OFFICIAL NOTICE AND AGENDA MEETING of the North Central Community Services Program Board to be held at North Central Health Care, 1100 Lake View Drive, Wausau, WI 54403, Wausau Board Room, at 3:00 pm on Thursday, January 30, 2020

In addition to attendance in person at the location described above, Board 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. 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.

A QUORUM OF THE RETAINED COUNTY AUTHORITY COMMITTEE, COMPRISED OF APPOINTEES FROM LANGLEDE, LINCOLN, AND MARATHON COUNTIES, MAY BE PRESENT AT THE NORTH CENTRAL COMMUNITY SERVICES PROGRAM BOARD MEETING; HOWEVER, NO VOTE OR ACTION WILL BE TAKEN BY THE RETAINED COUNTY AUTHORITY COMMITTEE.

1. Call to Order
2. Public Comment for Matters Appearing on the Agenda – Limited to 15 Minutes
3. Chairman’s Report and Announcements – J. Zriny
4. Consent Agenda
   A. FOR ACTION: Approval of 12/12/2019 NCCSP Board Meeting Minutes
   B. Board Committee Minutes and Reports
      i. Draft Minutes of the January 16, 2020 Executive Committee Meeting
      ii. Draft Minutes of the January 16, 2020 Nursing Home Operations Committee Meeting
   C. Monitoring Reports
      i. CEO Work Plan Review and Report – M. Loy
      ii. Executive Updates - Executive Team
      iii. FOR ACTION: Review and Accept the December Quality Dashboard and Executive Summary – M. Loy
   D. FOR ACTION: Annual Review of Board Policy
      i. Medical Staff Bylaws – M. Loy
   E. FOR ACTION: Approve Medical Staff Privileges for Laurence Gordon, DO; Gabriella Hangiandreou, M.D.; Patrick Helfenbein, M.D.; William Nietert, M.D.; Sencan Unal, M.D.

5. Board Discussion and Possible Action
   A. FOR EDUCATION: Overview of the Political Landscape in 2020 – Eric Borgerding, CEO, Wisconsin Hospitals Association
   B. ACTION: Review and Accept December Preliminary Financial Statements – B. Glodowski
   C. Overview of Proposed Revisions to the Agreement for Joint Sponsorship of Community Programs – L. Leonard
   D. Memorandum on Provision of Legal Services to North Central Health Care – L. Leonard
   E. FOR ACTION: To Recommend the Divestiture and Transfer of Adult Protective Services from North Central Health Care to the Aging & Disability Resource Center of Central Wisconsin – M. Loy
   F. FOR EDUCATION: Status and Future Direction for Psychiatry Recruitment – M. Loy
   G. FOR EDUCATION: Board Review of the Joint Commission Re-Accreditation Process – J. Peaslee

6. MOTION TO GO INTO CLOSED SESSION
   A. Pursuant to Section 19.85(1) (c) and (f) Wis. Stats. for the purpose of considering employment and performance evaluation of any public employee over which the governmental body exercises responsibility, and preliminary consideration of specific personnel problems, which if discussed in public, would likely have a substantial adverse effect upon the reputation of any person referred to in such problems, including specific review of performance of employees and providers of service and review of procedures for providing services by Agency, to wit: Report of Investigations related to Corporate Compliance Activities and Significant Events – J. Peaslee
   B. Pursuant to Section 19.85(1)(c) Wis. Stats. for the purpose of considering employment, compensation, or performance evaluation data of any public employee over which the governmental body has jurisdiction or exercises responsibility, to wit: CEO Evaluation and Compensation Recommendation to the Retained County Authority Committee - Todd Penske, PeopleFirst HR Solutions Inc.

7. RECONVENE to Open Session and Report Out and Possible Action on Closed Session Item(s)
8. Review of Board Calendar and Discussion of Future Agenda Items for Board Consideration
9. Assessment of Board Effectiveness: Board Materials, Preparation and Discussion
10. Adjourn
NORTH CENTRAL COMMUNITY SERVICES PROGRAM
BOARD MEETING MINUTES

December 12, 2019  12:00 Noon  Wausau Board Room

Present:
X Eric Anderson   X Norbert Ashbeck   X Randy Balk
X Steve Benson   X Ben Bliven         X via phone John Breske
X via phone Meghan Mattek   X Bill Metter     X Corrie Norrbom
X Rick Seefeldt   X Romey Wagner      X via phone Bob Weaver
EXC Theresa Wetzsteon   X Jeff Zriny

Staff Present:  Michael Loy, Dr. Rob Gouthro, Jarret Nickel, Brenda Glodowski, Tom Boutain, Kim Gochanour, Laura Scudiere, Jennifer Peaslee

Guests:  Nancy Bergstrom, Dr. Ed Krall (via phone)

1. Call to order
   • Meeting was called to order at 12:06 p.m. by J. Zriny.

2. Public Comment for Matters appearing on the Agenda
   • No public comment.

3. Chairman’s Report and Announcements – J. Zriny
   • Introduction of Dr. Rob Gouthro, Chief Medical Officer. Dr. Gouthro will be sharing his time between NCHC and the Medical College of Wisconsin. He will be working closely with Dr. Krall on the psychiatry residency program and the NCHC Medical team.

