North Central Health Care
Person centered. Outcome focused.

OFFICIAL NOTICE AND AGENDA of a meeting of the Board or Committee

A meeting of the **North Central Community Services Program Board** will be held at **North Central Health Care, 1100 Lake View Drive, Wausau, WI 54403, Wausau Board Room** at **12:00 PM** on **Thursday, May 26th, 2016**.
(In addition to attendance in person at the location described above, Committee members and the public are invited to attend by telephone conference. Persons wishing to attend the meeting by phone should contact Debbie Osowski at 715-848-4405 24 hours prior to the start time of the meeting for further instructions.)

AGENDA

1. Call to Order
2. Roll Call
3. Consent Agenda
   a. Action: Approval of 4/28/16 Board meeting minutes
4. Chairperson's Report: J. Zriny
   a. Review draft minutes of the 5/16/16 Executive Committee meeting
   b. Action: Announcement and Approval of NCCSP Board Committee Appointments
5. Finance, Personnel & Property Committee Report: B. Weaver
   a. Review draft minutes of the 4/28/16 Finance, Personnel & Property Committee meeting
   b. Overview of 5/26/16 Finance, Personnel & Property Committee meeting
6. Financial Report: B. Glodowski
   a. Action: Accept the Financial Report and April Financial Statements
7. Quality Committee Report
   a. Action: Accept the Organizational Quality Dashboard
8. Human Services Operations Committee (HSOC) Report: J. Robinson
   a. Action: Review draft minutes of the 5/13/16 Human Services Operations Committee meeting
   b. Action: Approval of Crisis Structure Modification Proposal
9. Nursing Home Operations Committee (NHOC) Report: J. Burgener
   a. Action: Review draft minutes of th 4/29/16 Nursing Home Operations Committee meeting
   b. Overview of 5/20/16 Nursing Home Operations Committee meeting
10. Action: Approval NCHC Facilities Capital Plan and CIP Requests
11. Action: Consideration of Collaborative Care Model
12. Action: Approval of Performance Management Contract
13. Action: Consideration of LeadingChoice Network Participation Agreement
14. Update on Dr. Black Event on May 12, 2016
15. CEO Report
16. Future Agenda Items for Committee Consideration
17. Adjourn

Signed: /s/Michael Loy
Presiding Officer or His Designee

COPY OF NOTICE DISTRIBUTED TO:

Wausau Daily Herald
Antigo Daily Journal
Tomahawk Leader
Merrill Foto News
Lincoln & Marathon County Clerk Offices

DATE: 05/20/16 TIME: 4:00 PM
VIA: X FAX X MAIL
BY: K. Coles

THIS NOTICE POSTED AT:

North Central Health Care
DATE: 05/20/16 TIME: 4:00 PM
By: Katlyn Coles

Any person planning to attend this meeting who needs some type of special accommodation in order to participate should call the Administrative Office at 715-848-4405. For TDD telephone service call 715-845-4928.

NORTH CENTRAL COMMUNITY SERVICES PROGRAM
BOARD MEETING MINUTES

April 28, 2016 | 12:00 Noon | NCHC – Antigo Campus

Present:

X	Randy Balk	X	Ben Bliven	X	Jean Burgener
EXC	Joanne Kelly	X	Holly Matucheski	X	Bill Metter
X	Bill Miller	X	Scott Parks	X	Dr. Eric Penniman
X	John Robinson	X	Greta Rusch	X	Robin Stowe
X	Bob Weaver	X	Jeff Zriny		

Also present: Gary Bezucha, Brenda Glodowski, Kim Gochanour, Laura Scudiere, Ron Nye, Gary Olsen, Debbie Osowski, Michael Loy, Becky Schultz, Sue Matis

Board meeting was called to order at 12:08 p.m.

Recognition of and presentations to Ron Nye and Dr. Penniman were made by Chair Zriny for their participation and service to the NCCSP Board and the community; introduction of Robin Stowe as new board member representing Langlade County; and introduced Sue Matis, Interim Human Resources Senior Executive. Presentation was also made to Gary Bezucha, by Chair Zriny, in recognition of his retirement and years of service as the CEO of North Central Health Care.

Consent agenda

- **Motion**/second, Burgener/Metter, to approve the consent agenda which includes the 3/31/16 NCCSP Board meeting minutes. Motion carried.

Chairperson's report

- The Executive Committee reviewed the Performance Management Contract approved by county board as a precursor to the proposed alternate approach developed with Counsel. The Executive Committee authorized the Interim CEO to continue to move forward with proposed alternatives.
- The Executive Committee approved and is recommending the amendment to the NCCSP Bylaws to allow the appointment of vice-chairs to NCCSP Board Committees.
- **Motion**/second, Weaver/Robinson, to approve the amendment to the NCCSP Bylaws. Motion carried.

Finance, Personnel & Property Committee report

- Committee met today and reviewed the March financial statements, received an update on the newly established IT Governance Committee, and reviewed the 2015 Year End Fund Balance/Invested Cash by County policy.
- Accounts Receivable Action plan was also reviewed which will be discussed later in this meeting.

Financial report

- Deficit for March of $406,000 contributed almost entirely in the expense area; health insurance was over by $214,000, other institutes were over by $170,000, drugs were also high due mostly to the hospital.

- Revenue is OK but there is room for improvement.
- Action plans related to the Behavioral Health Unit-Inpatient Hospital and Mount View Care Center were reviewed (see attached).
    - Diligently looking for ways to optimize revenues and minimize expenses including pharmacy, enrollment process, productivity targets.
    - Reviewing services to the criminal justice system to verify if changes have made a difference in areas such as recidivism, etc. and at financial impact.
    - Process improvement teams monitoring progress and working together for a successful system.
- **Motion**/second, Burgener/Weaver, to accept the financial report for March. Motion carried.

<u>Quality Committee Report</u>

- Organizational Quality Dashboard was reviewed.
    - Patient experience indicator not going in the direction we want. Working on improving the processes of survey volumes and returns. April data is showing improvement in this area.
    - Community Partner indicator for the first quarter is within target. Receiving more positive feedback from the community.
    - Overall clinical indicators are solid.
    - Access to behavioral health services is heading in the right direction. Driven largely by a remarkable turn-around in outpatient services.
    - Days in Accounts Receivable continues to head in the right direction.
    - Regarding performance metrics, the board would like NCHC to engage the community in identifying/meeting expectations of the external customers.
    - Board members expressed the need to share successes with community partners and encouraged the county board representatives to share NCHC successes with the rest of the County Board members.
    - **Motion**/second to approve the Quality Outcome Dashboard. Motion carried.
- Crisis Process Improvement update
    - Presentations have been made to many community partners and county board meetings.
    - Last summer the Quality Committee identified from qualitative feedback on the survey and outcome measures, to look at how we provide crisis services. In October a team was initiated including representatives from law enforcement, all three counties, ER's, NCHC and primary care providers, and Bridge Clinic. The team applied a systematic review and developed a work plan. Key elements/status include:
        - Changes to how NCHC staff crisis services. Results are reflected on the partner survey. New staff doing very well and having impact.
        - Formulating a different crisis service model to provide immediate crisis care as well as assessment and referral. Volume continues to increase as well as complexity. New care model being deployed includes a nurse in the crisis service area, possible stabilization services in crisis, coordinating with area ER's to manage movement between crisis and the emergency room, including identifying medical clearance criteria, better collaboration with providers, etc.
        - Chief Deputy Chad Billeb was recognized for his leadership in promoting a new educational concept on how law enforcement handles people in crisis.
        - Laura attended a Crisis Intervention Team (CIT) conference in Chicago with law enforcement representatives. Program is evidence-based, collaborative with

law enforcement and community providers on how to provide assessment and deal with individuals in crisis.

- A van has been provided for the purpose of transporting individuals between facilities. Working on whether law enforcement or mental health professionals will do transport.
- Board members expressed concern with how these positive efforts and results are being communicated in lieu of the vote of the Marathon County Board in September as to whether or not to continue in the Tri-County Agreement.
    - Facts must be provided
    - We must work together as a community
    - NCHC is more than just crisis services
    - Collaboration has made a positive difference
    - Education and ownership is valuable
    - There must be a sense of urgency to delivering these important messages to the counties with every opportunity.

<u>Human Services Operations Committee</u>

- Refocusing meetings into policy resources.
- Looking at information reporting to the committee relating to issues before us at county.
- Developing metrics for tracking, etc. and looking at outcomes.
- Looking at how we can be a leader in assessment and treatment.

<u>Nursing Home Operations Committee</u>

- Looking to invite non-board members to participate on the committee.
- Asked Executive Team to investigate the number of licensed nursing home beds, impact of a reduction in licensed beds, bed hold expenses, etc.
- Committee feels the nursing home renovation project should be reviewed as it has been two years since its development. Want to provide a current and viable document when asked.
- NCHC is currently working with Marathon County Facilities and Maintenance on a 5-Year Capital Plan (broad vision). Plan will be reviewed with Committees and the Board next month, followed by the County Health & Human Services Committee before going to CIP.

<u>2016 Operational Plan quarterly update</u>

- A current Operational Plan was distributed and reviewed.
- The Operational Plan is the internal work plan to meet operational objectives.

<u>Medical Staff Credentialing</u>

- **Motion**/second, Metter/ Burgener, to approve the following reappointments as recommended by the Medical Staff:
    - Jessica Altis, PA-C
    - Jean Baribeau-Anaya, PA-C
    - Joan Hauer, APNP
    - Diane Mansfield, APNP
    - Ruth Nelson-Lau, APNP
    - Barb Torgerson, PA-C

<u>Update on Ongoing Initiatives with County</u>

- Have reviewed operational objectives with Marathon County and also supporting the county in what is best for the community.
- Recommendation of Oversight Task Force were approved.

- Performance contract was given to NCHC to consider and continue with negotiations. Working with Scott Corbett and Brad Karger to clarify our relationship, create framework, and manage expectations and performance.
- Continue to scope out and working on parameters with transferring maintenance services to Marathon County. Do not feel changes will happen before first of year.
- Transition Oversight Task Force is working to clarify the decision being voted on in September and oversees the Administrative Workgroup which has been meeting weekly for several months.
- Morningside Needs Assessment – Morningside has been onsite once in March, met with executive team. Have had limited interactions. We have provided an enormous amount of information. Their recommendations should be received in June.
- Marathon County is actively involved in new priority based budgeting program. NCHC was not previously part of this but is now participating.

Overview of Financial Implications

- 2016 Budget Analysis of Marathon County and Lincoln/Langlade was reviewed (attached).
- The bulk of shared services are located at Wausau Campus.
- Likely Marathon County would maintain services so all revenue and expense would stay with Marathon County as well as the overhead.
- Must stay on top of federal and state funding; if the CCS program is a single county, the rates revert back to prior structure which would decrease revenue by approximately $1.3 million. All programs would need to be re-credentialed and NCHC state grants would be reallocated.
- A plan would need to be in place for how the accounts receivable balance would be distributed.
- All NPI numbers stay with NCHC.
- Client records stay with NCHC. The state was clear that Marathon County would need to get authorization from every client, plus there would be an expense to getting copies of a record.
- Challenges would occur in billing and accounts receivable with new and ID provider numbers.
- Several important items to consider: Costs to 'flip the switch' while maintaining the same level of service, and transitional costs which could be greater.
- We will continue to provide more information and how these changes could impact services.

CEO Report

- Our crisis staff in Langlade County have been active in supporting the community following the recent shooting. Counselors have met with over 100 students and will continue to provide aftercare.
- Dr. Ticho, Inpatient Psychiatrist/Medical Director, is reducing to part-time beginning in June.
- Looking to have board retreat soon.
- First week in June we are inviting all three county board members to come to the Wausau Campus, tour, present annual report, and engage in conversations with leaders and staff.
- Please sign up and attend Just Like Us event and support North Central Health Foundation.

Future agenda items

- Communication/activities

Motion/second, Penniman/Bliven, to adjourn at 2:07 p.m. Motion carried.

dko

NORTH CENTRAL COMMUNITY SERVICES PROGRAM BOARD
EXECUTIVE COMMITTEE

May 16 2016 10:30 AM NCHC – Wausau Campus

Present: Jeff Zriny, Bob Weaver, Jean Burgener, Robin Stowe

Also Present: Michael Loy

10:32 a.m. – Jeff Zriny called the meeting to order

Action: Approve 04/12/2016 Executive Committee meeting minutes
Motion to approve the 04/12/2016 Executive Committee meeting minutes made by Bob Weaver, seconded by Jean Burgener, motion passed 4-0.

Robin Stowe requested additional insight from the minutes on the HIPPA investigation and information regarding the recommended training on the 51 procedures and HIPPA for our county partners. Training objectives were overviewed and Robin will meet with Michael Loy to get more information.

Transition Oversight Committee
The purpose of Marathon County's Transition Oversight Committee was reviewed along with the progress to date. One meeting has occurred and the next meeting in Monday May 23rd, at 2pm. The interaction and progress of the Administrator's Work Group was discussed in relationship to the Transition Oversight Committee. Discussion occurred on how we got to this point along with emphasis of disappointment of Langlade and Lincoln counties not being part of the process. Committee has requested a copy of the Jail Report to better understand issues of mental health to the offender population.

