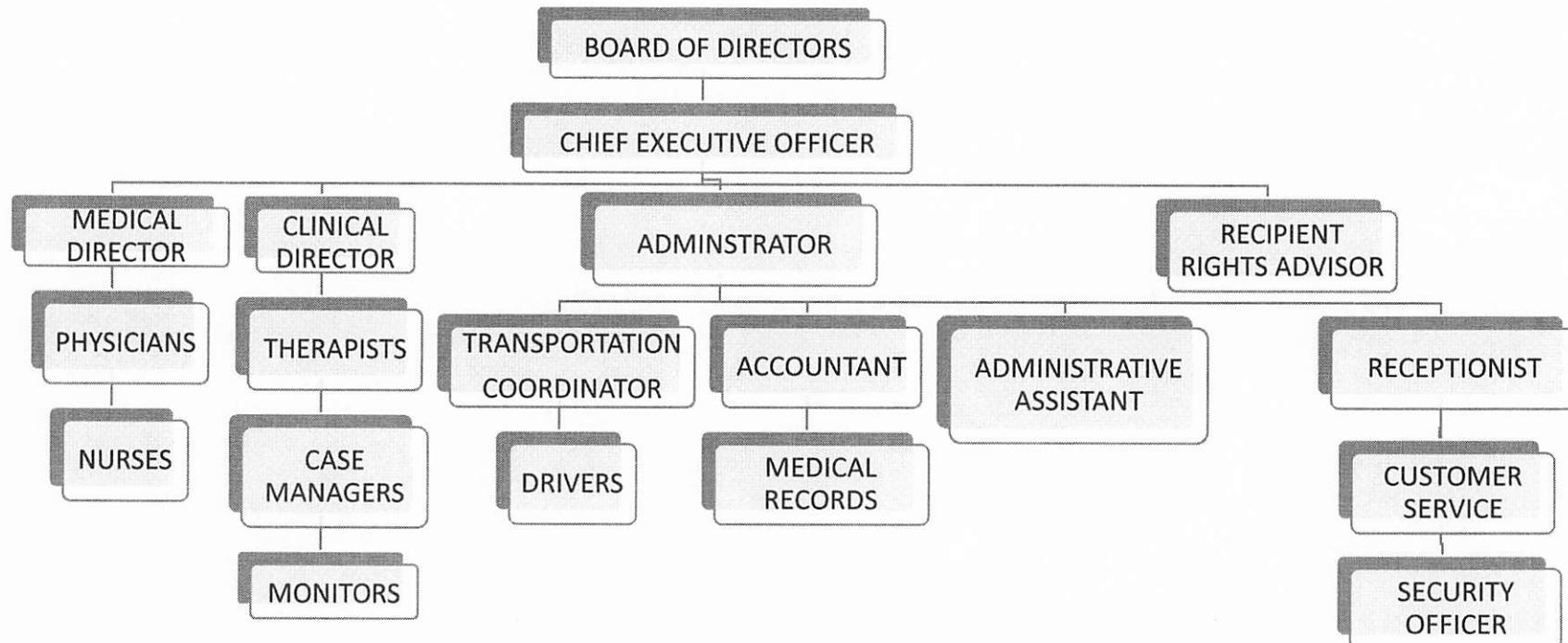
Again, we extend our deepest thanks.

Sincerely,

CEO, Quality Behavioral Health, Inc.

- 751 E Grand Blvd. Detroit, MI 48207 Tel: 313 922 2222
- 37490 Dequindre, Sterling Heights MI 48310 Tel: 586 480 1438
- 7220 Gratiot, Detroit, MI 48213 Tel: 313 922 3333
- 6821 Medbury St, Detroit MI 48211 Tel: 313 922 2222
- 1059 Owendale, Troy MI 48083 Tel: 313 922 2222
- Fax # 1 866 287 5710 Email : mail@qbhrecovery.org

ORGANIZATIONAL CHART



Quality Behavioral Health, Incorporated

745 EAST GRAND BLVD., DETROIT MI. 48207 TEL: 313 922 2222 FAX: 313 922 8771

RECEIPT AND AGREEMENT FOR SAFE KEEPING

RECEIVED _____

TRANSACTION

DATE	CREDIT	DEBIT	BALANCE	STAFF INT.

FROM _____

STAFF

DATE/TIME

I understand that the above amount has been kept by QBH for safe-keeping and will be returned to me upon my discharge. I also understand that the only time I can get this money back is during 9AM and 5 PM Monday through Friday. I am fully aware that I cannot get this money after 5 pm and during weekends. In an event that I leave the program or get terminated after the above hours I will have to come back during these hours to pick up the money. In order to receive the money, I must have a receipt.

Patient Information**Client Fee Agreement**

And

**Declaration of Personal and Household Income
(Must be updated every 90 days)**

I understand that a portion of the cost of my treatment is being subsidized by public funds. As required by eligibility guidelines, I certify the following income information and agree to pay established fees. If personal or household income changes during treatment, I will notify the treatment provider.

Traditional Household
(Complete Section I, II III & IV)

Non-Traditional Household
(Complete Section I, II & III)

- I. Household members include: Spouse/Significant Other Other Adults
 Dependent Children # _____ Live Alone/Homeless
 Other Family Other _____
- II. Total number of dependents in family including yourself _____
- III. Personal Income: Current income in last 30 days Comments

Regular Employment	\$ _____
Unemployment Compensation	\$ _____
Food Stamps/Aid to Families	\$ _____
SSD/SSI/Workman Compensation	\$ _____
Child Support Received	\$ _____
Miscellaneous Income	\$ _____

Total of Current Personal Income Last 30 Days \$ _____
Total Projected 12 Month Income \$ _____
- IV. Traditional Household Income Last 30 days

Spouse Income	\$ _____
Significant Other Income	\$ _____
Parents (if client is dependent)	\$ _____
Dependent Children (if they receive income other than child support)	\$ _____

Total Household Income Last 30 days \$ _____
(Include clients' income)
Total Projected Household 12 Month Income \$ _____
(Include clients' income)

Client Signature**Date****Family Size** _____ **Approved Income Category** _____**Co-Pay** _____

(Traditional only)

Staff Signature**Date**

I understand that all employees of QBH are required to adhere to the following Social Media Management Policy:

SOCIAL MEDIA MANAGEMENT

- Social media includes all forms of electronic formats to interact with other people for social purposes. Such media include, but not exclusively: Facebook, Twitter, LinkedIn, WeChat, internet browser- specific social links, blogs, "texting" for social purposes, message boards, etc.
- Use of these media on QBH property and/or during working hours, whether on or off the property, is not allowed as such activities do not relate to the job or job responsibilities of any staffs and can interfere with one's focus and accountability in fulfilling job responsibilities in a timely, quality fashion.
- If any such sites are deemed beneficial to marketing and promotion of the Agency, such posts may be entered and/or modified by the CEO only.
- Use of social media/interaction sites shall not be used to communicate Agency, care recipient or their significant others/family, or staff information; nor shall Agency owned phones, tablets, I pads, or computers be used to connect to such sites at any time. Violation of this requirement is a federal offense as stipulated in HIPAA statutes.
- Staff may not communicate with potential, current or former patients using these social interaction networks.
- Any phone and electronic media belonging to QBH and/or used in the conduct of one's job at QBH may be searched at any time by the CEO or Safety Officer; privacy settings must be as set forth in Agency policy.
- All staff is responsible to immediately report any violation to the CEO or Safety Officer if they become aware of violations of this policy; failure to report, if prior knowledge is validated, will result in the same disciplinary actions as may apply to the actual violator.
- Violations of confidentiality and security using social media, or any other means, by a staff member is grounds for discipline up to and including immediate dismissal. Further, if a HIPAA violation is involved, federal fiscal penalties and/or legal action may also occur.
- See the Technology Plan and Information Management Policy for additional information regarding confidentiality and protection of health information.