4. Consent Agenda
   • Motion/second, Wagner/Ashbeck, to approve the consent agenda which includes:
     o Approval of 10/31/19 NCCSP Board Meeting Minutes
     o Draft Minutes of the November 13, 2019 Executive Committee Meeting
     o Draft Minutes of the November 21, 2019 Nursing Home Operations Committee Meeting
     o CEO Work Plan Review and Report
     o Executive Updates – Executive Team
     o November Quality Dashboard and Executive Summary
     o Complaints and Grievance Policy
     o Employee Grievance Policy
     o Medical Staff Privileges for Robert Gouthro, MD and Graig Aders, MD
     o It was noted that the occurrence reporting processes have improved; with J. Peaslee on board we have seen compliance strengthen.
   • Motion carried.
5. **Board Education**
   - Update from the Medical College of Wisconsin Central Wisconsin Psychiatry Residency Program by Dr. Ed Krall
     - The Residency Program has great partnerships that make for a successful program. NCHC has become the flagship of the program.
     - There are nine residents in the program and interviews are occurring now to recruit three additional residents for the start of year four when the program will have a full roster of residents from first year through fourth year residents.
     - We are beginning to see the fruits of our labor in that several residents are considering staying in the area and/or Wisconsin.
     - Will soon be developing the PGY 4 Curriculum for our fourth year residents.
     - We are delighted to have Dr. Gouthro on board who brings experience and expertise to the program and NCHC. He will provide day to day supervision, teach and provide learning experiences to help make the program and NCHC better.
   - **Overview of the System for Managing Diversions** – L. Scudiere
     - When an individual is on a commitment NCHC is responsible for the cost of care.
     - Care coordination conferences occur regularly to review individual cases with the physician in charge to identify potential wrap-around services.
     - Assigned staff work on diversions to help bring them back to the county and provide services here. CART has helped but new options, training and resources are needed.
     - There needs to be a timeline on how we will chisel away at the cost overages related to diversions; being aggressive to reduce lengths of stay, structuring resources within counties, risk sharing with counties, developing new resources, continually reviewing cases, etc.
     - Activities currently utilized to reduce expenses include working with psychiatry residency program, new psychologist, regular calls with Winnebago and Mendota to work together to bring patients back to area for services, and a diversion team continually working to improve the number of diversions.