Performance Contract Update
Negotiations are ongoing. The County rejected our counter-proposal which integrated the Collaborative Care Model concept as it was much broader than the authority which was given by the resolution passed by the County Board to develop a contract for mental health services to the offender population. Administration and legal counsel have since met with the Corporation Counsel to make minor adjustments to the original agreement. The Collaborative Care model will be separated from the Performance Contract effort and will be presented to the NCCSP Board to make a recommendation to develop the model as a functioning component of our Board to address expectations, quality and performance issues with our County partners in a privileged and confidential environment. The Performance Contract for mental health for the offender population will be finalized and brought to the NCCSP Board as soon as it's available.

2017-2021 Capital Plan
Development of the plan and timelines for input were reviewed. Jean Burgener made recommendations to frame the plan as a four-year plan and not five-year because there are currently no requests in 2021. A recommendation was also made to incorporate any alternate revenues and actual tax levy requests for each project. A chart with total requests by year was also requested.

NCCSP Board Committee Appointments

Dr. Steven Benson will be recommended for appointment to NCCSP Board by Marathon County. Dr. Benson used to work at NCHC and is a locally practicing Psychologist. Dr. Benson will be appointed to the Quality Committee.

With Dr. Penniman's resignation, Joanne Kelly will be appointed as Chair of the Quality Committee.

Robin Stowe was appointed by Jeff Zriny to the Executive Committee. The Bylaws require the Executive Committee to consist of the Board Chair, Vice-Chair, Secretary/Treasurer and Past-President. With Ron Nye leaving the board, and no other currently serving Past-Presidents on the Board the appointment authority will be delegated to the normal appointment authority of the Board Chair for committee appointments. Robin's appointment ensures representation from each of the three counties on the Executive Committee.

Discussion of formal appointment of Vice-Chairs was the following appointments are made:

-Randy Balk as Vice-Chair of the Finance, Personnel & Property Committee
-Greta Rusch as Vice-Chair of the Human Services Operations Committee
-Bill Metter as Vice-Chair of the Nursing Home Operations Committee
-Ben Bliven as Vice-Chair of the Quality Committee

Other appointments:

Margaret Donnelly has been appointed as a non-board committee member to the Nursing Home Operations Committee. She is currently the Vice President of Post-Acute Care at Aspirus. The Nursing Home Operations Committee is also seeking a former family member to join the Committee as a non-board member.

Jeff Zriny will announce the appointments for approval at the Board meeting.

Board Retreat

The Committee discussed potential dates for a retreat and determined it would be best to hold on organizing a retreat for now. The Board should prepare to have some potentially longer meetings or special meetings in the months to come.

CEO Report

- Open House is on June 9th. Recommendation was to treat present it as an annual meeting and request County's to support per diems for the meeting for County Board members.
- Dr. Black response and follow-up action was reported.
- Pharmacy audit will begin in June, expect a report by the end of June.
- Priority Based Budgeting initiative with the County was overviewed.

Agenda for 4/28/16 Board meeting

- Collaborative Care Model
- 5-Year Capital Plan
- LeadingChoice Network Agreement

Future agenda items for committee consideration

No items were requested.

Motion by Jean Burgener to adjourn, seconded by Robin Stowe, motion carried.

NORTH CENTRAL COMMUNITY SERVICES PROGRAM
FINANCE, PERSONNEL & PROPERTY COMMITTEEMEETING MINUTES

April 28, 2016 11:00 a.m. NCHC – Antigo Health Care Center

Present:

X	Randy Balk	X	Bill Miller
X	Bob Weaver	X	Jeff Zriny

Others Present: Ben Bliven, Michael Loy, Gary Bezucha, Brenda Glodowski, Robin Stowe

Introductions: Robin Stowe was introduced as new Langlade County Board member.

The meeting was called to order at 11:00 AM, roll call taken, and a quorum noted.

Minutes

- **Motion**/second, Weaver/Balk, to approve the minutes of the 3/31/16 Finance, Personnel & Property Committee meeting. Motion carried.

Financials

- March showed a deficit of $406,000.
- Revenue targets overall were met in March.
- Nursing home census averaged 205 per day in March; Medicare census improved over February averaging 21 per day; Hospital census averaged almost 15 per day.
- Several expenses that were high for the month were: health insurance, salaries in the hospital and nursing home, Crisis, other institutes, drug costs, and accrued PLT which typically goes down over summer months.
    - In regard to expenses for other institutes, the Crisis Manager visited Trempealeau County to case manage the individuals currently there and determined four individuals can return to NCHC.
    - Private room/capacity is under discussion and in process of seeking clarification on code requirements.
- Excess expenses year to date is $781,000 overall for the organization.
- The nursing home census is still down; March averaged 205.
- **Motion**/second, Balk/Miller, to approve March financial statements. Motion carried.

Write-off's

- Write-off's are in line overall.

CFO Report

- We continue to work closely with the electronic medical record vendor, Netsmart, who was on site to work through concerns we are having with the system. Action items were laid out including establishing an IT Governance Committee. Its role will be to assist prioritization of IT, how to strategically utilize resources, how to work well with the vendor, begin culture change i.e. clinical practice should drive IT rather than IT driving clinical practice.
- Days in Accounts Receivable improved in March.

Review 2015 Year End Fund Balance/Invested Cash by County

- Year end fund balance/invested cash by county with policy was reviewed. Policy was developed by the three county finance directors.
- Intent was to monitor and understand the fund balance level of each county, to look for consistencies, and to keep counties informed on the invested reserves and at what point counties have the options as to what they would like to do with funds.
- Each county receives information at the end of the audit.
- Brenda reviewed handouts.
- Not all fund balance is cash; at the time discussion looked at reserves (invested cash).

Accounts Receivable Action

- Accounts Receivable is still high; higher than what we would have predicted being into the 2nd year of conversion.
- This action plan helps us work through items that contribute to billing issues.
- We continue to implement the billing software.
- The organization has multiple software programs i.e. ECS for nursing home, TIER for mental health system. TIER was supposed to be used to do both programs but has not been working in the nursing home. We will be using ECS for nursing home billing; we already use ECS for electronic medical record and there is a small expense to utilize the ECS nursing home billing system.
- Weekly calls with vendor are being made to help address the unique issues between nursing home and mental health billing.
- A target for this year is to implement more frequent billing. This process will start in Birth to Three and Outpatient.

Motion/second, Balk/Miller, to adjourn the Finance, Personnel & Property Committee meeting. Motion carried. Meeting adjourned at 11:55 a.m.

dko

North Central Health Care
Person centered. Outcome focused.

MEMO

TO: **North Central Health Care Finance Committee**
FROM: **Brenda Glodowski**
DATE: **May 20, 2016**
RE: **Attached Financials**

Attached please find a copy of the April Financial Statements for your review. To assist in your review, the following information is provided:

BALANCE SHEET

The Balance Sheet is consistent with the prior month which reflects the change in the format.

STATEMENT OF REVENUE AND EXPENSES

The month of April shows a small gain of $1526, compared to the targeted gain of $12,680.

Overall revenue for April exceeded targets. While the overall revenue exceeded overall targets, not all individual areas did. Nursing home census continues to struggle, with an average census for the month of 204 per day. This is a decrease from the previous month. The target is 210 per day. The Medicare census did improve, with an average of 22 per day. The target is 23 per day. The Hospital census averaged over 15 per day compared to the target of 14 per day. Community treatment exceeded targets again for April; however, Outpatient continues to be below target.

Overall expenses continue to exceed budget targets. There was improvement compared to the prior month, but more work continues to be done in this area. Health insurance was back in line with budget for April, however, state institutions exceeded target by $217,000. Drugs was another area over target for April.

Crisis and the hospital continue to exceed budget targets, and likely will for the rest of the year as work continues to be done in these areaa.

If you have questions, please feel free to contact me.

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF NET POSITION
APRIL 2016

	Human Services	Nursing Home	Total	Prior Year Combined
Current Assets:				
Cash and cash equivalents	4,669,041	1,162,605	5,831,646	7,754,318
Accounts receivable:				
Patient - Net	3,815,860	3,605,463	7,421,323	7,690,598
Outpatient - WIMCR	495,000	0	495,000	400,333
Nursing home - Supplemental payment program	0	136,100	136,100	143,014
Marathon County	189,754	0	189,754	72,809
Net state receivable	103,997	0	103,997	1,137,872
Other	262,354	0	262,354	187,009
Inventory	0	303,535	303,535	273,822
Other	615,893	521,911	1,137,804	464,235
Total current assets	10,151,900	5,729,614	15,881,514	18,124,010
Noncurrent Assets:				
Investments	9,800,000	0	9,800,000	7,092,791
Assets limited as to use	1,937,716	946,426	2,884,142	2,207,210
Restricted assets - Patient trust funds	25,750	34,459	60,209	56,851
Net pension asset	2,642,551	2,204,387	4,846,938	0
Nondepreciable capital assets	233,507	523,562	757,069	1,085,690
Depreciable capital assets - Net	7,680,005	3,326,919	11,006,924	10,626,335
Total noncurrent assets	22,319,528	7,035,753	29,355,281	21,068,877
Deferred outflows of resources - Related to pensions	2,645,224	2,206,618	4,851,842	0
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	35,116,652	14,971,985	50,088,637	39,192,886

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF NET POSITION
APRIL 2016

	Human Services	Nursing Home	Total	Prior Year Combined
Current Liabilities:				
Current portion of related-party note payable	151,257	0	151,257	148,264
Accounts payable - Trade	655,084	572,585	1,227,669	1,204,527
Appropriations advances	1,069,965	283,333	1,353,298	1,383,445
Accrued liabilities:				
Salaries and retirement	874,615	729,595	1,604,210	1,969,687
Compensated absences	911,434	760,309	1,671,743	1,625,115
Health and dental insurance	467,236	389,764	857,000	652,000
Other Payables	223,741	186,642	410,383	422,806
Amounts payable to third-party reimbursement programs	416,667	0	416,667	335,000
Unearned revenue	476,903	0	476,903	188,489
Total current liabilities	5,246,902	2,922,227	8,169,129	7,929,333
Noncurrent Liabilities:				
Related-party note payable	636,181	0	636,181	787,438
Patient trust funds	25,750	34,459	60,209	56,503
Total noncurrent liabilities	661,931	34,459	696,390	843,941
Total liabilities	5,908,833	2,956,686	8,865,520	8,773,274
Deferred inflows of resources - Related to pensions	46,273	38,600	84,873	0
Net Position:				
Net investment in capital assets	7,913,512	3,850,481	11,763,992	11,712,025
Unrestricted	16,224,931	4,325,884	20,550,815	17,970,242
Restricted - Pension benefit	5,235,835	4,367,677	9,603,512	0
Operating Income / (Loss)	(212,732)	(567,343)	(780,075)	737,345
Total net position	29,161,546	11,976,699	41,138,244	30,419,612
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	35,116,652	14,971,985	50,088,637	39,192,886

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF REVENUES AND EXPENSES
FOR PERIOD ENDING APRIL 30, 2016

51.42./.437 PROGRAMS	CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE	YTD ACTUAL	YTD BUDGET	YTD VARIANCE
Revenue:						
Net Patient Service Revenue	$1,687,013	$1,518,063	$168,949	$6,422,387	$6,128,932	$293,455
Other Revenue:						
State Match / Addendum	324,658	325,120	(462)	1,298,632	1,300,479	(1,847)
Grant Revenue	204,800	190,538	14,262	793,651	762,243	31,407
County Appropriations - Net	598,953	598,899	54	2,395,812	2,395,596	216
Departmental and Other Revenue	162,683	169,287	(6,604)	591,073	677,300	(86,227)
Total Other Revenue	1,291,095	1,283,844	7,250	5,079,167	5,135,618	(56,451)
Total Revenue	2,978,107	2,801,908	176,200	11,501,554	11,264,550	237,004
Expenses:						
Direct Expenses	2,250,040	1,991,342	258,698	8,799,807	7,955,914	843,894
Indirect Expenses	643,659	804,279	(160,620)	2,953,755	3,242,645	(288,890)
Total Expenses	2,893,699	2,795,621	98,078	11,753,563	11,198,559	555,004
Operating Income (Loss)	84,408	6,287	78,121	(252,009)	65,991	(318,000)
Nonoperating Gains (Losses):						
Interest Income	8,577	7,500	1,077	36,312	30,000	6,312
Donations and Gifts	165	0	165	2,965	0	2,965
Gain / (Loss) on Disposal of Assets	0	0	0	0	0	0
Total Nonoperating Gains / (Losses)	8,742	7,500	1,242	39,277	30,000	9,277
Operating Income / (Loss)	$93,150	$13,787	$79,364	($212,732)	$95,991	($308,723)