I have read this form and fully understand the above statements and that violation of this policy could lead to termination of employment or other sanctions.

Printed Name: _____

Signature: _____

Witness Signature: _____

Date: _____

QUALITY BEHAVIORAL HEALTH, INC.**SPEAK UP FEEDBACK FORM**

QBH leadership and staff invite you to speak up about your needs, concerns, recommendations, suggestions, or satisfactions with the Agency, its services and/or its staff. Unless you choose to include your name, your comments will be submitted anonymously into the "Speak Up" box. Thank you for your feedback! You can be certain we will take your feedback seriously.

Please check the box that best describes your feedback:

Need not being met Concern or complaint Suggestion/recommendation Satisfaction/commendation

Describe your feedback. Be as specific as possible. _____

QUALITY BEHAVIORAL HEALTH, INC.**SPEAK UP FEEDBACK FORM**

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Please check the box that best describes your feedback:

Need not being met Concern or complaint Suggestion/recommendation Satisfaction/commendation

Describe your feedback. Be as specific as possible. _____

QUALITY BEHAVIORAL HEALTH, INC.**FEEDBACK FORM**

QBH leadership and staff invite you to speak up about your needs, concerns, recommendations, suggestions, or satisfactions with the Agency, its services and/or its staff. Unless you choose to include your name, your comments will be submitted anonymously into the "Speak Up" box. Thank you for your feedback! You can be certain we will take your feedback seriously.

Please check the box that best describes your feedback:

Need not being met Concern or complaint Suggestion/recommendation Satisfaction/commendation

Describe your feedback. Be as specific as possible. _____

STRATEGIC PLAN ROLLOUT 2024

GOAL STATEMENT	OBJECTIVES/BREAKDOWN TO STEPS	OVERSIGHT BODY OR PERSON	INITIATION/TARGET DATE(S)	COMPLETION DATE	AUDIT DATE(S)	BUDGET ASSIGNED

STRENGTHS

WEAKNESSES

OPPORTUNITIES

THREATS

BARRIER	DATE IDENTIFIED	HOW/WHO IDENTIFIED	CURRENT STATUS	DATE/DESCRIBE RESOLUTION

NOTE: Current Action might be a specific measure taken to resolve the barrier immediately; a decision to defer and consider it as a possible goal in next fiscal year Accessibility Roll Out Plan item; not able to be addressed due to legal, fiscal, other reason (define reason in box).

ACCESSIBILITY PLANNING

Calendar year _____

AGENDA ITEM	JAN	FEB	MAR	APL	MAY	JUN	JLY	AUG	SEP	OCT	NOV	DEC
PRIVILEGING (AS NEEDED)	X	X	X	X	X	X	X	X	X	X	X	X
FINANCIAL REPORT	X			X			X			X		
FINANCIAL EXTERNAL AUDIT REPORT APPROVAL											X	
BUDGET APPROVAL											X	
BOARD EDUCATION SESSION	X			X			X			X		
BOARD BYLAWS REVIEW							X					
BOARD BYLAWS APPROVAL	X											
BOARD SELF EVALUATION/RESULTS				E			R					
BOARD COLLECTIVE EVALUATION/RESULTS							E			R		
STRATEGIC PLAN UPDATE/APPROVAL	A						U					
ANNUAL PERFORMANCE SUMMARY REVIEW										X		
CEO EVALUATION/RESULTS			E				R					
MEDICAL DIRECTOR EVALUATION /RESULTS	E			R								
CORPORATE COMPLIANCE PLAN UPDATE/APPROVAL				U						A		
ACCESSIBILITY PLAN UPDATE/APPROVAL	A						U					
RISK MANAGEMENT PLAN UPDATE/APPROVAL (including insurance coverage)				U						A		
PMI REPORTS	X			X			X			X		
TECHNOLOGY PLAN UPDATE/APPROVAL	A						U					
HR SYSTEM REPORT (including contracts renewals)										X		
CONSUMER SATISFACTION SURVEY RESULTS	X			X			X			X		
STAFF SATISFACTION SURVEY RESULTS					X							
STAKEHOLDER SATISFACTION RESULTS					X							
OFFICERS ELECTION	X											
ANNUAL CONFLICT OF INTEREST AND CODE OF CONDUCT FORMS SIGNED										X		
REVIEW OF GOVERNANCE POLICIES	X											
INSURANCE PACKAGE ANNUAL REVIEW									X			

BOARD CHAIRPERSON POSITION DESCRIPTION

TITLE: President, Quality Behavioral Health, Inc. Board of Directors

REPORTS TO: Board Members

PURPOSE: To serve the Board as the principal officer, subject to the Articles of Incorporation and the Board Bylaws.

TERM: Three years, renewable.

- EXPECTED MEETING ATTENDANCE**
- Regularly attend and preside at meetings as scheduled
 - Attend committee meetings as a standing member
 - Participate as an ex-officio member of all ad hoc committees
 - Attend board retreats, in-service workshops and other board development activities
 - Attend and participate in special events as needed
 - Represent the Board during accreditation activities

- OBLIGATIONS OF THE BOARD:**
- Establish policy
 - Hire, fire, supervise and evaluate the CEO
 - Assist CEO in hiring, firing and evaluating the Medical Director
 - Secure adequate funds
 - Monitor finances
 - Maintain and update strategic and long-range plans
 - Other responsibilities as set forth in the Governing Board Bylaws

- SPECIFIC DUTIES:**
- Convene and preside at Board meetings and show commitment to and leadership in board activities
 - Be well informed on issues and collaborate with the CEO to establish agenda items in advance of meetings
 - Contribute skills, knowledge, and experience when appropriate
 - Listen respectfully to and elicit other points of view
 - Except as otherwise specified, appoint the chairperson and members of each Board committee, subject to full Board approval
 - Sign on behalf of the corporation any documents or instruments which the Board has authorized to be executed, except where the signing and execution is expressly delegated by the Board or its Bylaws to some other officer or agent
 - Participate in organizational decision-making
 - Assume leadership roles in all board activities, including fund raising
 - Represent the organization to the public and to private industry
 - Educate yourself about the needs of the people served
 - Other duties as set forth in the Board bylaws or as may be incident to the office of President or as assigned by the Board from time to time

Chairperson's Signature

Date

BOARD OF DIRECTORS COLLECTIVE EVALUATION AGGREGATE REPORT INSTRUCTIONS

To generate scores in order to aggregate data, assign the following numeric values to the responses: 4 = excellent; 3 = good; 2 = fair; 1 = poor. Do not score N/A items.

1. **ITEM SCORE:** FOR EACH ITEM TOTAL THE SCORES GIVEN TO THAT ITEM AND DIVIDE BY THE TOTAL NUMBER OF RESPONDANTS TO THE ITEM. (If done by individual members as opposed to the collective board together)

Example: ITEM - "I think to Board is the right size."

For purposes of example, ten persons respond, giving the following scores: 3, 4, 4, 2, 0, 3, 4, 3, 3, 4

Total of scores for this item is 30 divided by 10 (number of members answering this question) = 3.0 score for this item

2. **SECTION SCORE:** TO GET A SECTION SCORE, TOTAL THE AVERAGE SCORE CALCULATED FOR EACH ITEM AND DIVIDE BY THE TOTAL NUMBER OF ITEMS IN THAT SECTION. (Done regardless of whether an individual or collective exercise)

Example: SECTION - "Duty of Care"

This section has 10 items. For purposes of example, the averaged scores of these 10 items are: 3, 2, 3, 3, 3, 4, 5, 3, 2, 3, 3

Total of scores for these 10 items is 34 divided by 10 = 3.4 score for this section

Graphing: Use a bar graph to show performance in each of the three sections, giving each bar a different color. Provide a color code.