6. **Board Discussion and Possible Action**
   - Review and Accept October and November Financial Statements – B. Glodowski
     - Cash noted on balance sheet for human services is a negative $1.8 million. We expect to receive about $3.5 million by end of December i.e. $2.5 million related to human services programs reconciliation through WIMCR. In addition, we anticipate about $1 million in a supplemental payment for the nursing home.
     - Oct/Nov. financials continue to struggle. Both nursing home and hospital census are down. Community treatment revenue is up, however expenses are up also. The revenue does include adjustments for projected settlements with WIMCR and CCS.
     - Expenses through November continue to be significantly over target. Salaries are below budget but when including agency staff and contract physicians this becomes over budget. Employee benefits continue to be over budget, with this mainly due to health insurance which is over by $1.2 million. Diversions continue to be over target through November and are over target by over $1.6 million. Legal and recruitment are other areas that are high this year. Through November these items are over target by almost $442,000.
- Expenses are mainly due to an overage in salaries of $500,000 related to overtime and increased staff due to patient acuity. Benefits are over budget by $1.2 million related to health insurance (3-4 hit stop loss). Legal expenses are high being almost $300,000 over budget.
- For 2020 we are looking closely at our benchmarking targets for write-off, charity, as well as the other dashboard items.
- **Motion/second, Wagner/Bliven, to accept the October and November Financial Statements. Motion carried.**
- **Approval of Operating Agreement Between NCHC and North Central Health Foundation, Inc. – M. Loy**
  - Intent is to bring in additional money to help with future program funding. The Foundation determined they want to build and invest in the future by hiring an Executive Director who would be an employee of NCHC but financed by the Foundation to start. The individual must be successful to continue and performance will be evaluated regularly.
  - **Motion/second, Metter/Norrbom, to approve the Operating Agreement between NCHC and North Central Health Foundation, Inc. Motion carried.**
- **Overview and Approval of the 2020 Operational Plan – M. Loy**
  - A total of 49 items are listed on the Operational Plan of which 29 should be closed in the next 30 days. Remainder of the items focus on improving quality, safety and compliance for 2020, implementing a project management structure and an employee well-being program, replacing our current electronic medical records system, and consistently achieving vacancy targets.
  - Board was asked their input on any additional priorities to include for 2020.
  - Retained County Authority RCA has agreed with closing current initiatives and has not added new initiatives.
  - **Motion/second, Anderson/Benson, to approve the 2020 Operational Plan. Motion carried.**
- **Overview and Approval of the 2020 Quality, Compliance and Safety Plan – J. Peaslee**
  - It is the Board’s responsibility for quality of care for patients and staff. Overview of structures are needed in all areas for excellent outcomes.
  - Board members requested a copy of the approved document.
  - **Motion/second, Balk/Benson, to approve the 2020 Quality, Compliance and Safety Plan. Motion carried.**
- **Overview and Approval of the 2020 Utilization Review Plan – M. Loy**
  - CMS regulations for hospitals require a formal utilization review (UR) function. The UR Committee meets monthly to review data on admissions, readmissions, etc. and will focus on items in operational plan.
  - **Motion/second, Ashbeck/Seefeldt, to approve the 2020 Utilization Review Plan. Motion carried.**
- **Overview and Approval of the 2020 Organizational Dashboard – M. Loy**
  - The Dashboard connects to End Statements. Targets have been adjusted slightly giving staff a more realistic target they can achieve and exceed.
  - Board members requested additional information on turnover and vacancy rates that are industry standards.
  - **Motion/second, Balk/Norrbom, to approve the 2020 Organizational Dashboard as reviewed. Motion carried.**
7. MOTION TO GO INTO CLOSED SESSION
   - Motion/second, Metter/Ashbeck, to move into closed session pursuant to Section 19.85(1) (c) and (f) Wis. Stats. for the purpose of considering employment and performance evaluation of any public employee over which the governmental body exercises responsibility, and preliminary consideration of specific personnel problems, which if discussed in public, would likely have a substantial adverse effect upon the reputation of any person referred to in such problems, including specific review of performance of employees and providers of services and review of procedures for providing services by Agency, to wit: Report of Investigations related to Corporate Compliance Activities and Significant Events, and, Annual CEO Succession Plan Exercise, and, Consideration of a motion to adjourn into closed session pursuant to Section 19.84(1)(e) for deliberating or negotiating the purchase of public properties, the investing of public funds, or conducting other specified public business, whenever competitive or bargaining reasons require a closed session, to wit: Consideration and Possible Action on a Negotiated Settlement with Waldinger Investments, LLC, for the leased property located at 504 N. 6th Street, Wausau WI 54403. Roll Call. All ayes. Motion passed 13-0. Meeting convened in closed session at 1:51 p.m.

8. RECONVENE to Open Session and Report Out and Possible Action on Closed Session Item(s)
   - Motion/second, Ashbeck/Metter, to reconvene into Open Session. All Ayes. Motion passed 13-0. Meeting convened in Open Session at 2:22 p.m.
   - Motion/second, Wagner/Bliven, to approve terms of proposed settlement for the leased property located at 504 N. 6th Street, Wausau WI 54403. Motion carried.

9. Review of Board Calendar and Discussion of Future Agenda Items for Board Consideration
   - Next Board Meeting is Thursday, January 30, 2020 at 3:00 p.m.

10. Assessment of Board Effectiveness: Board Materials, Preparation and Discussion
    - No comments made.

11. Adjourn
    - Motion/second, Norrbom/Anderson, to adjourn the meeting at 2:25 p.m. Motion carried.

Minutes prepared by Debbie Osowski, Executive Assistant to CEO
NORTH CENTRAL COMMUNITY SERVICES PROGRAM BOARD
EXECUTIVE COMMITTEE

January 16, 2020    7:30 AM    NCHC – Wausau Board Room

Present:  X  Jeff Zriny    X  Steve Benson
          X  Corrie Norrbom    X  Bob Weaver

Others Present: Michael Loy, Jarret Nickel

Call to order
• Meeting was called to order at 7:37 a.m.

Public Comment for Matters Appearing on the Agenda
• No public comment(s) made.

ACTION: Approval of 11/13/19 Executive Committee Meeting Minutes
• Motion/second, Weaver/Benson, to approve the 11/13/19 Executive Committee meeting minutes; motion passed.

CEO Report
• Draft Board agenda review
  o In addition to the typical items in the Consent Agenda for approval there will be updated Medical Staff Bylaws, which have been reviewed and approved by the Medical Staff, a Procurement Policy which has had legal review, and Medical Staff Privileges.
  o Eric Borgerding, CEO, Wisconsin Hospitals Association will provide education and talk about the political landscape of 2020, etc.
  o Preliminary Year End Financial Statement will be presented and reviewed.
  o Overview of the proposed revisions to the Joint County Agreements.
  o Memorandum on the Provision of Legal Services.
  o Action on divesting Adult Protective Services to the Aging and Disabilities Resource Center (ADRC). ADRC has voted to accept the program. If approved by the Board approval by the three counties would be occur next.
  o Review of the Joint Commission Accreditation process will be provided by Jennifer Peaslee. We have entered into our window for a recertification survey.
  o A closed session will include the significant events report as well as an analysis and discussion on the CEO evaluation and compensation recommendation to the Retained County Authority (RCA) led by Todd Penske.