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF REVENUES AND EXPENSES
FOR PERIOD ENDING APRIL 30, 2016

NURSING HOME	CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE	YTD ACTUAL	YTD BUDGET	YTD VARIANCE
Revenue:						
Net Patient Service Revenue	$2,048,099	$2,040,628	$7,471	$7,933,047	$8,208,257	($275,210)
Other Revenue:						
County Appropriations - Net	141,666	141,667	(1)	566,664	566,667	(3)
Departmental and Other Revenue	43,273	31,296	11,977	224,428	125,182	99,246
Total Other Revenue	184,939	172,962	11,976	791,092	691,849	99,243
Total Revenue	2,233,037	2,213,590	19,448	8,724,139	8,900,106	(175,967)
Expenses:						
Direct Expenses	1,685,813	1,612,373	73,440	7,019,364	6,442,742	576,623
Indirect Expenses	639,204	602,325	36,879	2,274,286	2,428,417	(154,131)
Total Expenses	2,325,017	2,214,698	110,319	9,293,650	8,871,158	422,492
Operating Income (Loss)	(91,980)	(1,108)	(90,871)	(569,511)	28,948	(598,458)
Nonoperating Gains (Losses):						
Interest Income	0	0	0	0	0	0
Donations and Gifts	355	0	355	2,168	0	2,168
Gain / (Loss) on Disposal of Assets	0	0	0	0	0	0
Total Nonoperating Gains / (Losses)	355	0	355	2,168	0	2,168
Operating Income / (Loss)	($91,626)	($1,108)	($90,518)	($567,343)	$28,948	($596,290)

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF REVENUES AND EXPENSES
FOR PERIOD ENDING APRIL 30, 2016

TOTAL	CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE	YTD ACTUAL	YTD BUDGET	YTD VARIANCE
Revenue:						
Net Patient Service Revenue	$3,735,112	$3,558,691	$176,421	$14,355,434	$14,337,189	$18,245
Other Revenue:						
State Match / Addendum	324,658	325,120	(462)	1,298,632	1,300,479	(1,847)
Grant Revenue	204,800	190,538	14,262	793,651	762,243	31,407
County Appropriations - Net	740,619	740,566	53	2,962,476	2,962,263	213
Departmental and Other Revenue	205,956	200,583	5,373	815,501	802,482	13,019
Total Other Revenue	1,476,033	1,456,807	19,226	5,870,259	5,827,467	42,792
Total Revenue	5,211,145	5,015,499	195,647	20,225,693	20,164,656	61,037
Expenses:						
Direct Expenses	3,935,853	3,603,715	332,138	15,819,172	14,398,655	1,420,516
Indirect Expenses	1,282,863	1,406,604	(123,741)	5,228,041	5,671,062	(443,021)
Total Expenses	5,218,716	5,010,319	208,397	21,047,213	20,069,717	977,496
Operating Income (Loss)	(7,571)	5,180	(12,751)	(821,520)	94,939	(916,458)
Nonoperating Gains (Losses):						
Interest Income	8,577	7,500	1,077	36,312	30,000	6,312
Donations and Gifts	519	0	519	5,133	0	5,133
Gain / (Loss) on Disposal of Assets	0	0	0	0	0	0
Total Nonoperating Gains / (Losses)	9,097	7,500	1,597	41,445	30,000	11,445
Operating Income / (Loss)	$1,526	$12,680	($11,154)	($780,075)	$124,939	($905,013)

NORTH CENTRAL HEALTH CARE
REPORT ON AVAILABILITY OF FUNDS
April 30, 2016

BANK	LENGTH	MATURITY DATE	INTEREST RATE	AMOUNT	Collaterized/ Insured
BMO Harris	395 Days	5/28/2016	0.30%	$500,000	
Abby Bank	365 Days	7/19/2016	0.75%	$500,000	X
People's State Bank	365 Days	8/21/2016	0.50%	$500,000	
BMO Harris	395 Days	8/26/2016	0.50%	$500,000	
Abby Bank	365 Days	8/29/2016	0.75%	$500,000	X
Abby Bank	456 Days	9/1/2016	0.95%	$500,000	X
CoVantage Credit Union	456 Days	9/1/2016	1.00%	$500,000	
People's State Bank	365 Days	10/30/2016	0.55%	$500,000	
Abby Bank	365 Days	1/6/2017	0.75%	$500,000	X
Abby Bank	730 Days	2/25/2017	0.80%	$500,000	X
People's State Bank	395 Days	3/28/2017	0.65%	$250,000	
CoVantage Credit Union	455 Days	3/30/2017	1.00%	$500,000	
CoVantage Credit Union	578 Days	5/7/2017	1.05%	$500,000	
People's State Bank	395 Days	5/29/2017	0.75%	$350,000	
People's State Bank	395 Days	5/30/2017	0.75%	$500,000	
CoVantage Credit Union	578 Days	7/28/2017	1.10%	$300,000	
Abby Bank	730 Days	10/29/2017	1.10%	$500,000	X
CoVantage Credit Union	730 Days	11/18/2017	1.10%	$500,000	
Abby Bank	730 Days	12/30/2017	1.10%	$500,000	X
Abby Bank	730 Days	3/15/2018	1.20%	$400,000	X
Abby Bank	730 Days	5/3/2018	1.20%	$500,000	X
TOTAL FUNDS AVAILABLE				$9,800,000	
WEIGHTED AVERAGE	510.70 Days		0.848%	INTEREST	

NCHC-DONATED FUNDS
Balance Sheet
As of April 30, 2016

ASSETS	
Current Assets	
Checking/Savings	
CHECKING ACCOUNT	
Adult Day Services	5,180.38
Adventure Camp	798.41
Birth to 3 Program	2,035.00
Clubhouse	23,617.86
Community Treatment	10,366.66
Fishing Without Boundries	2,663.00
General Donated Funds	61,851.67
Housing - DD Services	1,370.47
Langlade HCC	3,262.03
Legacies by the Lake	
Music in Memory	1,848.25
Legacies by the Lake - Other	4,138.50
Total Legacies by the Lake	5,986.75
Marathon Cty Suicide Prev Task	10,360.53
National Suicide Lifeline Stipe	3,176.37
Northern Valley West	1,966.00
Nursing Home - General Fund	2,763.52
Outpatient Services - Marathon	101.08
Pool	12,529.82
Prevent Suicide Langlade Co.	2,444.55
Resident Council	1,021.05
United Way	260.00
Total CHECKING ACCOUNT	151,755.15
Total Checking/Savings	151,755.15
Total Current Assets	151,755.15
TOTAL ASSETS	**151,755.15**
LIABILITIES & EQUITY	
Equity	
Opening Bal Equity	123,523.75
Retained Earnings	35,991.07
Net Income	-7,759.67
Total Equity	151,755.15
TOTAL LIABILITIES & EQUITY	**151,755.15**

North Central Health Care
Budget Revenue/Expense Report

Month Ending April 30, 2016

ACCOUNT DESCRIPTION	CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	YTD ACTUAL	YTD BUDGET	DIFFERENCE
REVENUE:					
TOTAL NET REVENUE	5,211,145	5,015,499	20,225,693	20,164,656	61,037
EXPENSES:					
Salaries and Wages	2,461,240	2,551,520	9,975,557	10,191,068	(215,511)
Fringe Benefits	1,004,656	945,189	4,177,430	3,775,211	402,219
Departments Supplies	529,040	466,527	2,159,124	1,866,109	293,016
Purchased Services	325,506	270,981	1,616,573	1,098,925	517,648
Utilitites/Maintenance Agreements	284,275	323,097	1,409,276	1,326,387	82,889
Personal Development/Travel	50,193	39,229	144,985	156,917	(11,932)
Other Operating Expenses	109,185	153,317	396,789	613,267	(216,478)
Insurance	36,844	47,292	148,378	189,167	(40,789)
Depreciation & Amortization	134,110	138,167	536,840	552,667	(15,826)
Client Purchased Services	283,667	75,000	482,261	300,000	182,261
TOTAL EXPENSES	**5,218,716**	**5,010,319**	**21,047,213**	**20,069,717**	**977,496**
EXCESS REVENUE (EXPENSE)	**(7,571)**	**5,180**	**(821,520)**	**94,939**	**(916,458)**

North Central Health Care
Write-Off Summary
April 2016

	Current Month	Current Year To Date	Prior Year To Date
Inpatient:			
Administrative Write-Off	$12,022	$23,962	$6,325
Bad Debt	$343	$2,286	$442
Outpatient:			
Administrative Write-Off	$12,034	$12,308	$27,728
Bad Debt	$623	$2,712	$901
Nursing Home:			
Daily Services:			
Administrative Write-Off	$561	($18,066)	$0
Bad Debt	$761	$5,394	$5,495
Ancillary Services:			
Administrative Write-Off	($106)	($4,869)	$527
Bad Debt	$0	($126)	$0
Pharmacy:			
Administrative Write-Off	$0	$0	$0
Bad Debt	$0	$0	$0
Total - Administrative Write-Off	$24,511	$13,335	$34,580
Total - Bad Debt	$1,727	$10,266	$6,838

North Central Health Care
2016 Patient Days

Month		Budget	Actual	Variance	Budgeted Occupancy	Actual Occupancy
January	Nursing Home	6,510	6,441	(69)	87.50%	86.57%
	Hospital	434	402	(32)	87.50%	81.05%
February	Nursing Home	6,090	5,953	(137)	87.50%	85.53%
	Hospital	406	407	1	87.50%	87.72%
March	Nursing Home	6,510	6,363	(147)	87.50%	85.52%
	Hospital	434	459	25	87.50%	92.54%
April	Nursing Home	6,300	6,131	(169)	87.50%	85.15%
	Hospital	420	462	42	87.50%	96.25%
May	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%
June	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%
July	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%
August	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%
September	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%
October	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%
November	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%
December	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%

North Central Health Care
Person centered. Outcome focused.

QUALITY OUTCOME DASHBOARD

DEPARTMENT: NORTH CENTRAL HEALTH CARE FISCAL YEAR: 2016

PRIMARY OUTCOME GOAL	Continuous Improvement Target	Benchmark	⇧⇩	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD	2015
PEOPLE																	
Vacancy Rate	6-8%	N/A	⇩	8.0%	5.8%	4.8%	5.2%									6.3%	7.6%
Employee Turnover Rate*	20-23%	17%	⇩	19.6%	29.2%	29.3%	28.4%									28.4%	28.9%
SERVICE																	
Patient Experience: Satisfaction Percentile Ranking	70-84th Percentile	N/A	⇧	53rd	48th	45th	46th									45th	51st
Community Partner Satisfaction	75-80%	N/A	⇧	\	\	77%	\									77%	76%
CLINICAL																	
Nursing Home Readmission Rate	11-13%	18.2%	⇩	13.8%	6.7%	12.0%	10.7%									10.7%	13.7%
Psychiatric Hospital Readmission Rate	9-11%	16.1%	⇩	12.8%	11.1%	3.2%	5.0%									9.0%	10.8%
AODA Relapse Rate	18-21%	40-60%	⇩	30.0%	33.3%	20.7%	25.0%									28.0%	20.7%
COMMUNITY																	
Crisis Treatment: Collaborative Outcome Rate	90-97%	N/A	⇧	\	\	\	\										N/A
Access to Behavioral Health Services	90-95%	NA	⇧	58%	65%	87%	86%									74%	73%
Recidivism Rate for OWI	27-32%	44.7%	⇩	22.6%	20.5%	29.2%	28.2%									25.5%	26.4%
FINANCE																	
*Direct Expense/Gross Patient Revenue	58-62%	N/A	⇩	71%	65%	66%	64%									67%	63%
Days in Account Receivable	60-65	54	⇩	70	65	64	64									64	68

KEY: ⇧ Higher rates are positive
⇩ Lower rates are positive

* Monthly Rates are Annualized

Target is based on a 10%-25% improvement from previous year performance or industry benchmarks.

NCHC OUTCOME DEFINITIONS

PEOPLE	
Vacancy Rate	Total number of vacant positions as of month end divided by total number of authorized positions as of month end.
Employee Turnover Rate	Percent of employee terminations (voluntary and involuntary) of the total workforce. Monthly figures represent an annualized rate. *Benchmark: Society of Human Resource Management (SHRM) for the north central region of the U.S.*
SERVICE	
Patient Experience: Satisfaction Percentile Ranking	Comparison rate (to other organizations in the Health Stream database) of the percent of level 9 and 10 responses to the Overall rating question on the survey. *Benchmark: HealthStream 2015 Top Box Percentile*
Community Partner Satisfaction Percent	Percentage of "Good and Excellent" responses to the Overall Satisfaction question on the survey.
CLINICAL	
Nursing Home Readmission Rate	Number of residents re-hospitalized within 30 days of admission to nursing home / total admissions. *Benchmark: American Health Care Association/National Center for Assistive Living (AHCA/NCAL) Quality Initiative*
Psychiatric Hospital Readmission Rate	Percent of patients who are readmitted within 30 days of discharge from the Inpatient Behavioral Health hospital for Mental Health primary diagnosis. *Benchmark: Medicare Psychiatric Patients & Readmissions in Impatient Psychiatric Facility Prospective Payment System, May, 2013, The Moran Company*
AODA Relapse Rate	Percent for patients admitted to Ambulatory Detoxification or the Behavioral Health hospital for detoxification then readmitted within 30 days of discharge for repeat detoxification. *Benchmark: National Institute of Drug Abuse: Drugs, Brains, and Behavior: The Science of Addiction*
COMMUNITY	
Crisis Treatment: Collaborative Decision Outcome Rate	Total number of positive responses (agreement with crisis response and plan) on by referring partners on the Crisis Collaboration Summary divided by total cases by referring partners.
Criminal Justice System Service	
NCHC Access	% of clients obtaining services within the Best Practice timeframes in NCHC programs. • Adult Day Services - within 2 weeks of receiving required enrollment documents • Aquatic Services - within 2 weeks of referral or client phone requests • Birth to 3 - within 45 days of referral • Community Corner Clubhouse - within 2 weeks • Community Treatment - within 60 days of referral • Outpatient Services - within 14 days of referral • Prevocational Services - within 2 weeks of receiving required enrollment documents • Residential Services - within 1 month of referral
Recidivism Rate for OWI	Percentage of AODA clients who receive treatment at NCHC that have 2 or more OWI convictions. *Benchmark: 2012-OWI Related Convictions by Violation County and Repeat Offender Status, State of Wisconsin DOT, Bureau of Driver Service, Alcohol & Drug Review Unit*
FINANCE	
Direct Expense/Gross Patient Revenue	Percentage of total direct expense compared to gross revenue.
Days in Account Receivable	Average number of days for collection of accounts. *Benchmark: WIPFLI, sources 2015 Almanac of Hospital Financial and Operating Indicators published by Optum-Psychiatric Hospitals, 2013 data.*

NORTH CENTRAL COMMUNITY SERVICES PROGRAM
HUMAN SERVICES OPERATIONS COMMITTEE
MEETING MINUTES

May 13, 2016 **10:30 a.m.** **NCHC – Wausau Campus**

Present:

X	John Robinson	EXC	Holly Matucheski	EXC	Greta Rusch
X	Scott Parks	X	Nancy Bergstrom	X	Lee Shipway
X	Linda Haney				

Others Present: Michael Loy, Kim Gochanour, Laura Scudiere, Becky Schultz, Toni Kellner Michelle Hazuka, Ben Bliven

The meeting was called to order at 10:36am, roll call was noted, and a quorum declared. Meeting attendees introduced themselves.