3. **EVALUATION COMPOSITE SCORE:** TO GET A FINAL SCORE FOR THE EVALUATION, ADD THE AVERAGED SCORE FOR EACH OF THE SECTIONS AND DIVIDE BY THE NUMBER OF SECTIONS IN THE EVALUATION. (Done regardless of whether an individual or collective exercise)

Example: COMPOSITE SCORE FOR THE EVALUATION

This tool has 6 sections. For purposes of example, the averaged scores for these 6 sections are: 3, 4, 3, 3, 3, 3

Total of scores from all sections is 19 divided by 6 = 3.3
which is the composite or overall score of how the Board
evaluated themselves on a 4 point scale

BOARD OF DIRECTORS SELF-EVALUATION AGGREGATE REPORT TEMPLATE

EXAMPLE OF SCORES BY SECTION AND COMPOSITE:

SECTION TITLE	SCORE (4 MAXIMUM)
LEGAL FRAMEWORK	
BOARD STRUCTURE	
BOARD COMPREHENSION	
And so on....	

LIST OF ITEMS WITH AGGREGATE SCORES OF 2 (Fair) OR LESS:

COMMENTS:

BOARD CONCLUSIONS AND RECOMMENDATIONS FOR IMPROVEMENT:

BOARD COLLECTIVE EVALUATION FORM

Please evaluate the collective performance of the QBH, Inc. Board in response to the questions below.
 Rate each question as to the Board's performance as:

Excellent, no improvement needed

Good, adequate performance but room for improvement

Fair, definite need for improvement

Poor, action is needed for immediate improvement in this area

N/A, not currently part of our operations

Performance Question	Excellent	Good	Fair	Poor
LEGAL FRAMEWORK				
1. Board bylaws and policies that set forth the Board's function and duties are:				
BOARD STRUCTURE				
2. The Board's size, in relation to the Agency's needs is:				
3. The Board's spread and balance in regard to expertise, age, diversity, interest and points of view are:				
BOARD COMPREHENSION				
4. The Board's comprehension of the interests of various constituencies (funders, care recipients, advocates, staff, other stakeholders) with which the organization deals is:				
BOARD PRACTICES				
5. The Board's orientation to the organization is:				
6. The frequency of Board meetings in relation to Agency needs is:				
7. The Board's practices with regard to establishing committees and their mandates are:				
BOARD PERFORMANCE				
8. The Board's performance in formulating the Agency's long-term goals is:				
9. The Board's ability to monitor its own accomplishments and progress is:				
10. The Board's discipline to spend its time on the most important governance topics is:				
11. The Board's ability to use its time effectively is:				
12. Performance standards expected by the Board for attending all regularly scheduled meetings are:				
13. Performance standards expected by the Board for committee participation are:				
14. Performance standards expected by the Board for referral of prospective Board members are:				
RELATIONS WITH EXECUTIVE LEADERSHIP				
15. The Board's working relationship with the CEO is:				
16. The definitions of the roles of the CEO are Board are:				

*This evaluation may be completed by each member with regard to the full board, or as a collective exercise at a scheduled Board meeting

BOARD MEMBER CODE OF ETHICS

Directions: As a Board member, you need to be aware that more is expected of those in leadership roles. Review the following statements. Signing this Code of Ethics solidifies your commitment to honest Board service.

As a member of this board, I will:

Represent the interests of all people served by this Agency, and to favor special interests inside or outside of this Agency.

Not use my service on this board for my own personal advantage or for the advantage of my friends or associates.

Keep confidential information confidential.

Respect and support the majority decisions of the Board.

Approach all board issues with an open mind, prepared to make the best decisions for everyone involved.

Do nothing to violate the trust of those who elected or appointed me to the Board and of those we serve.

Focus my efforts on the mission of the Agency and not on my personal goals.

Never exercise authority as a board member except when acting in a meeting with the full Board or as I am delegated by the Board.

Be actively involved in Board activities, be accountable to the Agency in all my actions and contribution to decisions, and committed to stay informed of Agency practices and performance results.

Consider myself a "trustee" of this Agency and do my best to oversee that it is well-maintained, financially secure, growing and always operating in the best interests of those we serve.

Board Member Signature

Date

BOARD OF DIRECTORS SELF-EVALUATION AGGREGATE REPORT INSTRUCTIONS

1. ITEM SCORE: FOR EACH ITEM TOTAL THE SCORES GIVEN TO THAT ITEM AND DIVIDE BY THE TOTAL NUMBER OF RESPONDANTS TO THE ITEM

Example: ITEM - "I think to Board is the right size."

For puposes of example, ten persons respond, giving the following scores: 3, 4, 4, 2, 0, 3, 4, 3, 3, 4

Total of scores for this item is 30 divided by 10 (number of members answering this question) = 3.0 score for this item

2. SECTION SCORE: TO GET A SECTION SCORE, TOTAL THE AVERAGE SCORE CALCULATED FOR EACH ITEM AND DIVIDE BY THE TOTAL NUMBER OF ITEMS IN THAT SECTION

Example: SECTION - "Duty of Care"

This section has 10 items. For purposes of example, the averaged scores of these 10 items are: 3, 2, 3, 3, 3, 4, 5, 3, 2, 3, 3

Total of scores for these 10 items is 34 divided by 10 = 3.4 score for this section

Graphing: Use a bar graph to show performance in each of the three sections, giving each bar a different color. Provide a color code.

3. EVALUATION COMPOSITE SCORE: TO GET A FINAL SCORE FOR THE EVALUATION, ADD THE AVERAGED SCORE FOR EACH OF THE SECTIONS AND DIVIDE BY THE NUMBER OF SECTIONS IN THE EVALUATION

Example: COMPOSITE SCORE FOR THE EVALUATION

This tool has 3 sections. For purposes of example, the averaged scores for these 3 sections are: 3, 4, 3

Total of scores from the 3 sections is 10 divided by 3 = 3.3 which is the composite or overall score of how the Board evaluated themselves on a 5 point scale

**BOARD OF DIRECTORS SELF-EVALUATION
AGGREGATE REPORT TEMPLATE****EXAMPLE OF SCORES BY SECTION AND COMPOSITE:**

SECTION TITLE	SCORE (5 MAXIMUM)
DUTY OF CARE	
DUTY OF LOYALTY	
DUTY OF OBEDIENCE	
EVALUATION COMPOSITE	

LIST OF ITEMS WITH AGGREGATE SCORES OF 2 OR LESS:

COMMENTS:

BOARD CONCLUSIONS AND RECOMMENDATIONS FOR IMPROVEMENT:

BOARD MEMBER POSITION DESCRIPTION

TITLE:	Member, Quality Behavioral Health, Inc. Board Director
REPORTS TO:	Board Chairperson
PURPOSE:	To serve the Board as a voting member; to develop policies, procedures and regulations for the operation of QBH, INC.; to monitor finances of the organization, its programs and performance.
TERM:	Three years
EXPECTED MEETING ATTENDANCE:	<ul style="list-style-type: none">• Regularly attend meetings as scheduled (minimum 4 per year)<ul style="list-style-type: none">• Attend and participate in special events as needed• Attend board retreats, inservice workshops and other board development activities
OBLIGATIONS OF THE BOARD	<ul style="list-style-type: none">• Establish policy• Hire, fire, supervise and evaluate the chief executive officer (CEO)• Assist CEO in hiring, firing and evaluating the medical director• Secure adequate funds• Monitor finances• Maintain and update long-range plans• Other responsibilities as set forth in the Governing Board Bylaws
SPECIFIC DUTIES:	<ul style="list-style-type: none">• Attend meetings and show commitment to board activities• Be well informed on issues and agenda items in advance of meetings• Contribute skills, knowledge, and experience when appropriate• Listen respectfully to other points of view• Participate in organizational decision-making• Financially support the organization• Assume leadership roles in all board activities, including fund raising• Represent the organization to the public and to private industry• Educate yourself about the needs of the people served• Other duties as set forth in the board bylaws

Board Member Signature

Date

**ORIENTATION CHECKLIST
BOARD DIRECTORS/MEMBERS**

Directions: Please initial and date each item as it is reviewed with the new board director or member.