• Actual financials for December ended with $78,000 to the positive. However, year-end loss was $3 million. Diversions continue to be a challenge, health insurance should be properly budgeted for in 2020, and we do not anticipate the same high physician costs as seen last
At this time, our census in the hospital is a little below budget as well as in the nursing home but this is not unusual for this time of year.

- Zriny noted that the Marathon County Finance Committee discussed the resolution for bonding of Phase 1 of the Renovation along with the debt retirement schedule. Concern was expressed about the ability of NCHC to retire the debt based on NCHC’s current financial status and questioned the 20 year debt payment schedule vs 10 year. Marathon County Finance Director did not share the same concerns as the committee. Loy stated that everything presented to Marathon County has been on a 20-year repayment schedule so that discrepancy will need to be addressed.

- Norrbom indicated she has conflicts with the 3:00 p.m. change in meeting time but will do her best to attend as often as possible.

- A patient letter recently sent to the Board is being addressed. J. Peaslee has been in contact with the individual, communications are occurring, and all are engaged in addressing the concerns.

- Langlade County hired new county manager from outside the county.

- Sober Living project in Langlade County continues. Project was originally based on $390,000 budget shared equally between the city, county, and NCHC. Project is exceeding budget due to purchasing a known contaminated property and higher than expected renovation estimates. Project will go out for bid soon and additional fundraising will occur as necessary.

- TIER replacement continues with two onsite demos with vendors this month. Open forums are being held for any staff to attend and provide feedback. Final selection should be made by end of the month with a kick off in March. Anticipate financials may swing through implementation, however, the strategy is to reserve more cash rather than investing.

- Physician recruitment continues with successfully hiring another inpatient psychiatrist who will begin the summer of 2021. Dr. Yassin is coming from the Green Bay Residency Program along with Dr. Hoppe. They are both PGY3 residents. We have extended an offer to one of our residents and hope to hear a decision soon. Dr. Zimany, a PFY3 resident has been accepted into the MCW Child Adolescent Fellowship in Milwaukee and will be leaving at the end of this year. Even though she will not be staying in this area it appears she is planning to stay in Wisconsin. We will continue our search for another child psychiatrist. We should then be able to focus on decreasing the need for Telehealth. Zriny requested a diagram of the plan for the psychiatry program i.e. where we were, where we are, and where we are going; grouped by inpatient and outpatient. Will need to develop a communication and marketing plan to make the community aware of the success in psychiatry recruitment and what it means for the community.

- Campus renovation updates:
  - The new pool construction is on schedule. Anticipate March/April for soft opening with Grand Opening 4-6 weeks later. Therapy is fully staffed and currently there is no wait list.
  - MMT moved this week from E Wing (Evergreen) to the remodeled area of C Wing (Gardenside Crossing). Asbestos abatement is occurring in E Wing which will then be torn down for the construction of the 4-story tower.
  - Construction of the Youth Hospital and Crisis CBRF is on schedule and anticipate opening this summer.
• Life Report will be out next week. Anticipate mental health and addiction will be a large part of the report. Homelessness will also take a high priority this year with local Foundations taking a higher interest in potential solutions.
• HSRI is on schedule to wrap up their analysis by May and in time for the Board Retreat.
• We will be hosting a neuropsychologist who is interested in NCHC. This is important to NCHC to address physiological aspect and its supporting advanced dementia care. He is well trained, strongly referred, and would be a great addition.
• The Aspirus Clinically Integrated Network agreement is signed. Moving to clinically integrated network requires that: 1) payer contracts have signature authority vested with Aspirus; 2) we participate in quality initiatives with them; 3) we change to their patient experience tool for physician service.
• Pine Crest transition has gone well. As of 1/1/20 the employees of Pine Crest became employees of NCHC. Current challenge is getting the network set up; CCIT is working on this. Therapy, transportation, and dietary have transitioned well. Pharmacy will be transitioned in early summer.
• Executive Recruitment
  o 27 applicants received for CFO position. Todd Penske is working on the process and has completed 8 initial interviews. On site interviews will occur in the next few weeks. Interview candidates have health care experience with a variety of backgrounds and training. Goal is to finish interviews by mid-February.
  o Job description for the Human Services Operations Executive is being finalized. Developmental disability services will be moving under the Operations Executive so the focus of the position can be on behavioral health and mental health. Position will be posted and recruited over the next 2 months.
  o Executive Director position for the Foundation is posted for recruitment.
• Legal Services
  o Leonhard has prepared an analysis and will provide an update as it relates to the Joint County agreement. Currently, NCHC can hire private counsel for legal work. Marathon County will hire an attorney specifically to represent NCHC and be housed at NCHC but under the supervision of Marathon County Corporation Counsel.
  o By law, counties have the first right of refusal for all legal services. By contract Marathon County has said we can hire for our legal services. The proposed arrangement would change the Agreement provisions.
• Joint County Agreement
  o Updates to the Joint County Agreement are good for the long term health of our organization. In the future state the RCA will become part of the Executive Committee rather than a separate Committee with the NCCSP Board chair continuing to chair the Executive Committee. The revised Agreement will be presented to Lincoln and Langlade County Boards in January and Marathon County Board in February.
  o Composition of the NCCSP Board would also change with bringing members of the RCA onto the NCCSP Board.
• Future agenda items for Executive Committee or Board Consideration
  o None
• Adjourn
  o **Motion**/second, Benson/Norrbom, to adjourn the meeting at 8:37 a.m. Motion carried.
Call to Order
Meeting was called to order at 3:02 p.m.