Consent Agenda

- **Motion**/second, Shipway/Parks, to approve the consent agenda which includes the 4/8/16 Human Services Operations Committee minutes. Motion carried.
- **Motion/**second, Shipway/Parks, to accept the financial report. Motion Carried.

Crisis Structure Modification Proposal

- Phase II of Crisis Structure Modification Proposal distributed to committee, discussed, and reviewed by members.
- Reviewed current FTE Crisis Workers allotment and proposed FTE status re- structure.
- New model would include the requisition of: Behavioral Health Service Line Director, RN Case Manager, and Law Enforcement Liaison. Also discussed other FTE position implementation requests that included the development of a transportation program to assist patients, implementation of crisis shift team leads, a clinical on-call staff and program, and youth crisis stabilization staff.
- Discussed benefit of minimization of diversions that would be a direct result of approval of new staffing re-structuring.
- Reviewed rationale for implementing a larger scale care model being centered on laying a solid and correct foundation for HSO programs. Stated that increased supervision for crisis workers, additional staff and clinical case management is necessary to ensure that the next phase of crisis design can be completed.
- Discussed an example of direct measurable items of potential outcomes, outputs and timelines of approval of Crisis Structure Modification Proposal. Presented formalized listing of outcomes, outputs and timelines to committee.
- Committee requested to include outcomes, outputs and timelines with the proposal to the Board to further detail the model.

- **Motion**/second, Shipway/Haney, to approve the Crisis Structure Modification Proposal for consideration by the Board. Motion carried.

5-Year Facilities Capital Plan

- Discussed 5-Year Facilities Capital Plan that was further detailed in the committee packet. Reviewed purpose, background and recommendation, potential costs and timelines. Also reviewed a summary of current Marathon County capital project requests and capital improvement project forecast for future program years.
- Discussed 5 main objectives:
    - Provide facilities that enable more efficient clinical operations to enhance health outcomes
    - Plan facilities that enable optimum care for a growing population
    - Invest wisely in future flexibility for changes yet to come
    - Clearly balance first cost versus life-cycle costs
    - Operate and maintain facilities more efficiently
- Discussed future potential for Adult Day Services program relocation, which will be critical to provide for main campus expansion for Behavioral Health Services.
- Reviewed division of North Central Health Care major project area into a number of workable parts in the scope of the 5-year Facilities Capital Plan which include:
    - Health Care Center (Administration, Community Treatment, Outpatient, Behavioral Health Services and Legacies Dementia units)
    - Mount View Care Center (Post-Acute Care, Long-term Care)
    - Lake View Center (Pool, Health Department, ADRC)
    - Lake View Professional Plaza (CCCW, Special Education)
- **Motion/**second, Bergstrom/Haney, to approve the 5-Year Facilities Capital Plan for recommendation to the Board. Motion carried.

Human Services Outcome Reporting Review

- Discussed transition task force put in place with Marathon County's initiative to dissolve the tri-county agreement with North Central Health Care.
- At this time, the question that will be reviewed by the Marathon County Board in September for vote is "Does the current governance structure best serve the residents of Marathon County".
- Discussed the priority-based budgeting that Marathon County is reviewing to create a hierarchy of priorities.

Operational Changes Review

- Reviewed Community Corner Clubhouse Hope House Concept. Discussed goal of looking at ways of best supporting membership and participants by diversifying services such as a supported housing opportunity, which prompted the idea of Community Corner Clubhouse Hope House.
    - Hope House will reflect the Oxford House (self-governing) model for clients in a current sobriety recovery process.
    - Community partners have taken on cost and some of the liability of the Hope House.
    - Hope House is set to open June 1st 2016. Open house May 25th 4pm-5:30pm. Invitations will be emailed to committee.
    - Hope House is a 5 bedroom, 3 bathroom facility with laundry on-site. Male and female residents of age 18 or older are welcome and residents must pay rent of $450 per month. Residency will be regularly reviewed and program is an effort to eventually move residents to independent living, Hope House is not meant for a long-term living solution.
    - Within 30 days of residents moving into Hope House, residents must have a sponsor.

    - Goal of Clubhouse is to pilot Hope House program for one year.

- Reviewed Residential Services Bellewood CBRF Facility Transition to Andrea Street. Toni Kellner presented an overview of the CBRF expansion.
    - Discussed renovations needed to progress.
    - DHS 83 required that buildings meet CBRF regulations, therefore renovations were needed.
    - Andrea Street property requires renovations with a cost impact of $25,693.00 for total start-up cost (cost does not include paying the duplicate rental fee while the renovations are occurring).
    - Andrea Street projects for a profit margin of $14,674.00 monthly.
    - Overall operating margin would increase by about $114,300 annually to transition from Bellewood CBRF facility to Andrea Street facility.

Human Services Operations Committee Charter Review

- Due to the interest of time, a motion/second, to approve the Human Services Operations Committee Charter, Work Plan and Objectives will be reviewed and placed for motion at the next committee meeting.

Future Items for Committee Consideration

- Human Services Operations Committee charter review.

Motion/second, Parks/Haney, to adjourn at 12:40p.m. Motion carried.

KCC

Phase II Crisis Services Model Transition Proposal

Purpose:

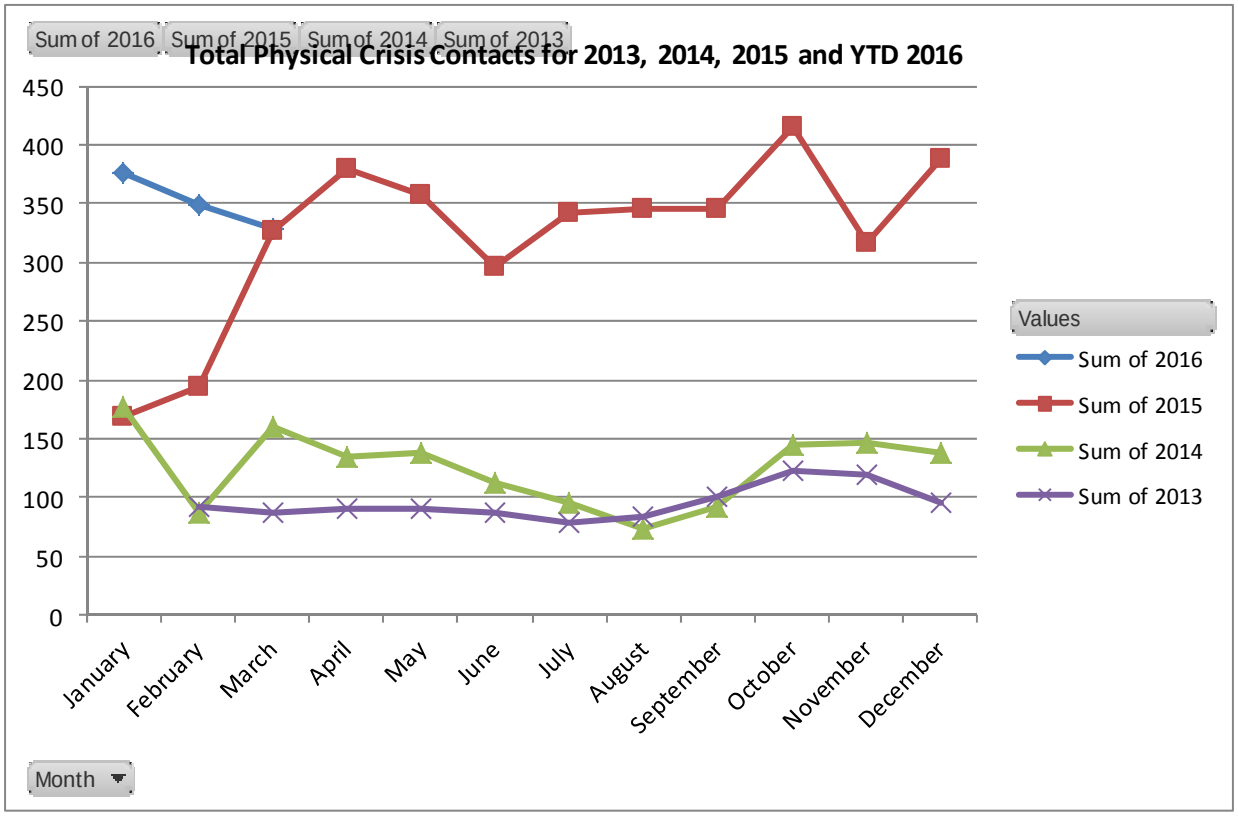
Restructuring of crisis services is necessary if NCHC is going to meet community need.

Current Situation:

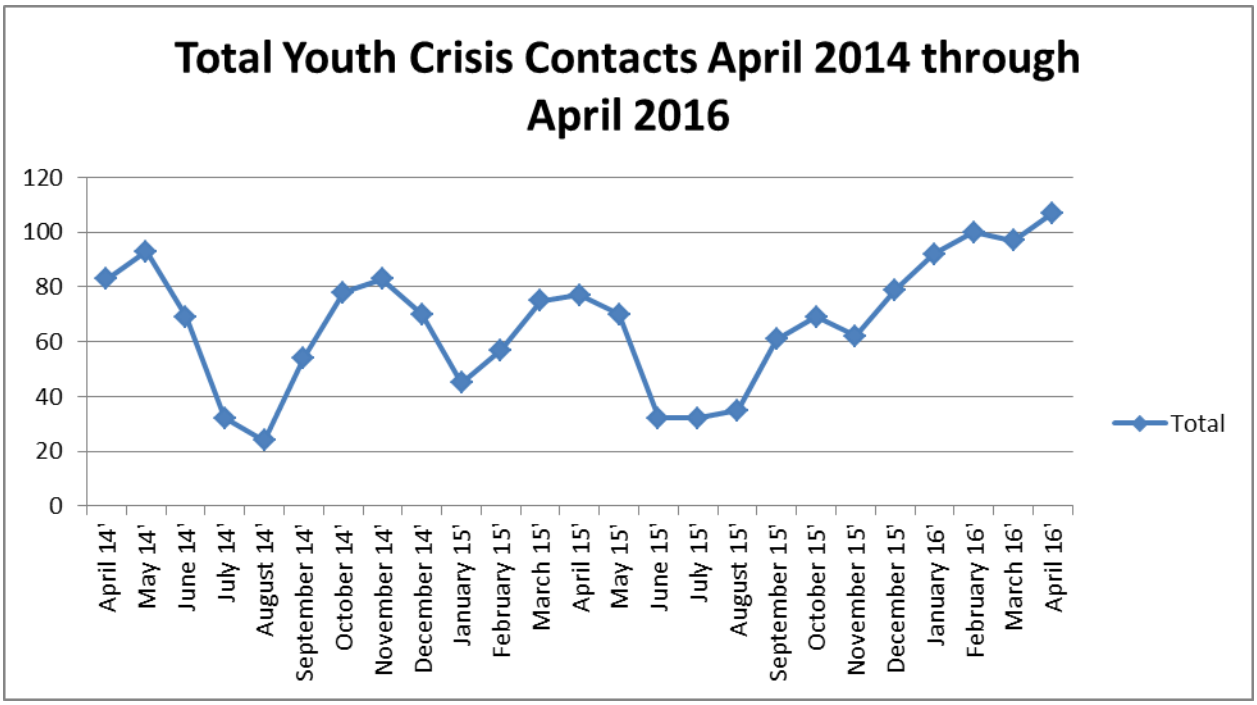
Volume and demand of crisis services is exceeding NCHC's ability to meet community need. NCHC doesn't have appropriate clinical (medical) case management in crisis, nor does the supervision structure support the volume and frequency of calls and it doesn't provide consistency between crisis workers, a common complaint of partners. Also, patients are being transported in Sheriff's department vehicles, and their policy is to cuff every patient. Crisis services lack the ability to bridge the gap between law enforcement and mental health, and there needs to be ongoing support and training for law enforcement on crisis services.