ORIENTATION ITEM	DATE	INITIALS
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ORIENTATION STRUCTURE

Whom we serve	_____	_____
What we do	_____	_____
Other	_____	_____

TOURS

Administrative office	_____	_____
Other facilities	_____	_____

RESPONSIBILITIES AND IMPORTANT INFORMATION

Letter of Welcome from Board President	_____	_____
Board Director/Member Position Description	_____	_____
Administrator Job Description	_____	_____
Board Bylaws and Board Policies	_____	_____
Mission Statement, Vision Statement, Strategic Plan, Goals and Objectives	_____	_____
Board Meeting Agenda Calendar	_____	_____
Meeting Attendance	_____	_____
Clinical Services Plan	_____	_____
Performance Improvement System Plans	_____	_____
Agency Chart and Narrative	_____	_____
Roster of Board Directors/Members	_____	_____
Roster of Key Administrative Contacts	_____	_____
Educational Plan, Calendar and External Ed Forms	_____	_____
Conflict of Interest Statement	_____	_____
Current Budget, Annual Audit (if applicable)	_____	_____
Board Code of Ethics	_____	_____
List of Board Officers	_____	_____

INTRODUCTIONS

Board Chair	_____	_____
Other Board Members	_____	_____
Key Staff	_____	_____

Board Member Signature

Date

BOARD SECRETARY POSITION DESCRIPTION

TITLE: Secretary, Board of Directors

REPORTS TO: Board President/Chairperson

PURPOSE: To provide guidelines for the performance requirements as the Secretary to the Governing Body.

TERM: Three years, renewable

- EXPECTED MEETING ATTENDANCE:**
- Regularly attend meetings as scheduled (about 12/year)
 - Attend standing committee meetings if a member
 - Participate as an ad hoc committee member if appointed
 - Attend board retreats, inservice workshops and other board development activities
 - Attend and participate in special events as needed

- OBLIGATIONS:**
- Reliably fulfill the duties of Secretary as set forth below.

- SPECIFIC DUTIES:**
- Provide for the keeping of minutes of all meetings of the Board and its committees.
 - Give or cause to be given appropriate notices in accordance with these Bylaws or as required by law.
 - Act as custodian of all corporate records and reports.
 - Keep or cause to be kept a current roster showing the names of the current Board members and their addresses.
 - Keep or cause to be kept a record of the attendance of each Board member at Board meetings and committee meetings as appropriate.
 - Keep or cause to be kept accurate records of Board member orientation and continuing education/development.
 - Perform any and all other duties incident to the office of Treasurer as may be assigned from time to time by the Board President or the Board.

Board Secretary

Date

BOARD TREASURER POSITION DESCRIPTION

TITLE:	Treasurer, Board of Directors
REPORTS TO:	Board President/Chairperson
PURPOSE:	To provide guidelines for the performance requirements as the Treasurer to the Governing Body.
TERM:	Three years, renewable
EXPECTED MEETING ATTENDANCE:	<ul style="list-style-type: none">• Regularly attend meetings as scheduled (about 12/year)• Attend standing committee meetings if a member<ul style="list-style-type: none">• Participate as an ad hoc committee member if appointed• Attend board retreats, inservice workshops and other board development activities• Attend and participate in special events as needed
OBLIGATIONS:	<ul style="list-style-type: none">• Reliably fulfill the duties of Treasurer as set forth below.
SPECIFIC DUTIES:	<ul style="list-style-type: none">• Keep or cause to be kept correct and accurate accounts of the properties and financial transactions of the Corporation.• If required by the Board (and at the expense of the Corporation), give a bond for the faithful discharge of duties in such sum and with such sureties as the Board shall determine.• Perform as a signatory on the checking account(s) of the Corporation.• Chair the Finance Committee of the Board.• Perform any and all other duties incident to the office of Treasurer as may be assigned from time to time by the Board President or the Board.

Board Treasurer

Date

BOARD VICE CHAIRPERSON POSITION DESCRIPTION

TITLE:	Vice Chairperson, Quality Behavioral Health, Inc. Board of Directors
REPORTS TO:	Board Chairperson
PURPOSE:	To serve the Board as a leader and voting member; to give direction and coordination to the Board's effort to develop policies, procedures, and regulations for the operation of QBH, Inc. to monitor finances of the organization, its programs and performance.
TERM:	Three years, renewable
EXPECTED MEETING ATTENDANCE:	<ul style="list-style-type: none">• Convene meetings in the absence of the Board President• Attend standing committee meetings as an ex-officio member in the Board President's absence• Chair any committees as directed by the Board President
OBLIGATIONS:	<ul style="list-style-type: none">• Fulfill the obligations of the Board President in his/her absence• Other responsibilities as set forth in the Governing Board Bylaws
SPECIFIC DUTIES:	<ul style="list-style-type: none">• Show a commitment to and motivation for Board activities• Be well informed on issues and agenda items in advance of meetings• Participate in organizational decision-making• Financially support the organization• Assume leadership roles in all board activities, including fund raising• Represent the organization to the public and to private industry• Educate yourself about the needs of the people served• Other duties as set forth in the Board Bylaws

Board Vice Chairperson

Date

CEO SELF EVALUATION FORM

Directions: CEO complete form. Results will be reviewed with the Corporate Board. Thank you.

Date: _____ Signature: _____

Rating Scale: 5=exceptional performance; 4=consistently reliable performance;
3=satisfactory performance; 2=inadequate or inconsistent performance; 1=unacceptable performance.

Elements of CEO Evaluation	Rating Scale	Comments
I have and comply with a written agreement and a job description that specify my duties, responsibilities, compensation and other items of importance.	5 4 3 2 1	
BOARD RELATIONS:		
I keep others informed of Agency activities, progress and problems.	5 4 3 2 1	
I am receptive to others' ideas and suggestions.	5 4 3 2 1	
I make sound recommendations for Board action.	5 4 3 2 1	
I facilitate the decision-making process of the Board and staff.	5 4 3 2 1	
I accept others' criticism as constructive suggestion for improvement.	5 4 3 2 1	
I give constructive criticism in a friendly, firm and positive way.	5 4 3 2 1	
I follow up on problems and issues brought to my attention.	5 4 3 2 1	
MANAGEMENT ABILITIES:		
I maintain a smooth running administrative office.	5 4 3 2 1	
I prepare all necessary reports and keep accurate records.	5 4 3 2 1	
I speak and write clearly.	5 4 3 2 1	
I propose Agency goals and objectives prior to each fiscal year.	5 4 3 2 1	
I am progressive in attitude and action.	5 4 3 2 1	