Public Comment for Matters Appearing on the Agenda
- No public comments.

Approval of December 19, 2019 Nursing Home Operations Committee Meeting Minutes
- **Motion**/second, Voermans/Metter, to approve the December 19, 2019 Nursing Home Operations Committee meeting minutes. Motion carried.

Financial Report
- Preliminary financial statements were distributed as staff are closing out the year and preparing the year end statements. Audits are scheduled in a few weeks for both locations.
- Mount View Care Center saw a small loss of just over $30,000 with lower census driving the loss. Expenses were close to being on target. Year to date we show a small gain of $141,058; the CPE funds of $1.2 million helped both facilities. Analysis of patient days was completed. There was an average census of 174. Rates are on target for the month however we are still waiting on clarification of rates from June/July. Mount View rates are not as favorable being driven by a lower case mix index which directly impacts rates. We are at or above target but not as favorable as Pine Crest. Year to date we are almost 1,900 days below target which is driving the negative bottom line of $432,766.
- Pine Crest financials are also preliminary. Have received information on sick accrual which had not been included in previous audit reports; the calculation comes in at $386,000. Pine Crest staff began punching on NCHC system on 1/1/20. Human Resources staff have been at Pine Crest helping with the first payroll this week. Benefits are showing higher at year end. Also included are the CPE funds which was about $805,000 which has made a positive difference in bottom line. Revenue analysis shows an average census of 136 with overall year to date average of 151. Variances are quite favorable going back to rates; though volumes down rates were favorable to bring up and more positive.
Committee discussed differences in accounting practices. Also discussed was the unusually low census, lower referrals, and long term resident deaths. On a positive, Medicare numbers are doing well.

Nursing Home Operations Reports

Mount View Care Center – Kristin Woller and Connie Gilniecki
- Employee Engagement Committee continues to meet weekly with Human Resources to review applicant pool. The areas with the largest number of employee vacancies are nursing and dietary. Staff are working diligently on creative ways to increase the applicant base. Currently 42 staff openings (does not include staff on FMLA which is typically about 10-12 employees).
- December showed the lowest number of falls in several years. Many of the residents who fell in November had terminal restlessness. Falls correlate to higher risk level of patient population. Definition of a fall includes any change/transfer of level of surface i.e. lowering resident to the floor, resident found on floor, etc.
- One resident was hospitalized their average length of stay was 4-7 days which is significant.
- Mount View has not been able to be a nurse aid training site for NTC due to a previous citation. We did not agree with the citation and submitted for an administrative law review. We recently learned that the State has agreed to allow us to be a clinical training site again through NTC which can be implemented immediately. With each class that trains at Mount View 2-3 CNAs generally want to work at Mount View.
- Currently Dietary Aide vacancies are at 9.75 FTS’s of 70 FTE’s. Majority of vacancies are in student level vacancies.

Pine Crest Nursing Home – Zach Ziesemer and Ryan Hanson
- Made it through transition and finishing up loose ends. Staff are asking for more communication. Continue to print information for staff until email communication is in place for all staff. Currently only Managers have email; all Pine Crest staff should have email in February according to CCIT.
- Number of open positions have reduced.
- Finalized closure of 700 wing and all residents have been relocated. Hoping to eventually utilize that area of the building and better utilize staff throughout the building.
- Working with Human Resources in setting up job fairs to offer job opportunities as there was a recent closing of an area business and people are out of work.
- Working the process for patient survey implementation.
- A self-report of an injury of unknown origin was submitted to the State. The State subsequently visited based on that self-report. Received one citation at level D and just received State of Deficiency. Had already been working on the Plan of Correction which must be submitted within 10 days. Have been completing a therapy assessment, reviewing criteria, etc. Completed formal questionnaire of all and sent report to State.

Pine Crest Transition Updates
- Therapy transition is complete; new equipment has arrived.
- UltiPro is in place and being tested; implementation will occur soon.
- Jan. 6 laundry services transitioned and is going well.
• Working with Communications and Marketing on a marketing plan. Working for a concise message for both organizations.
• SafetyZone training will occur soon.
• Dietary transitioned well; Food Service Director is spending time each week at Pine Crest to help enhance the dining experience.
• Pharmacy transition will occur in July. Meetings to prepare for the transition are occurring regularly.
• Admissions team is being established for a better streamlined process. Committee members expressed concern with reasons stated for not selecting the nursing home and asked for staff to continue tracking information.