Background and Historical Information:

Feedback was received from the Crisis Process Improvement group and from community partners. Crisis has also been handling increasing volumes. Crisis services needed to grow and change with community need. The NCHC Crisis Process Improvement consultant and the BHS leadership team came together to adjust the supervision structure of the department, as well as analyze and add appropriate systems and staff in place to support future growth and change.



Year	Total Crisis Contacts
2013	1048
2014	1500
2015	3878
2016 Annualized	4220



The model in crisis was re-evaluated and a phased project to restructure was initiated.

1. **Phase I** increased the base educational requirement of crisis staff and increased the number of FTEs from 13.6 budgeted FTEs to 17.25 FTEs in the crisis center. Phase I has been completed to respond to the immediate community demand.
2. **Phase II** is necessary in order to implement the Trauma-Informed-Care transportation program, clinical case management, supervision changes, and to develop the law enforcement liaison.
3. **Phase III** will include in-house medical clearance as well as care model changes. This phase will also require the approval of the capital plan, and will largely focus on aligning the model of care with an urgent-care crisis clinic.

Proposal:

- **Recruit new Behavioral Health Service Line Director.** This role would not only be responsible for day-to-day operations, but would be accountable for developing strategy and achieving strong relationships with partners. It is imperative that the person in this role have strong clinical operations experience and hold a Master's degree. This role has been provisionally filled by a consultant. Long term success of the program is contingent on recruiting a strong manager in this role.

- **Hire an RN Case Manager.** This position will have case management responsibilities for patients diverted to other facilities and Crisis clients. Currently, a Unit Clerk (budgeted in the hospital) performs some of the UR functions and the risk for denials are increasing due to the fact that the individual does not have a clinical background. It is proposed that this position would eliminate the Unit Clerk role, and the duties of that role would be included in the RN Case Manager's position. The salary for this position, using the midpoint of the RN salary range, is estimated to be $62,649.60, representing an increase of $24,745 to the budgeted salary. Case Management and Utilization Review require clinical knowledge. An RN in this role will help to decrease denials. In addition, Crisis staff spend time doing case management functions which takes crisis workers away from their primary function. The FY 2016 impact is $12,372.80

- **Develop a law enforcement liaison position**. This role is being developed with CIT gathered information and will provide much needed ongoing training and support between crisis workers

and law enforcement. This would be a part-time position. The average law enforcement liaison salary is $48,000-$57,000/year. The midpoint between this range would be $52,500/year which is $25.24/hour. Using this rate, the salary for a 0.5 FTE would be $26,250. The FY 2016 impact is 13,125

- **Develop a transportation program to assist patients.** Ensure trauma informed care transportation, to extent possible, with our own van and staff trained in de-escalation.
  This can be done in two steps. First step would be hiring staff for 12 pm to 8 am coverage with a 1.4 FTEs at 16.48/hr. This can be provided by a part-time crisis technician, who can also be utilized in other crisis functions when not transporting patients. This would be a part-time position. Initial FY 2016 cost to this would be $47,989.76.

  The second implementation would provide for 24/7 coverage. Salary costs=$157,680 4.6 FTEs total at 16.48/hr. This includes benefits as it would be unlikely to fill positions that are not benefit eligible. You would need 6 people in this role to create a schedule that rotates every other weekend, but should consider a couple of casual staff for vacation coverage. This service will improve relationships, improve public safety, and most importantly the position supports trauma informed care. The client would receive the right care at the right time more frequently. The second implementation impact is $78,840

- **Implement Crisis Shift Team Leads.** This will provide consistency for crisis response and appropriate supervision.

- **Clinical On-Call** will be incorporated into the position description for the three manager positions to provide a resource for BHS staff during off hours and weekends. It is recommended that a salary adjustment be made based on where current salaries fall within the pay range to compensate for 24/7 coverage on an every third weekend rotation. The associated cost is $14,600 (2.50/hr x 16hr/dayx365 days/week). The FY 2016 impact is $7,300

- **Youth Crisis Stabilization Staff:** The volume of youth seeking services at NCHC has increased. To meet the demand, a predictable schedule to provide youth crisis stabilization services 24/7 is recommended. Currently, the area is staffed by on-call employees. The current staffing plan leaves gaps in coverage and causes delays in stabilization. Providing 24/7 services requires 4.2 FTEs. Given 2.78 FTEs are currently being utilized, the net increase in FTEs for this recommendation is 1.48. The FY 2016 impact is $26,551.20.

Total cost (First implementation of transportation): $98,769

Rationale:

In order to implement a larger scale care model transition, we need to lay the correct foundation. Increased supervision for crisis workers, additional staff, and clinical case management is necessary to ensure that the next phase of crisis design can be completed.

Outcome	Outputs
1. Patient Impact: Improved patient experience top box rating by 20% 2. Community Health Impact: Decrease re-hospitalizations within 30 days 3. Community Health Impact: Decrease in % of clients requiring hospitalization through use of effective less-restrictive treatment options.	100% of transport staff hired and trained in trauma-informed care and de-escalation as a requirement
	Number of patients that receive a ride by sheriff's department (in handcuffs) down by 60%
	New supervision structure will result in employee engagement improvement by 30%.
	And reduction in Crisis Staff turn-over by 10%
	10% decrease in the length of stay for diverted patients due to case management
	20% improvement in medical partner satisfaction scores
	15% improvement in LE partner satisfaction scores
	Number of patients that receive a ride by sheriff's department down by 60%
	Decrease in youth crisis diversions by 15%.

NORTH CENTRAL COMMUNITY SERVICES PROGRAM
NURSING HOME OPERATIONS COMMITTEE MEETING MINUTES

April 29, 2016 8:00 A.M. NCHC – Wausau Campus

Present:	X	Jean Burgener	X	Bill Metter	X	Bill Miller
	X	John Robinson				

Also Present: Gary Bezucha, Brenda Glodowski, Sue Matis, Becky Schultz

The meeting was called to order at 8:00 a.m.

Minutes

- **Motion**/second, Metter/Miller, to approve the 3/31/16 Nursing Home Operation Committee meeting minutes. Motion carried.

Financial Report

- No questions

Senior Executive Nursing Home Operations and Quality Report

- NCHC pharmacy utilization – According to a report from M3, in 2015 employee savings totaled about $300,000 by utilizing the NCHC pharmacy organization-wide. If an outside pharmacy would be utilized the cost would be substantially higher due to specialty packaging, etc. Outsourcing pharmacy services would have an added expense to NCHC and Medicare Part A patients also.
- NCHC offers this specialty service unlike most nursing homes which is a unique benefit.
- Pharmacy consultant will be hired soon to provide a thorough review of the pharmacy operations and revenue cycle.
- A high-level analysis was completed regarding decreasing bed capacity:
    - If beds are decreased by 15 (from 240 to 225) there would be an anticipated savings of $75,000/year.
    - Beds stay with license and cannot be sold; may possibly be leased to another company.
    - Leading Age dues is based on revenues not beds.
    - May need to look at bed variances.
    - Rooms are set up for double occupancy, but currently using rooms as single.
    - Current remodeling plan requires 219 licensed beds. Post-acute will stay the same. If beds are reduced to 215, we are paid 94% occupancy for bed hold rates which is 202. Is reduction to 215 a valid number? Note: reducing beds is permanent.
- High level capital improvement plan is needed next month for the county. It is a placeholder for dollars not details.
- Recommended we rework the renovation plan and may want a supplement meeting before the regular NHOC meeting.
- Would like more information from staff before making recommendation on reducing beds.
- Wipfli is being asked to see if they can offer additional input.
- Also want to look to change next meeting to review the 5 year capital plan prior to next board meeting and a review of the renovation plan. Next meeting will be moved to May 20, 8:00 a.m.

- Informational handouts were reviewed:
    - Doctors question nursing home fines for rehospitalization
    - Hospitals Brace for New Medicare Payment Rules
    - The Skilled Nursing Facility Value-Based Purchasing Program (SNFVBP)
    - State of Wisconsin/DHS/Western Regional Office/Top Ten Federal Health Citations 1Q2016
    - CMS proposes raising payment rates for hospice, skilled nursing and rehab
    - 6 new quality measures coming to Nursing Home Compare, Five-Star rating system
    - What's Happening in County Nursing Homes
- Graph of monthly referrals to admissions was reviewed
    - Seeing a slight uptick in 2016. However referrals to admissions are trending down: some reasons for lower admissions is not having appropriate bed, no payer source, or just not choosing us.
    - Actual rehab referrals are fewer; less 80-90 year olds but more 55-65 population.
- Working on survey prep beginning May 11, implemented care planning in ECS, working on transitioning the financial billing from TIER to ECS by July.
- Largest struggle is with hiring qualified CNA.
    - Looking at orientation changes with approaches and ideas to attract, retain, and recruit.
    - Looking at attendance incentives and sign-on's as well as reviewing occasional staff requirements.
- Program director resigned recently and will look at restructuring nursing department.
- Identified minor overages in supplies. Looking at other purchasing organizations.
- Staffing is a concern – depending how they gather it may change numbers.
- Structure of the committee:
    - Due to vacancy left by John Bandow, committee felt it may be important to have another county board member appointed. Bill Miller offered to talk with Brad Karger regarding another appointment.
    - Margaret Donnelly, VP Post-Acute Care at Aspirus, will begin attending meetings in consideration of being a committee member.
    - Family member of a former resident will be contacted by Bill Metter.

<u>Appoint a Vice-Chair for the Nursing Home Operations Committee</u>
Motion/carried, Burgener/Miller to appoint Bill Metter as vice chair. Motion carried.

<u>Future agenda items</u>
- Capital plan
- Renovation plan review

Motion/second, Metter/Miller, to adjourn the meeting at 8:56 a.m. Motion carried.

dko

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MEMO

DATE: May 11, 2016
TO: Human Services Operations Committee
Nursing Home Operations Committee
FROM: Michael Loy, Interim CEO
RE: Draft Five Year Capital Plan

Purpose

To deliver on the final recommendation to develop a five year capital plan for the NCHC campus as identified in the Final Report of the Oversight Task Force of Marathon County.

Background

As described in the Final Report of the Oversight Task Force:

> ***B. Marathon County Task Force to Oversee the Creation of a Facilities Plan for North Central Health Care Facilities.***
> *The Facilities Task Force* (of Marathon County) *was told by NCHC representatives that a long range facilities plan existed for the entire campus except for the space occupied by ADRC-CW. NCHC did not present a written plan. They did present efforts for the remodeling of Mount View Care Center and the aquatic therapy pool study. ADRC-CW expressed frustration with the lack of movement on a plan to remodel space consistent with their needs. This planning was tabled until a decision is made on the current aquatic therapy pool. Given an inability to secure a plan for NCHC and its assertion that a long range facilities plan does not make sense in the fluid and dynamic health care world, the Facilities Task Force recommended that Health & Human Services develop a plan for ADRC-CW's needs once there was clarity regarding the aquatic therapy pool.*
>
> *No additional action or recommendations were developed by the NCHC Oversight Task Force at that time.*
>
> **Final Recommendation: Develop a five year capital plan for the NCHC campus which should include but not be limited to the nursing home renovation, aquatic therapy pool, psychiatric hospital, behavioral health unit, and other facility needs.**

Recommendation

NCHC Administration has developed a draft Strategic Long-Range Facility and Corresponding Five Capital Year Plan for Service Delivering by North Central Health Care. The narrative plan is accompanied by a summary of 2017 Capital Project Requests and a summary of Forecasted Projects anticipated in 2018-2021. These documents provide a vision but would benefit from further Master Facility Planning in partnership with Marathon County Facilities Management and external resources to determine structurally how we achieve this vision once it is endorsed. We anticipate that work not to be a capital request which could be accomplished in the latter part of 2016 supported by operational funding.

NCHC's Operational Capital funding requests, including small IT projects, replacements furniture and equipment will be further developed through our annual budgeting process and submitted as part of NCHC's 2017 Budget in the fall.

Financial Analysis
Estimated financial impacts are outlined in the adjoining documents.

Timelines
These documents and requests have the following timeline for review, input and approval:

Friday May 13, 2016: NCHC Human Services Operations Committee
Friday May 20, 2016: NCHC Nursing Home Operations Committee
Monday May 23, 2016: Marathon County Health and Human Services Committee
Thursday May 26, 2016: 11:00 a.m. NCHC Finance, Property & Personal Committee
Thursday May 26, 2016: 12:00 p.m. NCCSP Board
Friday June 3, 2016: CIP Requests due to Marathon County

Strategic Long-Range Facility and Corresponding Five Year Capital Plan for Service Delivery by North Central Health Care

North Central Health Care (NCHC) will publish a Strategic Long-Range Facility Plan and corresponding rolling Five Year Capital Plan for North Central Health Care services on an annual basis. These plans describe NCHC's multi-year capital program vision, the potential financing mechanisms and impact on services. NCHC's Capital Plan focuses on the renewal of existing facilities and systems. Capital planning for an operation the size and age of NCHC's facilities carry a large price tag, but are absolutely necessary to keep NCHC at the forefront of providing health care to our communities. We are providing a vision for more than brick and mortar, we are investing in the healing and well-being of those we serve for generations to come. The main campus for NCHC has over 500,000 square feet with the majority of the campus being 50 years or older with the exception of the Mount View Care Center which has operated for slightly over 30 years. We have reached the thresholds of useful life and operate in a shell of inefficient design and operation; future large scale investment is imminent.