Initiated: 4/2017

Reviewed/Revised: 1/2023, 1/2024, 1/2025

I develop/maintain policies/procedures and plans to guide and from which to monitor staff performance.	5 4 3 2 1	
Elements of CEO Evaluation	Rating Scale	Comments
I appropriately delegate authority when I am absent from the Agency.	5 4 3 2 1	
I project a professional demeanor and pursue continuing education and professional activities to maintain/build my administrative skills.	5 4 3 2 1	
SERVICE ORIENTATION: I understand and stay current with the needs of consumers and of staff.	5 4 3 2 1	
I use the mission as a basis for decision-making, including decisions relative to serving consumers' needs.	5 4 3 2 1	
I am responsive to customer satisfaction feedback.	5 4 3 2 1	
FISCAL MANAGEMENT: I participate with the Corporate Board in formulating, and completing the year with, a balanced budget.	5 4 3 2 1	
I display common sense and good judgment in business transactions.	5 4 3 2 1	
I adequately monitor physical plant expenses.	5 4 3 2 1	
COMMUNITY RELATIONS: I represent the Agency in a positive and professional manner.	5 4 3 2 1	
I actively promote the Agency to the public.	5 4 3 2 1	
I encourage advisory board membership and respect members' contributions.	5 4 3 2 1	
I provide education to business and community agencies.	5 4 3 2 1	

Initiated: 4/2017

Reviewed/Revised: 1/2023, 1/2024, 1/2025

I communicate regularly to maintain a positive liaison relationship with the courts, probation, attorneys and industry	5 4 3 2 1	
STAFF MANAGEMENT		
I hire and retain competent staff members.	5 4 3 2 1	
I provide support for and encourage staff development.	5 4 3 2 1	
I adhere to personnel policies in my management of staff.	5 4 3 2 1	
Elements of CEO Evaluation	Rating Scale	Comments
I monitor and model high staff performance and productivity.	5 4 3 2 1	
CLINICAL SERVICE PERFORMANCE:		
I effectively conduct alcohol/drug information school as needed.	5 4 3 2 1	
In the absence of a clinical director, I effectively supervise clinical programs.	5 4 3 2 1	
As needed, I effectively deliver various clinical services to consumers.	5 4 3 2 1	

List below professional development activities in which you engaged this year.

List below the professional opportunities you utilized and what you consider your greatest accomplishments this year:

**CEO EVALUATION OF PERFORMANCE
BY MEDICAL AND NURSING STAFF**

Directions: Medical and Nursing Director/Medical and Nursing Staff complete form. Results will be reviewed with the Corporate Board. Thank you.

Date: _____ Signature: _____		
Rating Scale: 5=exceptional performance; 4=consistently reliable performance; 3=satisfactory performance; 2=inadequate or inconsistent performance; 1=unacceptable performance.		
Elements of CEO Evaluation	Rating Scale	Comments
MEDICAL AND NURSING STAFF RELATIONS: The CEO keeps the Medical and Nursing staff informed of Agency activities, progress and problems pertinent to them.	5 4 3 2 1	
The CEO is receptive to Medical and Nursing staff ideas and suggestions.	5 4 3 2 1	
The CEO gives constructive criticism in a friendly, firm and positive way.	5 4 3 2 1	
The CEO follows up on problems and issues the Medical and Nursing staff brings to his/her attention.	5 4 3 2 1	
MANAGEMENT ABILITIES: The CEO maintains a smooth running administrative office.	5 4 3 2 1	
The CEO is progressive in attitude and action.	5 4 3 2 1	
The CEO develops/ maintains policies/ procedures and plans to guide and from which to monitor staff performance.	5 4 3 2 1	
The CEO appropriately delegates authority when absent from the Agency.	5 4 3 2 1	
The CEO projects a professional demeanor and pursue continuing education and demonstrates effective administrative skills.	5 4 3 2 1	
SERVICE ORIENTATION: The CEO understands and stays current with the needs of	5 4 3 2 1	

Initiated: 4/2017

Reviewed/Revised: 1/2023, 1/2024, 1/2025

consumers and of the Medical and Nursing staff.		
The CEO uses the mission as a basis for decision-making, including decisions relative to serving consumers' needs.	5 4 3 2 1	
Elements of CEO Evaluation	Rating Scale	Comments
The CEO is responsive to customer satisfaction feedback.	5 4 3 2 1	
FISCAL MANAGEMENT: The CEO keeps the Medical and Nursing staff informed of pertinent budgetary issues.	5 4 3 2 1	
The CEO displays common sense and good judgment in business transactions.	5 4 3 2 1	
COMMUNITY RELATIONS: The CEO represents the Agency in a positive and professional manner.	5 4 3 2 1	
The CEO communicates regularly to maintain a positive liaison relationship with the courts, probation, attorneys and industry.	5 4 3 2 1	
STAFF MANAGEMENT The CEO hires and retains competent staff members.	5 4 3 2 1	
The CEO provides support for and encourages physician/staff development.	5 4 3 2 1	
The CEO adheres to personnel policies in management of physicians/staff.	5 4 3 2 1	
The CEO monitors and models high staff performance and productivity.	5 4 3 2 1	
CLINICAL SERVICE PERFORMANCE: The CEO effectively conducts alcohol/drug information school as needed.	5 4 3 2 1	
In the absence of a clinical director, the CEO effectively supervises clinical programs.	5 4 3 2 1	

Initiated: 4/2017

Reviewed/Revised: 1/2023, 1/2024, 1/2025

As needed, the CEO effectively delivers various clinical services to consumers.	5 4 3 2 1	
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**CEO EVALUATION OF PERFORMANCE
BY CLINICAL DIRECTOR/STAFF**

<p>Directions: Clinical Director/Staff complete form. Results will be reviewed with the Corporate Board. Thank you.</p>		
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Date:	Signature:	
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<p>Rating Scale: 5=exceptional performance; 4=consistently reliable performance; 3=satisfactory performance; 2=inadequate or inconsistent performance; 1=unacceptable performance.</p>		
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Elements of CEO Evaluation	Rating Scale	Comments
CLINICAL DIRECTOR/STAFF RELATIONS:		
The CEO keeps the clinical staff informed of pertinent Agency activities, progress and problems.	5 4 3 2 1	
The CEO is receptive to clinical staff ideas and suggestions.	5 4 3 2 1	
The CEO facilitates the decision-making process of the clinical director/staff.	5 4 3 2 1	
The CEO accepts criticism as constructive suggestion for improvement.	5 4 3 2 1	
The CEO gives constructive criticism in a friendly, firm and positive way.	5 4 3 2 1	
The CEO follows up on problems and issues brought to his/her attention.	5 4 3 2 1	
MANAGEMENT ABILITIES:		
The CEO maintains a smooth running administrative office.	5 4 3 2 1	
The CEO speaks and writes clearly.	5 4 3 2 1	
The CEO is progressive in attitude and action.	5 4 3 2 1	
The CEO collaborates with clinical director/staff to develop/maintain policies/procedures and plans to guide and from which to monitor staff performance.	5 4 3 2 1	