Potential for Local Food Procurement
• Information is being gathered and will be presented in March by Jennifer Gorman, Food Services Director.

Update on the Governance Structure for NCCSP Board
• As Joint County Agreement is reviewed and revised, proposed modifications will affect the structure of the NCCSP Board by changing the number of representatives from the three counties i.e. Marathon County Board members will reduce from 10 to 9, Lincoln County increases from 2 to 3, and Langlade County remains with 2 representatives.
• The revisions propose to integrate the Joint County Committee into the NCCSP Board and takes one designated position from each county (total of 3) and becomes part of the NCCSP Board and Executive Committee. The President of the Medical Staff also takes one seat.
• NCHC is empowered to create sub-committees and enter into agreement with partners, etc. Management Agreement with Pine Crest dictates the current Nursing Home Operations Committee which will remain in place unless Marathon County feels differently, at which time we’d revisit the Agreement with Pine Crest.
• Election of officers and terms have been moved from December to May to coincide with County Board elections.
• The revised agreement will be presented to all three counties in January and February and will be effective May 1, 2020.

Discussion of Future Agenda Items
• Vision for NCHC by Loy as discussed recently on WPR.
• Monthly status update on nursing home project.
• Projected impact of MVCC as to how it would impact census, attract applicants.
• Next meeting will be Feb. 20 at 3:00 p.m. at Pine Crest. Gochanour and Ziesemer will be in Madison to meet with legislators; Woller, Gliniecki and Hanson will provide reports.

Motion/second, Gilk/Metter, to adjourn the meeting at 4:12 p.m. Motion carried.

dko
MEMORANDUM

DATE: January 24, 2020
TO: North Central Community Services Program Board
FROM: Michael Loy, Chief Executive Officer
RE: CEO Report

The following items are general updates and communications to support the Board on key activities and/or updates since our last meeting:

1) **Campus Renovations**: Construction of the new Aquatic Therapy Pool continues to progress on schedule. The opening remains slated for March/April with a public grand opening to follow 4-6 weeks following the tentative completion date. The new Youth Hospital and Crisis CBRF are a bit behind schedule with a delay in some construction materials. We are now looking at a summer 2020 opening. With the successful relocation of the MMT program, the “E” wing portion of the building is slated for demolition in the next 2-4 weeks as the construction for the new skilled nursing tower is set to begin shortly.

2) **Physician Recruitment**: We have successfully signed a new Inpatient Psychiatrist from the Green Bay MCW Psychiatry Residency program. He will be starting July, 2021. Onsite interviews are scheduled for a Neuropsychologist and Outpatient Psychiatrist in the next 60 days.

3) **Strategic Plan for a Modern and Effective Mental Illness and Addiction System**: The security agreement for the Medicaid data has been signed and the data set should be delivered shortly. Stakeholder interviews continue and the consultants are now reviewing the newly released Life Report.

4) **Recruitments**: There were several candidates who were screened for the Chief Financial Officer vacancy in early January. Initial onsite interviews will be completed by the end of January. Selection should occur in February. The posting for the Executive Director of the Foundation has received some recent activity and we will be to interview candidates shortly. Finally, the Behavioral Health Operations Executive position is now posted and will remain open until the end of February.

5) **Aspirus Network**: We have signed the agreements to join the Aspirus Clinically Integrated Network. This agreement will allow the Aspirus Network to have single signature authority for all of our commercial payer contracts. NCHC will also be required to participate in the networks quality reporting and patient experience surveying.