Health care is a rapidly evolving industry where capital projects must be measured in two ways – can they increase operational efficiency, and can they produce better health outcomes? In considering the impact of the Affordable Care Act (ACA) and supporting regulatory changes, everything the health care system provides is now an expense and not revenue. An organization operating in the new accountable care environment must learn to operate with the risk of providing all care for a large population for a fixed price per person per year. At NCHC we are part of a much broader healthcare delivery system which is poised to only integrate more in the shared responsibility for the health of our entire population in our communities. With these changing responsibilities and overall increase in patient population is a corresponding decrease in overall reimbursement and need for increased operational efficiency. Healthcare in a reform environment will start much farther upstream (preventive care) and deliver care much more downstream (home and community based). Clearly, not bricks and mortar solutions at the ends of the spectrum; however, despite these broad shifts in the delivery stream, the acuity of care will increase in the middle driving the need for innovative service delivery environments. Given that services can be done only so cheaply and care can be delivered only so efficiently, the following five major capital objectives come into the forefront of our long-range planning:

1. Provide facilities that enable more efficient clinical operations to enhance health outcomes
2. Plan facilities that enable optimum care for a growing population
3. Invest wisely in future flexibility for changes yet to come
4. Clearly balance first cost versus life-cycle costs
5. Operate and maintain facilities more efficiently

Facility Asset Composition and Ownership Portfolio for NCHC

North Central operates out of a number of different locations identified below by facility identifier, address and ownership status for each location.

Facility Identifier	Address	Ownership Status
Mount View Care Center	2400 Marshall Street Wausau, WI 54403	Leased – Marathon County
Health Care Center	1100 Lake View Drive Wausau, WI 54403	Leased – Marathon County
Lake View Center	1000 Lake View Drive Wausau, WI 54403	Leased – Marathon County
Lake View Professional Plaza	1200 Lake View Drive Wausau ,WI 54403	Leased – Marathon County
Lincoln County - Tomahawk Office	213 W. Wisconsin Avenue Tomahawk, WI 54487	Leased – Private Ownership
Langlade County - Antigo Center	1225 Langlade Road Antigo, WI 54409	Leased – Langlade County
Northern Valley – Prevocational Services	5424 Sherman Street Wausau, WI 54401	Leased – Private Ownership
Community Corner Clubhouse	319 N. Third Avenue Wausau, WI 54401	Leased – Private Ownership
Residential – Group Homes		
Bellwood	2211 Bellewood Avenue Schofield, WI 54476	Leased – Marathon County
Bissell	1408 Bissell Street Wausau, WI 54401	Leased – City of Wausau
Chadwick	5006 Chadwick Avenue Schofield, WI 54476	Leased – Marathon County
Heather	5010 Heather Street Schofield, WI 54401	Leased – Marathon County
Hillcrest	1115 Hillcrest Avenue Wausau, WI 54401	Owned – NCHC
Residential – Supported Apartments		
Riverview Towers	550 East Thomas Street Wausau WI, 54403	Leased – City of Wausau
Forest/Jackson	920 Forest Street Wausau, WI 54403	Leased – Private Ownership
Fulton	703 Fulton Street Wausau, WI 54403	Leased – City of Wausau
Jelinek 1	3102 Jelinek Street Schofield, WI 54476	Leased – Private Ownership
Jelinek 2	3104 Jelinek Street Schofield, WI 54476	Leased – Private Ownership

Five-Year Capital Plan for North Central Health Care Programs

Over the course of the next five years we anticipate most, if not all capital projects to be focused on our main campus location in Wausau. However, as with any facility, unanticipated capital funding eligible projects are likely to occur but none are contemplated in our current plan. Almost all NCHC facilities are leased and not owned by NCHC; therefore, any future capital projects would need to be supported by our landlords in form and likely with financial substance. Debt service and capital funding support is available through enhanced reimbursement mechanism through government payers (Medicare and Medicaid) to support projects such as the nursing home; the extent of available reimbursement will be dependent on the scope of each project and the program.

Within the next five years, programming in Langlade and Lincoln Counties is anticipated to grow sustainably to fit within the footprint of current leased space. Small aesthetic improvements in these facilities reaching the capital funding threshold of greater than $30,000 have the potential to occur in the next five years on an as needed basis. At this time, NCHC has not developed any anticipated major capital improvements in these locations. The same can be said for our Prevocational Services located at North Valley and at the Community Corner Clubhouse. Community Corner Clubhouse recently moved their location and continues on their journey to be non-levy supported. Any future capital projects would likely be handled through community supported capital campaigns and are not anticipated at this time.

The Adult Day Services program located on our main campus has the potential to be relocated. Two options exist: 1) relocation to the vacated space of the ADRC in the Lake View Center as the ADRC transitions off campus or 2) off campus, potentially to the Northern Valley location, which could serve to strengthen the developmental disability continuum and state initiated movement to community based services. The movement of the Adult Day Services program from the Health Care Center will be critical to providing for main campus expansion for Behavioral Health Services. At this time, we are not making a capital request for this move because it is predicated on a number of prior projects, most specifically the Nursing Home and regulatory approval.

Our Community Living “Residential” program provides residential services to the developmentally disabled in one of 10 residential facilities (5 supported apartments and 5 Community Based Rehabilitation Facilities (CBRF)). These facilities are scattered throughout the Marathon County community and vary by the scope of care needs of the consumer. The CBRF facilities are largely home-like environments with 6-8 higher acuity consumers in each location. Our supported apartment facilities typically provide apartment style living for a larger number of more independent consumers in each location. Almost all of these facilities are leased and NCHC is more likely to find alternative locations before making major capital investments in current facilities. Capital funding in our Residential services will likely result from unanticipated failures or an unwillingness of the landlord to provide the requisite updates. In the next five years we will address these capital needs for these facilities in shorter 1-2 planning cycles are not making long-range capital plans for any of these facilities at this time.

Main Wausau Campus

Our main Wausau campus can be divided into a number of workable parts in the scope of this five year capital plan. The main campus has four divisions all connected through interior walkways:

1. Health Care Center (Administration, Community Treatment, Outpatient, Behavioral Health Services and Legacies Dementia units)
2. Mount View Care Center (Post-Acute Care, Long-term Care)
3. Lake View Center (Pool, Health Department, ADRC)
4. Lake View Professional Plaza (CCCW, Special Education)

The first consideration in the long-range plan is how we can improve the experience of the community we serve in interacting and navigating our services through the eyes of those receiving care at NCHC. With this first priority, the primary issue is one of limiting access and providing better navigational structure. There are too many access points in our main campus where our constituents can lose their way. The long-range vision for our main campus facility is to constrict access points to three. This would include access to:

- Nursing Home and Aquatic Therapy services on the Northeast side
- Behavior Health and Crisis services on the West side
- Outpatient and Administrative services on the Southeast side

Separate entrances directly into the Marathon County Health Department and ADRC space in the Lake View Center would remain in addition to the three central access points identified above. Two other significant features of NCHC's main campus long-term capital planning would be to centralize administrative support (enrollment, registration etc.,) in each of these three access point areas. Centralizing functions would support reducing long-term indirect costs as a percentage of NCHC's annual operating budgets. Centralization would also increase coordination between similar programs. The last cornerstone of the long-term design is a single contiguous navigational hallway system from one end of the building to the other. Currently there are too many hallways which create a maze to navigate for the community we serve. Changes to the navigational system lessen the institutional feel and heighten patient experience.

Nursing Home

A major project in the five-year capital plan is the Nursing Home remodel. The Nursing Home project will be a 2017 Capital request but the project will span around two years. Decisions related to the Nursing Home project are significant as they impact long-term planning for Behavioral Health Services. The Nursing Home project rationale remains the same and the financial projections provided by WIPFLI in 2013 as predicted in the "status quo" approach have been playing themselves out on in terms of financial instability if we don't remodel. The project plans have been developed and NCHC awaits the bonding support from Marathon County to move forward.

The final plans for the Nursing Home remodel will be need to be adjusted to provide some minor adjustments to accommodate long-term planning for expanded Behavioral Health Services. This would include adjustment to the Mount View Care Center design to reduce the number of long-term beds in the 2nd floor to accommodate the transfer of the Evergreen dementia program from the Health Care Center. The Evergreen program transfer to long-term care program will reduce the conversion of one of the long-term care wings from double occupancy to private rooms which would reduce the project scope. However, there will be some new modifications to the floor plan to secure the unit. The Dementia wing in the long-term care program would accommodate the 22 beds the Evergreen program currently supports. The long-term care bed availability would be reduced by 12-14 beds from the 59 beds in the initial plan to 45-47 beds. We believe this is a prudent long-term strategy in the current local skilled nursing market.

Once the relocation of the Evergreen and Adult Day Services programs from the Health Care Center has occurred, it will allow the remodel of their current adjoining space to relocate the Lake View Heights Dementia program of approximately 44 beds. The Lakeview Heights space is currently located in the second floor space above Emergency Services and Inpatient hospital. Moving this program will allow for future remodel and expansion of the Inpatient hospital, CBRF and Medically Monitored Treatment program into this vacated space. Those projects are outlined below and would likely be 2018 and 2019 requests. Further, these adjustments to the nursing home project shuffle disparate program locations into more central service areas making our continuum and operational needs more synergistic for the people we serve.

Lake View Center

The Aquatic Therapy pool, Adult Protective Services, Community Treatment Youth team, Marathon County Health Department and the Aging & Disability Resources Center (ADRC) are located in the Lake View Center. Long-term, NCHC would be interested in centralizing Adult Protective Services and Community Treatment by moving these areas out of the Lake View Center to the Health Care Center. The Aquatic Therapy pool project will be submitted as a capital project request for 2017. The pool facility is in a critical status. Failure to commit to the project in the next year would likely result in significant new maintenance costs or complete facility failure. The relocation of the pool near the Nursing Home in a rectangular design makes sense and has strong potential to be operationally self-sufficient. Once the pool is relocated and operational, the current pool envelope and facility should be demolished to provide a new face for the Lake View Center.

Marathon County Health Department's facilities are new and likely will support their anticipated growth. The ADRC has expressed significant interest in relocating off campus in the near future which will free their space. A potential tenant is the relocation of our Adult Day Services program. Regardless, it is anticipated that whoever occupies this space, there will be likely renovations, the scope of which is unknown at this time.

Lake View Professional Plaza

The Lake View Professional Plaza is a separate building on the Southwest corner of our main campus but is connected through an underground walk-way. Currently, the first, second and part of the third floors of the Lake View Professional Plaza is occupied by Community Cares of Central Wisconsin (CCCW). The remainder of the third flood is occupied by Special Education who is interested in expanded space and will likely become the main tenant on the third floor over time. There is a risk that CCCW will continue to downsize or potentially move from this location as their lease expires at the end of 2016 and the Family Care program adapts through Family Care 2.0 recommendations. NCHC does not currently foresee major uses for this space if it becomes available at this time. Therefore, major long-term capital planning for this space is not anticipated at this time.

Health Care Center

The Health Care Center is the space between the Lake View Center and Mount View Care Center. There are two main sections for the Health Care Center that can be generally described as south and north of the cafeteria. The Health Care Center southern facility includes Administration and support services, Community Treatment, Outpatient and Birth to Three programs. The northern portion of the Health Care Center includes the Legacies Dementia programs (currently Evergreen, Gardenside Crossing and Lakeview Heights). The Adult Day Services program is part of this area but is anticipated to be relocated in our long-term planning. Behavioral Health and Emergency services programs are also located in the northern most portion of the Health Care Center and includes Crisis, Inpatient, Ambulatory Detox, Medically Monitored Treatment (MMT), CBRF, and youth stabilization programs.

Long-term, as the Evergreen program moves into the Mount View Care Center and the movement of ADS from this area occurs, there is significant opportunity to expand our Behavioral Health Services to better meet the community needs. The Gardenside Crossing and relocated Lakeview Heights programs would remain as part of the Health Care Center on the western and eastern ends of the northern portion of the Health Care Center.

There will be a major capital improvement request in 2018 for the Inpatient hospital to address the constraint the current unit provides with multiple bed rooms. The unit's design is not a contemporary care environment and has safety concerns. Additionally, the movement of the unit to single occupancy rooms would reduce the need for expensive diversions as a result of capacity issues related to single room assignments in a multi-bed environment. We are currently licensed for 16 beds with an emergency waiver to increase to 20 beds but are often faced with an artificial bed constrain when a patient needs a private accommodation. Along with the Inpatient remodel there will be a need to upgrade the Emergency and Crisis services intake area to support the expanded Emergency services model and improve patient experience in emergency assessment and treatment.