The CEO appropriately delegates authority when absent from the Agency.	5 4 3 2 1	
Elements of CEO Evaluation	Rating Scale	Comments
The CEO projects a professional demeanor and demonstrates effective administrative skills.	5 4 3 2 1	
SERVICE ORIENTATION: The CEO understands and stays current with the needs of consumers and of staff.	5 4 3 2 1	
The CEO uses the mission as a basis for decision-making, including decisions relative to serving consumers' needs.	5 4 3 2 1	
The CEO is responsive to customer satisfaction feedback.	5 4 3 2 1	
FISCAL MANAGEMENT: The CEO keeps the clinical director/ staff informed of pertinent budgetary issues.	5 4 3 2 1	
The CEO displays common sense and good judgment in business transactions.	5 4 3 2 1	
The CEO adequately monitors physical plant expenses.	5 4 3 2 1	
COMMUNITY RELATIONS: The CEO represents the Agency in a positive and professional manner.	5 4 3 2 1	
The CEO actively promotes the Agency to the public.	5 4 3 2 1	
The CEO communicates regularly to maintain a positive liaison relationship with the courts, probation, attorneys and industry	5 4 3 2 1	
The CEO provides support for and encourages staff development.	5 4 3 2 1	
The CEO adheres to personnel policies in management of staff.	5 4 3 2 1	

Initiated: 4/2017

Reviewed/Revised: 1/2023, 1/2024, 1/2025

The CEO monitors and models high staff performance and productivity.	5 4 3 2 1	
CLINICAL SERVICE PERFORMANCE: The CEO effectively conducts alcohol/drug information school as needed.	5 4 3 2 1	
In the absence of a clinical director, the CEO effectively supervises clinical programs.	5 4 3 2 1	
As needed, the CEO effectively delivers various clinical services to consumers.	5 4 3 2 1	

**CEO EVALUATION OF PERFORMANCE
BY THE CORPORATE BOARD**

<p>Directions: Advisory Member/Corporate Director complete form. Results will be reviewed with the Corporate Board. Thank you.</p>		
Date:	Signature:	
<p>Rating Scale: 5=exceptional performance; 4=consistently reliable performance; 3=satisfactory performance; 2=inadequate or inconsistent performance; 1=unacceptable performance.</p>		
Elements of CEO Evaluation	Rating Scale	Comments
The CEO has and complies with a written agreement and a job description that specify duties, responsibilities, compensation and other items of importance.	5 4 3 2 1	
BOARD RELATIONS: The CEO keeps the Board informed of Agency activities, progress and problems.	5 4 3 2 1	
The CEO is receptive to board ideas and suggestions.	5 4 3 2 1	
The CEO makes sound recommendations for Board action.	5 4 3 2 1	
The CEO facilitates the decision-making process of the Board.	5 4 3 2 1	
The CEO accepts Board criticism as constructive suggestion for improvement.	5 4 3 2 1	

Initiated: 4/2017

Reviewed/Revised: 1/2023, 1/2024, 1/2025

The CEO gives constructive criticism in a friendly, firm and positive way.	5 4 3 2 1	
The CEO follows up on problems and issues brought to his/her attention.	5 4 3 2 1	
MANAGEMENT ABILITIES:		
The CEO maintains a smooth running administrative office.	5 4 3 2 1	
The CEO prepares all necessary reports and keep accurate records.	5 4 3 2 1	
The CEO speaks and writes clearly.	5 4 3 2 1	
The CEO proposes Agency goals and objectives prior to each fiscal year.	5 4 3 2 1	
Elements of CEO Evaluation	Rating Scale	Comments
The CEO is progressive in attitude and action.	5 4 3 2 1	
The CEO develops/ maintains policies/ procedures and plans to guide and from which to monitor staff performance.	5 4 3 2 1	
The CEO appropriately delegates authority when absent from the Agency.	5 4 3 2 1	
The CEO projects a professional demeanor and pursues continuing education and professional activities to maintain/build administrative skills.	5 4 3 2 1	
SERVICE ORIENTATION:		
The CEO understands and stays current with the needs of consumers and of staff.	5 4 3 2 1	
The CEO uses the mission as a basis for decision-making, including decisions relative to serving consumers' needs.	5 4 3 2 1	
The CEO is responsive to customer satisfaction feedback.	5 4 3 2 1	

Initiated: 4/2017

Reviewed/Revised: 1/2023, 1/2024, 1/2025

FISCAL MANAGEMENT: The CEO participates with the Corporate Board in formulating, and completing the year with, a balanced budget.	5 4 3 2 1	
The CEO displays common sense and good judgment in business transactions.	5 4 3 2 1	
The CEO adequately monitors physical plant expenses.	5 4 3 2 1	
COMMUNITY RELATIONS: The CEO represents the Agency in a positive and professional manner.	5 4 3 2 1	
The CEO actively promotes the Agency to the public.	5 4 3 2 1	
The CEO encourages advisory board membership and respects members' contributions.	5 4 3 2 1	
The CEO provides education to business and community agencies.	5 4 3 2 1	
The CEO communicates regularly to maintain a positive liaison relationship with the courts, probation, attorneys and industry	5 4 3 2 1	
STAFF MANAGEMENT The CEO hires and retains competent staff members.	5 4 3 2 1	
The CEO provides support for and encourages staff development.	5 4 3 2 1	
The CEO adheres to personnel policies in management of staff.	5 4 3 2 1	
The CEO monitors and models high staff performance and productivity.	5 4 3 2 1	

AGGREGATE SUMMARY OF CEO EVALUATIONS

The following is a summary of evaluations, by average response, when multiple evaluations occurred. Rating Scale: 5=exceptional performance; 4=consistently reliable performance; 3=satisfactory performance; 2=inadequate or inconsistent performance; 1=unacceptable performance.

Elements of CEO Evaluation	Self Eval.	Eval. by MD's	Eval. by Clinical Staff	Eval. by Boards	Overall Average of Item
The CEO has and complies with a written agreement and a job description that specify duties, responsibilities, compensation and other items of importance.		N/A	N/A		
BOARD RELATIONS: The CEO keeps others informed, as appropriate, of Agency activities, progress and problems.					
The CEO is receptive to others' ideas and suggestions.					
The CEO makes sound recommendations for Board action.		N/A	N/A		
The CEO facilitates the decision-making process of the Board and staff.					
The CEO accepts others' criticism as constructive suggestion for improvement.					
The CEO gives constructive criticism in a friendly, firm and positive way.					
The CEO follows up on problems and issues brought to his/her attention.					
MANAGEMENT ABILITIES: The CEO maintains a smooth running administrative office.					
The CEO prepares all necessary reports and keep accurate records.		N/A	N/A		
The CEO speaks and writes clearly.		N/A			
The CEO proposes Agency goals and objectives prior to each fiscal year.		N/A	N/A		
The CEO is progressive in attitude and action.					
The CEO develops/maintains policies/procedures and plans to guide and from which to monitor staff performance.					

Initiated: 4/2017

Reviewed/Revised: 1/2023, 1/2024, 1/2025

Elements of CEO Evaluation	Self Eval.	Eval. by MD's	Eval. by Clinical Staff	Eval. by Boards	Overall Average of Item
The CEO appropriately delegates authority when absent from the Agency.					
The CEO projects a professional demeanor and pursue continuing education and professional activities to maintain/build administrative skills.					
SERVICE ORIENTATION:					
The CEO understands and stays current with the needs of consumers and of staff.					
The CEO uses the mission as a basis for decision-making, including decisions relative to serving consumers' needs.					
The CEO is responsive to customer satisfaction feedback.					
FISCAL MANAGEMENT:		N/A	N/A		
The CEO participates with the Corporate Board in formulating, and completing the year with, a balanced budget.					
The CEO displays common sense and good judgment in business transactions.					
The CEO adequately monitors physical plant expenses.		N/A			
COMMUNITY RELATIONS:					
The CEO represents the Agency in a positive and professional manner.					
The CEO actively promotes the Agency to the public.		N/A			
The CEO encourages advisory board membership and respect members' contributions.		N/A	N/A		
The CEO provides education to business and community agencies.		N/A	N/A		
The CEO communicates regularly to maintain a positive liaison relationship with the courts, probation, attorneys and industry					