6) **Updated Joint County Agreement**: Committees in Langlade, Lincoln and Marathon Counties will have all reviewed the proposed Joint County Agreement updates by the January NCCSP Board meeting. Lincoln County Board has approved the updates and the Langlade County Board will also have voted on the updates by January 30th. This leaves Marathon County Board as the last stop at their February Board meeting.
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<th>Objective</th>
<th>Accountability</th>
<th>Start Date</th>
<th>Measure(s) of Success</th>
<th>Interim Updates</th>
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<th>Jan</th>
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<td>Annual Audit</td>
<td>NCCSP</td>
<td>Jan-20</td>
<td>Acceptance of annual audit by NCCSP Board in April</td>
<td>The 2019 audit work has already begun. The audit is slated to be delivered at the April NCCSP Board meeting.</td>
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<td>Approve Board Recruitment Plan</td>
<td>NCCSP</td>
<td>Jan-20</td>
<td>Develop and approve Board Recruitment Plan</td>
<td>The recruitment plan is pending the approval of the new Joint County Agreement.</td>
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<td>Facility Use Agreements</td>
<td>NCCSP</td>
<td>Jan-20</td>
<td>Signed agreements with each of the three Counties</td>
<td>This item remains pending in the Marathon County Corporation Counsel’s office.</td>
<td>Pending</td>
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<tr>
<td>CEO Appraisal</td>
<td>NCCSP</td>
<td>Bi-annually</td>
<td>Completed Appraisal forwarded to the RCA by March</td>
<td>The NCCSP Board will begin the process at the January meeting with the receipt of the CEO Self-Evaluation</td>
<td>Open</td>
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<tr>
<td>Prepare Local Plan</td>
<td>NCCSP</td>
<td>Jan-20</td>
<td>Adopted 3 Year Local Plan at the Annual Board Retreat</td>
<td>The Human Services Research Institute will be providing this plan at the May NCCSP Board meeting.</td>
<td>Open</td>
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<tr>
<td>Approve Training Plan for Counties</td>
<td>NCCSP</td>
<td>Jan-20</td>
<td>Successful Stakeholder Summit in May 2020</td>
<td>We are still in the planning stages for the summit in May.</td>
<td>Open</td>
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<tr>
<td>Annual Report</td>
<td>NCCSP</td>
<td>Apr-20</td>
<td>Annual Report Released and Presentations made to County Boards in May</td>
<td>The drafting of the 2019 Annual Report will begin soon.</td>
<td>Open</td>
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<tr>
<td>Programs and Services Report</td>
<td>NCCSP</td>
<td>Bi-annually</td>
<td>RCA Accepts Report in April and September</td>
<td>Next report will be delivered in April.</td>
<td>Pending</td>
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<tr>
<td>County Fund Balance Reconciliation</td>
<td>NCCSP</td>
<td>Apr-20</td>
<td>Fund Balance Presentation and Adoption by NCCSP Board</td>
<td>Pending the audit acceptance.</td>
<td>Pending</td>
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<tr>
<td>Reserve Policy Review</td>
<td>RCA</td>
<td>Apr-20</td>
<td>CFO will meet with County Finance Directors annually to review Audit and financial performance relative to reserve policy and status</td>
<td>Pending the audit acceptance.</td>
<td>Pending</td>
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<tr>
<td>Approval of Annual Budget</td>
<td>NCCSP</td>
<td>Apr-20</td>
<td>Develop a recommended Budget to the RCA</td>
<td>The Budget process for 2021 will begin in May 2020.</td>
<td>Pending</td>
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<tr>
<td>Policy Governance for the NCCSP Board</td>
<td>NCCSP</td>
<td>Sep-20</td>
<td>Policy Governance Board Effectiveness Review</td>
<td>Performed annually at the September NCCSP Board meeting.</td>
<td>Pending</td>
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<tr>
<td>Annual Quality, Compliance and Safety Plan</td>
<td>NCCSP</td>
<td>Oct-20</td>
<td>Review current plan performance and approve plan for upcoming year</td>
<td>Performed annually at the October NCCSP Board meeting.</td>
<td>Pending</td>
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<tr>
<td>Approve Utilization Review Plan</td>
<td>NCCSP</td>
<td>Dec-20</td>
<td>Approve annual utilization review plan</td>
<td>Performed annually at the December NCCSP Board meetings.</td>
<td>Pending</td>
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<tr>
<td>Financial Review</td>
<td>NCCSP</td>
<td>Bi-annually</td>
<td>Meeting held between the County Finance Directors and CFO and follow-up items addressed</td>
<td>Ongoing.</td>
<td>Open</td>
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Approved Update Tri-County Agreement | RCA | Jan-20 | Recommendation to County Boards | All three counties will have reviewed and considered the updated agreement by February. Implementation of an updated agreement is slated for May 2020. | Open     |     |     |     |     |     |     |     |     |     |     |     |     |

CEO Appraisal & Compensation       | RCA | Jan-20 | Completed Appraisal              | The RCA will receive the completed evaluation and compensation recommendation for the CEO by the end of February. | Open     |     |     |     |     |     |     |     |     |     |     |     |     |

Annual Budget                      | RCA | May-20 | Adopted Budget within Budgetary Direction of the RCA and NCCSP Board               | The Budget process for 2021 will begin in May 2020.                                                                                   | Open     |     |     |     |     |     |     |     |     |     |     |     |     |

Performance Standards               | RCA | Jul-20 | Adopted Annual Performance Standards | The Performance Standards will be reviewed in July, 2020.                                                                                   | Open     |     |     |     |     |     |     |     |     |     |     |     |     |
The following items are general updates and communications to support the Board on key activities and/or updates of the Human Service Operations service line since our last meeting:

1. **Community Treatment DHS Recertification Review**: In December, Community Treatment programming received its normal recertification survey. The program did well during survey and was renewed for a two-year term. The program is required to make two adjustments, one adjustment is that service facilitators are documenting how dental needs will be addressed and also for NCHC staff to provide written response letters for every complaint and grievance that is addressed.