As the Lakeview Heights program is moved out of its current space above the inpatient unit it will provide the long-term opportunity to expand both the MMT and CBRF programs from 6 beds up to 20-24 beds each. The MMT program would provide an opportunity to be relocated onto one side of the current Lakeview Heights program to expand capacity to address the wait list for services of

approximately 150 people and counting. This move would increase the available beds up to 24 beds for MMT and CBRF would be able to expand from 6 beds to 12 beds within the current Lakeside Recovery footprint. During the remodel of the inpatient unit, the other side of the current Lakeview Heights program would be available for a temporary home for the inpatient unit during construction. When construction on the inpatient unit is complete, the CBRF could be moved upstairs and expanded to 20 beds adjoining the MMT program of 24 beds. Lastly, all these improvements and relocations are made; the current Lakeside Recovery space of 12 beds could be developed into an adolescent or geriatric psychiatric unit to further address community need. This final program expansion would be dependent on finding a physician and would be a request in 2019 or 2020.

As we consider long-term planning for the southern portion of the Health Care Center we are thinking out 5-10 years. This portion of our building contains a number of isolated outpatient programs and a maze of separate offices and hallways. Long-term this area would benefit from having one central outpatient and administrative services entrances where program coordination and support can be centralized for better patient experience and outcomes. Offices would be consolidated into two main areas, administration and outpatient services to include Community Treatment, Outpatient, Birth to Three and Adult Protective Services. There are operational efficiencies to be gained and an environment would be designed to support better outcomes.

Master Facility Plan

This document serves as the long-term facility vision. To materialize this vision, we need to engage in a long-term facility master planning initiative with Marathon County Facilities Management staff in addition to external resources to determine structurally how we achieve this vision and what are the potential costs. From there we can start to piece together the pro-forma projections on these projects. A detailed long-range facility plan would more adequately provide a visual for these moves and the major facility implications outside of making the spaces work for the capital planning objectives we laid out at the beginning of this plan, most importantly of which is the outcomes for those we serve.

Short-term projects, such as the Nursing Home and the Pool have more detail and are ready to move. However, in the absence of commitment to the Nursing Home project, there are a number of physical plant projects which must be addressed and will be requested in 2017 and 2018. If the Nursing Home project is initiated, these largely go away as part of the broader project.

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SUMMARY OF CURRENT (2017)
MARATHON COUNTY CAPITAL PROJECT REQUESTS

PROJECT	DESCRIPTION OF PROJECT	ESTIMATED COSTS
Air Handler 1 & 2	Rebuild HVAC 1 & 2 – New coils, dampers, drive and fan unit	$510,000
Asphalt Repair and Replacement	Replace the main road and small parking lot, crack fill all other parking lots	$130,000
HCC Roofing	Replace roofing on MVCC, HCC link and Doctor's Suite	$93,000
Legacies Flooring	Replace flooring on Evergreen	$48,000
Mt. View Nursing Home Remodel	Remodel the 240 bed nursing home	$15,000,000
MVCC Domestic Hot Water and Boiler Replacement*	New boilers and water tanks	$425,000
MVCC Window Replacement*	Window replacement in the MVCC Building	$437,750
New Aquatic Building	Build a new building for warm water therapy pool	$7,400,000
Special Education Upgrades	Replace flooring, paint, and wallpaper in the entire Special Education space in LVPP	$74,000
Purchasing Cooler/Freezer Replacement	Replace 44 year old walk-in cooler and freezer units	$68,000
Rolling Stock	Replace Rolling Stock	$222,000

*Projects included in the Nursing Home remodel project scope that will need to be addressed if further delay in the Remodel project occurs. If remodel project proceeds, these projects will not be additional separate requests.

Capital Improvement Project Forecast for Future Program Years

General Instructions for completing this form:

- *Enter requested information after placing the cursor (point and click) in the corresponding gray-shaded blank.*
- *For all but the most obvious items, more detailed instructions are available by typing the F1 key while the cursor is placed on the corresponding blank.*
- *Each box will expand as necessary to include your text. Limits on text length are noted in the F1 instructions.*
- *Use the tab key to advance the cursor to the next blank; use shift/tab to move the cursor to the previous blank.*

1. DEPARTMENT AND CONTACT INFORMATION			
Department	North Central Health Care		
Submitted By	Michael Loy	**Phone**	715-848-4402
Date	*May 10, 2016*	**Email**	mloy@norcen.org

2. FORECASTED PROJECTS *(1-5 years beyond next fiscal year)*

Program Year	Project	Description of Project	Estimated Cost
2018	NCHC Boiler Replacement	Replace 45 year old steam boilers	$2,000,000.00
2018	Replace Sloped Glazing	Replace leaking sloped window framing in LVC and HCC buildings	$720,000.00
2018	HCC Phase 1	Inpatient /CBRF/MMT/Behavior Health and Crisis renovation	$1,900,000.00
2018	HVAC Replacement in Pyramids	Replace the air handlers in the HCC units and related roof work	$850,000.00
2018	LVPP 3rd Floor Upgrade	Install new flooring, paint walls and new window treatments	$66,000.00
2018	Rolling Stock	2 small bus/ 1 small dump truck /1 Van	$190,000.00
2019	Brick Sealing	Seal the brick exterior on HCC,LVC,LVPP	$172,000.00
2019	LVPP 2nd Floor Upgrade	Paint and recarpet 2nd floor of LVPP	$155,000.00
2019	Laundry Windows	Replace laundry windows in plant	$120,000.00
2019	HCC Phase 2	Inpatient /CBRF/MMT/Behavior Health and Crisis renovation	$1,900,000.00
2019	Rolling Stock	2 Vans, 2 small cars	$120,000.00
2019	Nurse Call Replacement	Replace nurse call in MVCC & HCC	$245,000.00
2020	LVPP 1st floor Upgrade	New flooring and paint on the 1st floor of LVPP	$130,000.00
2020	LED parking lot lighting	Replace the lighting on the road and HCC parking lots to LED	$62,000.00
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Outline of Collaborative Care System

Establishment of Accountable System of Quality Delegated Services

1. Proposal for Collaborative Care System. This outline describes a new Collaborative Care System operated under the auspices of North Central Health Care. The Collaborative Care System would create a Collaborative Care Quality Committee that will operate as a subcommittee of the NCHC Quality Committee. The Collaborative Care Quality Committee would serve as a mechanism to address issues that are within the scope of NCHC's delegated functions that can be impacted by collaboration and coordination between various county and community stakeholders.

2. High Level Description of Concept. This outline contains a high level description of the general concepts behind the Collaborative Care System. Details would be created moving forward and details would be provided to the Board for further action and approval before implementation.

3. Requested Board Action. NCHC Administration is asking the NCHC Board to:

    - Give approval to move forward with creating the details of the Collaborative Care System, including the proposed committee structure, operation requirements, and other elements that are necessary to commence initial operation of the Collaborative Care System. This is not a final approval that would permit implementation. Rather, it is only an approval of the basic concept and assent to move forward with establishing the details of the System for further consideration by the Board.

    - Identify a work group that will be tasked with working with administration and legal counsel to create additional details for further consideration by the Board. This work group could be the current Executive Committee or a separate advisory committee.

4. Scope of NCHC Responsibilities. NCHC has been delegated various responsibilities from Marathon, Lincoln and Langlade Counties (the "Constituent Counties") under Wisconsin Statutes 51.42 including, skilled nursing and long term care (in the case of Marathon County), mental health, developmental disability, and alcohol and drug abuse responsibilities (the "Delegated Responsibilities"). The scope of NCHC's responsibilities include the obligation to coordinate with various community resources in furtherance of its Delegated Responsibilities.

5. Formal Mechanism to Facilitate Stakeholder Participation. The Collaborative Care System would create a formal mechanism for participation by county and other community stakeholders in the quality assessment process of NCHC. This will facilitate participation of various community resources through a process that protects sensitive health information and enhances immunities that are applicable to health care quality review.

6. Creation of Quality and Outcomes Committee. Central to the Collaborative Care System would be the Collaborative Care Quality and Outcomes Committee ("QOC").

    a. The QOC would consist of representatives from various County Stakeholders and NCHC representatives.

    b. The QOC would be comprised of representatives from the Health and Human Services Committee (or other similar Committee or representative from the Constituent County), members of NCHC administrative team (CEO, Quality and Compliance Officer, human service and nursing home operations), and representatives from key County stakeholders such as law enforcement, corrections, social services and other key stakeholders. The precise composition of the QOC would need to be determined with the objective of expanding involvement in quality issues that benefit the Managed Population.

    c. The QOC would be responsible for identifying areas of emphasis where cross Stakeholder solutions are expected to positively impact health and welfare of the Managed Population.

    d. The QOC would monitor and measure performance, establish expectations, develop cross-Stakeholder solutions, set baseline quality and performance metrics, develop reliable measurement systems, and continually review and modify to enhance achievement of defined goals.

7. Stakeholder Participation. County Stakeholders include various components of the Constituent County social system that impact the Collaborative System Responsibilities and welfare of the Managed Population. Stakeholders may include County courts, law enforcement, corrections, probation and parole, social services, welfare, and various other components of the County governmental structure that have an impact on Collaborative System Responsibilities and social welfare of the Managed Population.

8. Population Management Approach. NCHC has the primary responsibility to administer programs and services necessary to meet the social needs of the citizens of the Constituent Counties (the "Managed Population") subject to available resources. The Collaborative Care System applies a population management approach which assumes that the overall health and safety of the population requires the coordination and cooperation of a broad range of County resources, programs, departments and various other community resources. Although the Collaborative Care System is built around the responsibilities that are delegated from the Constituent Counties to NCHC under Wis. Stats. 51.42, it recognizes that the activities and responsibilities of a broad range of

Stakeholders have an opportunity to have a positive impact on the Collaborative System Responsibilities.

9. Shared Vision/Population Health Management Approach. NCHC and the Constituent Counties share the central goal of making the counties covered by NCHC the safest and healthiest in the state of Wisconsin ("Shared Vision"). In order to best fulfill this Shared Vision, the parties recognize the need to create an integrated and innovative system to coordinate all resources that are available by or through the Constituent Counties and in the various communities within Constituent Counties. The overall goal of the Collaborative Care System will be to apply a population health management approach and to identify other cutting edge health management concepts to maximize realization of the Shared Vision.

10. Formalizing Current Concepts. NCHC has been successful in this general approach in the area of crisis management which provides indication that this approach will be very successful. The proposed System expands on and formalizes the existing crisis System. Formalizing the process as a quality assessment function of NCHC will enhance the ability to share information among the participants, will permit more open discussion of quality issues while maintaining the highest level of immunity related to quality of care issues. This will enable the Collaborative Care Quality Committee to address quality issues in a more meaningful and productive manner without risk of violating patient confidentiality or creating potential liability.

11. Sustaining System of Collaboration. The Collaborative Care System would address the needs of the Constituent Counties for oversight of NCHC's activities and would create a sustaining system of continual quality improvement across a variety of stakeholders who are involved in or have an influence on meeting the Collaborative System Responsibilities. Issues are currently being addressed by contract which does not permit the flexibility to address changing community need and does not establish a process for continued quality improvement through a "living and breathing" process.

12. Integration of Innovative Collaborative Solutions. The Collaborative Care System would include elements taken from some of the most innovative social programs from around the country for addressing societal behavioral health issues. The Collaborative Care System would leverage innovations that have proven to demonstrate success in other areas and would build upon them to create a System that will be looked to as a System by others across the country.

13. Accountable Care Process. The Collaborative Care System would create an innovative system of addressing community issues involving Collaborative System Responsibilities that leverages the resources, knowledge and efforts of the various stakeholders to the creation of the system of collaborative, proactively cooperative, transparent, and

accountable processes for providing Collaborative System Responsibilities and social services.

14. Committee Charter. The QOC would establish a Committee Charter that sets forth the general scope and operation of the Collaborative Care System, qualifications of members, committee composition, terms of committee membership, and other organizational matters.

15. Evidence Based Standards, Protocols, Policies and Procedures. The structure would also include a set of policies and procedures that further define the Collaborative process. Some of the issues to be covered in policies and procedures will include:

    a. Definition of evidence-based standards and processes.
    b. Process for establishment of areas of emphasis.
    c. Standards for establishing baseline data that can be used to assess achievement of goals.
    d. Standards for establishing evidence based quality metrics to focus efforts and measure outcomes.
    e. Standards and process for defining goals and measuring results.
    f. Compilation and use of quality data.
    g. Parameters regarding use and disclosure of patient protected health information.

Assumptions of the Collaborative Care System

The Collaborative Care System is based upon the following assumptions:

1. NCHC Accountability. NCHC is accountable to the Constituent Counties for the quality and efficiency of the services that it administers under Wisconsin statute 51.42. NCHC is required to provide services in an open and transparent manner that permits County oversight of its responsibilities in compliance with applicable laws, rules, and regulations.

2. Coordination of Stakeholder Resources. NCHC's duties and authority include the obligation to cooperate and coordinate with other resources within the community, including various County and private stakeholders and providers to meet its responsibility to administer the Collaborative System Responsibilities programs.

3. Changing Needs of the Managed Population. The specific needs of the Managed Population are not static over time and require a process that continually operates to identify the areas of priority in order to effectively allocate limited resources in areas that are calculated, using evidence-based standards and processes, to result in the greatest positive impact on the community.