Initiated: 4/2017

Reviewed/Revised: 1/2023, 1/2024, 1/2025

STAFF MANAGEMENT					
The CEO hires and retains competent staff members.					
The CEO provides support for and encourages staff development.					
The CEO adheres to personnel policies in my management of staff.					
The CEO monitors and models high staff performance and productivity.					
Elements of CEO Evaluation	Self Eval.	Eval. by MD's	Eval. by Clinical Staff	Eval. by Boards	Overall Average of Item
CLINICAL SERVICE PERFORMANCE:				N/A	
The CEO effectively conducts alcohol/drug information school as needed.				N/A	
In the absence of a clinical director, the CEO effectively supervises clinical programs.				N/A	
As needed, the CEO effectively delivers various clinical services to consumers.				N/A	

**SUMMARY OF BOARD CONCLUSIONS
CEO EVALUATION**

Performance Strengths/Accomplishments:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Professional Development and Use of Opportunities:

1. _____

Initiated: 4/2017

Reviewed/Revised: 1/2023, 1/2024, 1/2025

2. _____

3. _____

4. _____

Areas for Performance Improvement:

1. _____

2. _____

3. _____

4. _____

5. _____

Performance Goals for 20 :

1. _____

2. _____

3. _____

4. _____

5. _____

Board Chair

Date

CEO

Date

CONFFLICT OF INTEREST QUESTIONNAIRE

The undersigned states:

No situation in which I am involved could be construed as placing me in a position of having a conflict of interest with the organization except the following:

Listed below are all relationships that I, or any members of my immediate family, may have with the following and the nature of the relationship. (Relationship means financial, work, consulting or contractual agreements, arrangements, affiliations and interest of any kind.)

A. Supplier of goods or services to the organization:

B. Other institutional or company affiliations:

Name

Date

MEDICAL DIRECTOR SELF-EVALUATION OF PERFORMANCE

Directions: Medical Director complete form. Results will be reviewed with CEO and Governing Board. Thank you.

Date: Signature:

Rating Scale: 5=exceptional performance; 4=consistently reliable performance; 3=satisfactory performance; 2=inadequate or inconsistent performance; 1=unacceptable performance.

Elements of Medical Director Evaluation	Rating Scale	Comments
I have a written agreement and a job description that specify my duties, responsibilities, compensation and other items of importance.	5 4 3 2 1	
I actively participate in assigned committees and carry out any associated assignments timely.	5 4 3 2 1	
I am included and contribute meaningfully to the development of plans, policies and procedures that impact clinical services.	5 4 3 2 1	
I have participated in the development of written policies and rules for physician and clinical services in this Agency.	5 4 3 2 1	
I periodically determine whether other physicians are providing accurate, timely and meaningful clinical record documentation as well as conduct other peer review activities.	5 4 3 2 1	
I review all accident and incident reports and make recommendations as appropriate.	5 4 3 2 1	
I participate in the PERFORMANCE IMPROVEMENT system and oversee medical involvement in that system.	5 4 3 2 1	

QUALITY BEHAVIORAL HEALTH, INC.**MEDICAL DIRECTOR EVALUATION FORMS**

Elements of Medical Director Evaluation	Rating Scale	Comments
I participate actively as an interdisciplinary team member and assist other team members in recognizing important changes in consumers' conditions.	5 4 3 2 1	
I maintain open communication with the Board, CEO, other physicians, clinicians and staff.	5 4 3 2 1	
I comply with the PSO policies and enforce the policies with physicians and clinicians.	5 4 3 2 1	
I provide effective supervision and education to other professional staff members.	5 4 3 2 1	
I advise the CEO regarding maintenance of a safe and healthy environment for staff and consumers.	5 4 3 2 1	
I monitor the over- and/or under-utilization of medical services.	5 4 3 2 1	
I represent the Agency in a positive manner within the community.	5 4 3 2 1	

MEDICAL DIRECTOR EVALUATION OF PERFORMANCE
BY MEDICAL and NURSING STAFF

Directions: Medical Practitioner complete form, evaluating the Medical Director's performance from your experience and perspective. Results will be reviewed with CEO and Governing Board. Thank you.

Date: Signature:

Rating Scale: 5=exceptional performance; 4=consistently reliable performance; 3=satisfactory performance; 2=inadequate or inconsistent performance; 1=unacceptable performance.

Elements of Medical Director Evaluation	Rating Scale	Comments
The Medical Director participates effectively carries out any assignments timely.	5 4 3 2 1	
The Medical Director contributes meaningfully to the development of plans, policies and procedures that impact medical/nursing services.	5 4 3 2 1	
The Medical Director participates in the development of forms and protocols for physician and nursing services in this Agency.	5 4 3 2 1	
The Medical Director periodically determines whether I and other physicians/nurses are providing accurate, timely and meaningful medical record documentation; he also conducts other peer review activities and provides me with useful feedback on my performance.	5 4 3 2 1	
The Medical Director participates in the Performance Improvement system and encourages medical / nursing involvement in that system.	5 4 3 2 1	

QUALITY BEHAVIORAL HEALTH, INC.**MEDICAL DIRECTOR EVALUATION FORMS**

Elements of Medical Director Evaluation	Rating Scale	Comments
The Medical Director participates actively as an interdisciplinary team member and assists other team members in recognizing important changes in consumers' conditions.	5 4 3 2 1	
The Medical Director serves as an advocate for medical/nursing staff and functions as an effective liaison between the medical/nursing staff and other personnel, the CEO and the governing board.	5 4 3 2 1	
The Medical Director keeps the medical/nursing staff informed of changes in policy, programs and/or operational issues that impact nurses and/or physicians.	5 4 3 2 1	
The Medical Director complies with the Agency policies and enforces the policies with physicians and nurses.	5 4 3 2 1	
The Medical Director provides effective supervision and education to physicians, nurses and other professional staff members.	5 4 3 2 1	
The Medical Director advises the CEO regarding maintenance of a safe and healthy environment for staff and consumers.	5 4 3 2 1	
The Medical Director effectively monitors the over- and/or under-utilization of medical /nursing services.	5 4 3 2 1	
The Medical Director represents the Agency in a positive manner within the community.	5 4 3 2 1	

**MEDICAL DIRECTOR EVALUATION OF PERFORMANCE
BY CLINICAL STAFF**

Directions: Clinical Practitioner complete form, evaluating the Medical Director's performance from your experience and perspective. Results will be reviewed with CEO and Governing Board. Thank you.

Date: Signature:

Rating Scale: 5=exceptional performance; 4=consistently reliable performance; 3=satisfactory performance; 2=inadequate or inconsistent performance; 1=unacceptable performance.

Elements of Medical Director Evaluation	Rating Scale	Comments
The Medical Director participates effectively and carries out any assignments timely.	5 4 3 2 1	
The Medical Director contributes meaningfully to the development of plans, policies and procedures that impact clinical services.	5 4 3 2 1	
The Medical Director participates in the development of written protocols and forms for clinical services in this Agency.	5 4 3 2 1	
The Medical Director participates in the Performance Improvement system and encourages clinical staff's involvement in that system.	5 4 3 2 1	
The Medical Director participates actively as an interdisciplinary team member and assists other team members in recognizing important changes in consumers' conditions.	5 4 3 2 1	
The Medical Director serves as an advocate for clinical staff and functions as an effective liaison between the clinical staff and other personnel, the CEO, and Board.	5 4 3 2 1	
Elements of Medical Director Evaluation	Rating Scale	Comments

QUALITY BEHAVIORAL HEALTH, INC.**MEDICAL DIRECTOR EVALUATION FORMS**

The Medical Director complies with the Agency policies and enforces the policies with clinicians.	5 4 3 2 1	
The Medical Director provides effective supervision and education to professional staff members.	5 4 3 2 1	
The Medical Director advises the CEO regarding maintenance of a safe and healthy environment for staff and consumers.	5 4 3 2 1	
The Medical Director represents the Agency in a positive manner within the community.	5 4 3 2 1	

**MEDICAL DIRECTOR EVALUATION OF PERFORMANCE
BY THE CEO**

Directions: CEO complete form. Results will be reviewed with the Governing Board. Thank you.

Date: _____ **Signature:** _____

Rating Scale: 5=exceptional performance; 4=consistently reliable performance; 3=satisfactory performance; 2=inadequate or inconsistent performance; 1=unacceptable performance.

Elements of Medical Director Evaluation	Rating Scale	Comments
The Medical Director complies with the written agreement and a job description that specify his duties, responsibilities, compensation and other items of importance.	5 4 3 2 1	
The Medical Director actively participates in assigned committees and carries out any associated assignments timely.	5 4 3 2 1	
The Medical Director contributes meaningfully to the development of plans, policies and procedures that impact medical/clinical services.	5 4 3 2 1	
The Medical Director has participated in the development of written protocols and forms for physician/nursing and clinical services in this Agency.	5 4 3 2 1	
The Medical Director periodically determines whether other physicians are providing accurate, timely and meaningful clinical record documentation as well as conducts other peer review activities.	5 4 3 2 1	
The Medical Director reviews all accident and incident reports and makes recommendations as appropriate.	5 4 3 2 1	

QUALITY BEHAVIORAL HEALTH, INC.**MEDICAL DIRECTOR EVALUATION FORMS**

Elements of Medical Director Evaluation	Rating Scale	Comments
The Medical Director participates in the Performance Improvement system and oversees medical involvement in that system.	5 4 3 2 1	
The Medical Director maintains open communication with the Board, CEO, other physicians, clinicians and staff.	5 4 3 2 1	
The Medical Director complies with the Agency policies and enforces the policies with physicians, nurses and clinicians.	5 4 3 2 1	
The Medical Director provides effective supervision and education to other physicians, nurses and professional staff members.	5 4 3 2 1	
The Medical Director advises me regarding maintenance of a safe and healthy environment for staff and consumers.	5 4 3 2 1	
The Medical Director monitors the over- and/or under-utilization of medical services.	5 4 3 2 1	
The Medical Director represents the Agency in a positive manner within the community.	5 4 3 2 1	

**MEDICAL DIRECTOR EVALUATION OF PERFORMANCE
BY THE CORPORATE/ADVISORY BOARDS**

Directions: Board Members complete form using information from personal observation and/or by report. Thank you.

Date: _____ **Signature:** _____

Rating Scale: 5=exceptional performance; 4=consistently reliable performance; 3=satisfactory performance; 2=inadequate or inconsistent performance; 1=unacceptable performance.

Elements of Medical director Evaluation	Rating Scale	Comments
The Medical Director complies with the written agreement and a job description that specify his duties, responsibilities, compensation and other items of importance.	5 4 3 2 1	
The Medical Director actively participates in assigned committees and carries out any associated assignments timely.	5 4 3 2 1	
The Medical Director contributes meaningfully to the development of plans, policies and procedures that impact medical/clinical services.	5 4 3 2 1	
The Medical Director has participated in the development of written protocols and forms for physician, nursing, and clinical services in this Agency.	5 4 3 2 1	
The Medical Director participates in the Performance Improvement system.	5 4 3 2 1	
The Medical Director maintains open communication with the Board.	5 4 3 2 1	
The Medical Director represents the Agency in a positive manner within the community.	5 4 3 2 1	

QUALITY BEHAVIORAL HEALTH, INC.

MEDICAL DIRECTOR EVALUATION FORMS

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AGGREGATE SUMMARY OF MEDICAL DIRECTOR EVALUATIONS

<p>The following is a summary of evaluations, by average response when multiple evaluations occurred. Rating Scale: 5=exceptional performance; 4=consistently reliable performance; 3=satisfactory performance; 2=inadequate or inconsistent performance; 1=unacceptable performance.</p>						
Elements of Medical Director Evaluation	Self Eval.	Eval. by MDs/ RNs	Eval. by CEO	Eval. by Clinical Staff	Eval by Gov. Brd.	Over-all avg. this Item
The Medical Director has and complies with a written agreement and job description that specify his duties, etc.		N/A		N/A		
The Medical Director participates actively (in assigned committees) and carries out any associated assignments timely.						
The Medical Director contributes meaningfully to the development of plans, policies and procedures that impact medical/ clinical services.						
The Medical Director participates in the development of written protocols and forms for physician, nursing, and clinical services in this Agency.						
The Medical Director periodically determines whether physicians are providing accurate, timely and meaningful clinical record documentation; he also conducts other peer review activities and provides useful feedback on performance.			N/A	N/A	N/A	

QUALITY BEHAVIORAL HEALTH, INC.

MEDICAL DIRECTOR EVALUATION FORMS

The following is a summary of evaluations, by average response when multiple evaluations occurred.
 Rating Scale: 5=exceptional performance; 4=consistently reliable performance; 3=satisfactory performance; 2=inadequate or inconsistent performance; 1=unacceptable performance.

Elements of Medical Director Evaluation	Self Eval.	Eval. by MDs/ RNs	Eval. by CEO	Eval. by Clinical Staff	Eval by Gov. Brd.	Over-all avg. this Item
The Medical Director participates in the Performance Improvement system, reviews incidents and encourages medical/nursing /clinical involvement in the Performance Improvement system.						
The Medical Director participates actively as an interdisciplinary team member and assists other team members in recognizing important changes in consumers' conditions.			N/A		N/A	
The Medical Director serves as an advocate for medical/clinical /nsg staff functions as an effective liaison between the medical staff and other personnel, the CEO and the governing board.						
The Medical Director keeps the medical and nursing staff informed of changes in policy, programs and/or operational issues that impact physicians.			N/A	N/A	N/A	
The Medical Director complies with the Agency policies and enforces the policies with physicians, nurses and clinicians.					N/A	
The Medical Director provides effective supervision and					N/A	

QUALITY BEHAVIORAL HEALTH, INC.**MEDICAL DIRECTOR EVALUATION FORMS**

The following is a summary of evaluations, by average response when multiple evaluations occurred.
Rating Scale: 5=exceptional performance; 4=consistently reliable performance; 3=satisfactory performance; 2=inadequate or inconsistent performance; 1=unacceptable performance.

Elements of Medical Director Evaluation	Self Eval.	Eval. by MDs/ RNs	Eval. by CEO	Eval. by Clinical Staff	Eval by Gov. Brd.	Over-all avg. this Item
education to physicians and other professional staff members.						
The Medical Director advises the CEO regarding maintenance of a safe and healthy environment for staff and consumers.					N/A	
The Medical Director effectively monitors the over-and/or under-utilization of medical services.				N/A	N/A	
The Medical Director represents the Agency in a positive manner within the community.						

SUMMARY OF BOARD OF DIRECTORS' CONCLUSIONS
MEDICAL DIRECTOR EVALUATION

Performance Strengths:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Areas for Performance Improvement:

1. _____
2. _____
3. _____
4. _____

Performance Goals for 20__ :

1. _____
2. _____
3. _____
4. _____
5. _____

Board Chair

CEO

Medical Director

Date