4. Limitations of Current and Contemplated System. It is currently difficult for quality to be monitored in an accountable way due to health care privacy laws and risks associated with open and public discussions relating to quality. Specific situations cannot currently be addressed by the County in an accountable manner without violating state and Federal laws that guarantee privacy of health care information. This problem exists in the current 51.42 structure and would be equally present within a human services System. There would likely be additional risks in the human services System because there would be no natural "wall" between health care and other social functions. The Collaborative Care System mitigates these limitations by creating a formal quality review organization under the auspices of NCHC. This structure permits much more open consideration of information within the confines of the designated quality review function related to NCHC, which is a "health care provider" and may use information if it is necessary to conduct quality review functions.

Primary Objectives of the Collaborative Care System

The goals and objectives of the Collaborative Care System are as follows:

1. Establish Lines of Communication and Reporting. To establish designated lines of communication, accountability, quality and information reporting between NCHC and County to permit the County to assess the quality, effectiveness, and efficiency of the services and programs of NCHC in the coordinated effort between the stakeholders through the operation of the Collaborative Care System.

2. Increased Involvement. To increase involvement of County and various component stakeholders in identifying goals, assisting system wide resources, establishing and measuring quality and service standards and creating innovative solutions to issues that have an impact on community health and welfare.

3. Population Management Focus. To apply population health management processes and systems to achieve the overall health and safety of the Managed Population.

4. Preservation of Quality Immunities and Confidentiality. To establish a process to assess and further the provision of quality of healthcare services provided or coordinated by and through NCHC in a manner that protects patient privacy and furthers the assessment of quality, taking advantage of state and federal laws that are designed to promote the quality of healthcare and the safety of individual members of the Managed Population.

5. Prioritize Expectation. To prioritize expectations, objectives, quality metrics, service standards, processes, protocols and innovative systematic approaches of addressing community health and social needs.

6. Monitor Results. To monitor results of collaborative and innovative solutions to the establishment of baselines, benchmarks, metrics and measurement processes and tools needed to assess outcomes in a uniform and meaningful way.

7. Measureable Performance Goals. To create clear and measurable goals to provide our central healthcare and other stakeholders with clear guidelines and focus for achievement of prioritize goals.

8. Stakeholder Collaboration. To identify and implement areas for collaboration and cooperation between stakeholders with common interests and shared responsibility for overall welfare of the Manage Population in their respective areas of responsibility, authority and expertise.

9. Evidence-Based Standards. To establish and continually apply evidence-based standards, processes, mechanisms and systems to establish and measure outcomes and make appropriate adjustments to enhance quality infected and effectiveness based upon results and to address changes in societal needs.

10. Centralized Problem Solving. The Collaborative Care System would create a defined system for handling grievances and identified problems in which the County and Stakeholders can have confidence. These systems would be accountable and highly responsive to identified issues. The objective is to minimize the need for other areas of County government to expend resources by assuring defined NCHC processes and accountability which are recognized and supported throughout the system. These mechanisms would also assure that issues are addressed in a manner that maintains patient confidentiality and encourages open exchange of information to improve quality of care.

Primary Elements of the Collaborative Care System

1. Preservation of Healthcare Privileges and Immunities. The Collaborative Care System would be operated under the auspices of NCHC in order to take advantage of various laws that are designed to enhance the quality of healthcare services and to permit open review of quality issues. (Health Care Quality Improvement Act and Equivalent State Laws). This assures a forum in which quality issues can be discussed with reduced risk of liability and in a manner that protects participants from liability for their involvement in the process.

2. Permits Consideration of Patient Information as Part of Review Function. The QOC establishes a forum where specific cases can be discussed in furtherance of review without creating risks of unauthorized release of confidential patient information. There is currently no forum outside of NCHC where patient information or description of specific cases and incidents may be discussed without risking legal violations. It is critical that appropriate channels be created to facilitate appropriate consideration of information for review and oversight purposes. The QOC would create policies and procedures governing consideration and confidentiality of patient information. These policies and procedures will establish the scope of appropriate use, the restriction on disclosure of information considered by the QOC, and other protections.

The HIPAA Reconciliation Act applies to Covered Entities such as NCHC and provides some relief from the stringent requirements of Wis. Stats. 51.30. The Reconciliation Act does not apply to the County Board of Supervisors, law enforcement, and other Stakeholders. The more restrictive standards apply to these Stakeholders under Wis. Stats. 51.30. The QOC would be an organization formed by NCHC as a Covered Entity. As a result, the less stringent requirements of HIPAA would apply to permit "minimum necessary" information to be made available to the QOC for purposes of its review of NCHC. Re-release by participants to their constituent organizations would be prohibited under HIPAA and the state law.

3. Identification of Information to be Reported from the QOC. The QOC would provide a facility through which the Constituent Counties, through the Health and Human Services Committee or other designated committee can receive data in scope and format that permits it to review the services of NCHC and of the Collaborative Care System without risking unauthorized disclosure of confidential patient information. Information policies would be created that clearly defines the information that can be provided legally and that establishes a process for the County to request data in support of its oversight function.

4. Collaborative Care Quality and Outcomes Committee. The Collaborative Care System would be operated through Collaborative Care Quality and Outcomes Committee (QOC).

6. Initial Performance and Quality Priorities. The Agreement would identify the scope of initial area of emphasis that will be subject to initial performance standards. For example, initial areas would likely follow along the lines of the "Offender Program" proposed by the County. Crisis Services could be another area of initial focus.

7. Systematic Approach to Defined Areas of Emphasis. The QOC will use a systematic and Evidence-Based approach to define problem areas in the community that may be impacted by application of the Coordinated Care System and to set priorities regarding areas of emphasis in which positive outcomes may be expected from the creation of cross Stakeholder solutions with Available Resources. These areas would be identified based on available evidence which will assist the QOC in identifying appropriate areas and prioritizing goals for optimal overall results based on available resources.

8. Development of Cross Stakeholder Solutions. Although NCHC will have primary responsibility for administration of Delegated Health Services, the Collaborative Care System recognizes that the resources available through other Stakeholders will be necessary to create multi-disciplinary solutions to identified areas of emphasis. Coordination of these resources is part of NCHC's duties to administer the Delegated Health services. The QOC will work to develop systematic processes, protocols and standards aimed at achieving positive outcomes in defined areas of emphasis. Solutions will be evidence-based and will integrate the entire array of health care, social and human services that are available and which are calculated to have a positive impact on the needs to the Managed Population.

9. Centralized Reporting to Constituent County Board of Supervisors. The QOC would be responsible for reporting progress, outcomes, policies, processes, benchmarks, goals and other information to defined individuals or committees of the Constituent County Board of Supervisors. Reported information will be subject to requirements and standards of applicable laws. Standards and policies would be developed by the QOC to assure reporting of outcomes

within applicable legal parameters. The objectives are to assure transparent reporting within the confines of law and to establish distinct lines of reporting from the QOC and NCHC to the Marathon County Board of Supervisors. The details of the reporting requirements and the nature of the reports will be detailed in the Operative Agreement.

10. Coordination of Program Changes With County and Other Stakeholders. The Collaborative Care System would create ongoing mechanisms to assure that regulatory, administrative, or other changes to the programs or services of Stakeholders are openly communicated to other Stakeholders. This will assure that other Stakeholders have the opportunity to adjust their programs and services as required to react to these changes. For example, changes to NCHC regulatory requirements may have an impact on how law enforcement provide access to the affected program. The Collaborative Care System will enhance earlier communication between the various Stakeholders which will result in coordination when program changes are required.

11. Application of Quality Standards. The QOC will establish systematic and evidence based programs to identify appropriate measurement of quality and other indications of success.

(a) Establishment of Quality Metrics. The QOC will establish reasonable quality metrics based on the scope of areas of emphasis. Quality Metrics are evidence-based and create reliable systems to measure results over reasonable improvement horizons. Each Quality Metric will be based on baseline data that establishes the current status of the area being measured. Quality Metrics will establish achievable goals for improvement of quality over time. The QOC will determine the methodology to be used to measure outcomes as indications of success. Quality Metrics will be defined to permit NCHC and other Stakeholders to focus appropriate processes and resources on achievement of quality goals. Only clearly stated goals and expectations can be used as a tool to achieve positive outcomes by all involved parties.

(b) Evidence-Based Quality Standards and Measurement. The Collaborative Care System will be based on evidence-based standards and measurement. Evidence-Based means that a criteria, area of emphasis, standard, protocol, process, program or practice is supported by evidence that is relevant and meaningful to support basic assumptions. Evidence Based Standards means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population. A Quality Standard is Evidence-Based if it creates a definable and reasonably attainable set of goals that can be used to create systems and processes to increase performance and quality. A Quality Measure is Evidence-Based if it reliably measures the degree of impact that a program or practice has on a defined Quality Standard.

12. Corrective Action Process. The QOC would establish a process for corrective action that could be created if identified metrics are not achieved as those metrics are defined and measured under the auspices of the QOC. This permits County to have significant and meaningful participation in the establishment of measurable goals and the process through which those goals are measured.

14. Grievance and Complaint Process. The QOC would establish, with consideration for NCHC's current processes, a Grievance System that centralizes all issues and assures that other County officials do not find it necessary to devote time and resources in this area. The Grievance System will create a processes through the QOC in which an individual receiving Delegated Services and other Stakeholders may express dissatisfaction about services provided by NCHC or through the Collaborative Care System. A Grievance is an expression of dissatisfaction about any matter. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the individual's rights. The Grievance System will include a process to triage grievance claims between the patient grievance process, a Stakeholder grievance process, external healthcare provider grievances, and NCHC compliance complaints.

13. Budget Integration. The goals and standards that are set by the QOC would be coordinated with NCHC budgeting process and any changes in program funding would need to be reflected through County funding allocations or alternate revenue sources.

Advantages of Collaborative Care System

This Collaborative Care System has many advantages.

1. The Collaborative Care System can be implemented without significant delays that are inherent in complete realignment of the system. NCHC believes that enhanced cooperation between various Stakeholders must be achieved very quickly to preserve the best chance for success in meeting the Shared Vision.

2. If a human services System is the eventual goal, the Collaborative Care System would enable a smoother transition and enables longer period of assessment, planning and implementation to the human services System.

3. The Collaborative Care System uses existing systems rather than creating an entirely new structure, transferring programs and responsibilities, and working out the various other details that would be required to transition to a human service System.

4. The Collaborative Care System permits participation by all Stakeholders in the quality process without violating laws protecting patient confidentiality under HIPAA and Wisconsin law. Currently, legal "walls," such as privacy restrictions, exist between the various Stakeholders that impede the ability to openly address system-wide issues. The same walls would need to be established in a human services System to protect inappropriate use and disclosure of protected health information.

5. The Collaborative Care System structure permits alignment of the interests of the various Stakeholders for the common goal of achieving the Shared Vision.

6. Health care operations are confined within a separate legal organization (NCHC) which permit specialized knowledge and management that is required in the highly regulated health care area. Maintaining clear boundaries for health care operation decreases potential compliance

and regulatory risk that would be inherent if health care operations were operationally merged within County Government.

7. The Collaborative Care System takes advantage of quality review procedures available to health care providers. The QOC would create a quality review body in which quality issues can be discussed under the immunities, confidentiality and legal protections that are created under Wisconsin and Federal Law. These laws are intended to encourage activities that are in furtherance of quality care.

8. Systemizes quality and coordination of stakeholders while maintaining advantages of a centralized healthcare provider.

9. There would be minimal conversion cost, no transfer of facilities, programs, licenses, agreements, and other expenses that would be necessary to continue to fulfill the statutory duty of the County.

10. The Collaborative Care System creates an appropriate forum for discussion of quality between representatives of various Stakeholders without jeopardizing patient confidentiality or otherwise creating potential unauthorized disclosure of protected information, or creating increased risk of liability.

North Central Health Care
Person centered. Outcome focused.

MEMO

DATE: May 20, 2016
TO: North Central Community Services Program Board
FROM: Michael Loy, Interim CEO
RE: Leading Choice Network

Purpose
Should North Central Health Care join the Leading Choice Network?

Background
North Central Health Care is a member of Leading Age Wisconsin. This organization provides education, political advocacy and a number of other services. Leading Age Wisconsin is launching the Leading Choice Network which is intended to assist its member Providers like NCHC with group contracting; clinical care coordination; and billing/claims processing with entities within the managed care environment. The feasibility study and ongoing consulting for the project is being done by Clifton Larson Allen. The benefit to NCHC is to increase daily census through an increase in monthly admissions, potential enhanced or maintenance of reimbursement and reduction in denial of claims. Through this Network, it may be possible that the negotiated rates with each insurance company and other payer contracts will be higher than what we are currently receiving. We anticipate a strong negotiation position with managed care organizations as well. The Leading Choice Network would only be for our Nursing Home Operations at this time.

Legal analysis of the network agreement is ongoing and further information will be reported to the NCCSP Board at our next meeting.

Recommendation
The recommendation is that North Central Health Care should join the Leading Choice Network.

Financial Analysis
The financial analysis of joining the Leading Choice Network is undetermined at this time; the number of members who join the network will determine the final fee. It is estimated that the initial fee would cost approximately $17,700 based on the 240 licensed skilled nursing beds in Mount View Care Center and 25% of the Leading Age members participating. The more members who participate will reduce the initial fees.