2. **Clubhouse New Hours**: In February, Clubhouse will be adjusting its hours to be in-line with the needs of its members. It will now be open M-F 9-5 pm and open on Tuesday until 6 pm. This new schedule extends hours into the afternoon when more members are attending and available.

3. **Outpatient Counseling Services**: North Central continues to evaluate the case loads of existing providers and is exploring how to provide the highest quality of care with the staff we currently have. Please note that while our intakes may be reduced, NCHC hasn’t stopped intakes entirely and continue to add them to providers who do not have full case loads. We are unable at this time to accept new intakes for counselors who are booking over 6 weeks out.

4. **Marathon County Exploration of Jail Medically Assisted Treatment Program**: Recruitment for the MAT Coordinator position continues and we hope to have it filled in February. NCHC is using the [NIATx model](#) for program design and implementation. One jail inmate was identified as a candidate for the program and received MAT in the jail in December.

5. **Langlade County Sober Living**: After discussions with the architects, the new implementation date for this program is in June 2020. Donations have been trickling in and are being stored in the Langlade County Health Department until the house is renovated and ready to be set up. NCHC Staff are actively recruiting for the Sober Living Coordinator position.
6. **North Central Recovery Coaching Collaborative:** Four coaches received the Connecticut Community for Addition Recovery (CCAR) certification since the start of this program at NCHC. One coach was recently removed from the program due to inactivity, but the others are still actively participating and coaching. Referrals for the program can be directed to the RecoveryCorps Warm Line at 715-221-8504. The RecoveryCorps staff will speak with the client and determine the best match for them based on their needs and the geographic location. NCHC is working to educate the public that recovery coaches are a support mechanism to get someone into treatment and support services. Staff have been receiving referrals for individuals who are interested or are in need of a sponsor, which are generally peers that can provide longer term emotional support, and not the same model as recovery coaches.

7. **Lincoln Industries:** In November, Toni Kellner assumed leadership over the Lincoln Industries programs. She has reported a smooth transition and staff are acclimating to all the changes including new computer systems and a change in leadership.

8. **Andrea Street Recertification Survey:** On 1/15/20, Andrea Street hosted a DHS surveyor, which reviewed its operations and facility. No citations were found and recertification has been authorized. This continues a great no-citation streak for the residential program, and is a testament to the staff’s hard work and attention to detail.

9. **Medically Monitored Treatment Program Move:** On 1/13/20, the MMT program moved to the site that was formerly Gardenside. Certification and licensure was obtained to move the site’s address, and treatment resumed on the same day as the move. The previous MMT space will be demolished in order to make room for the new Nursing Home tower. The MMT space looks very similar, as Gardenside’s facility layout was almost identical to MMT’s previous space.
MEMORANDUM

DATE: January 23, 2020
TO: North Central Community Services Program Board
FROM: Thomas Boutain, Information Services Executive
RE: Monthly Information Services Report

The following items are general updates and communications to support the Board on key activities and/or updates of Information Services since our last meeting:

1. **Replacement of our Human Resources Management System (HRMS):** We completed the implementation of the remaining UltiPro modules. During this time we also on boarded the Pine Crest and Lincoln Industries staff. In January we started the historical data import which should be completed in February with project closure in March. This project included replacement of our Learning Management System (LMS), payroll, recruiting, onboarding time clocks, benefits, with compensation and performance to be completed in January.

2. **Behavioral Health EHR Update:** We kicked off Wednesday 1/22 with a tradeshow like demo in the theater open to all NCHC staff to give them the opportunity to see Cerner. We then spent 2 days with in-depth discussion with the teams impacted by the replacement of Tier. These sessions were dedicated to specific functions and were dedicated for those associated team. We will duplicate this process with Sigmund on 1/28 and 1/29.
The following items are general updates and communication to support the Board on key activities and/or updates of the Nursing Home Operations since our last meeting.

1) **Pine Crest Transition:** December focused on the onboarding of current Pine Crest staff for the transition to NCHC on January 1, 2020. December training included Code of Conduct and HIPPA for NCHC. Transition meetings were held with the therapy company and maintenance team for last minute updates.

2) **Minimum Data Set (MDS) Audits:** The MDS is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. MDS consultants are scheduled for both facilities to review certain aspects to ensure compliance and optimization. For Mount View we are focusing on recommendations to incorporate an effective restorative program. An action plan was created and timeline set up for implementation that will be reviewed with the consultant. With this we should see some results in 6-12 months for our CMI (Case Mix Index) to enhance our Medicaid rates.

   Pine Crest audit will focus on the overall CMI. The team has developed an action plan that will be shared with consultant on reviewing lower scoring residents more frequently to capture higher overall rates. Currently Pine Crest has 8 residents that score low that are being reviewed and through time this will be evaluated as their needs change.

3) **Aquatics Program:** In December the aquatic consultant did a final visit. We are awaiting the report to develop an action plan around their recommendation for capturing and enhancing our pool revenue and productivity.

4) **Regulatory Update Mount View:** In December Mount View had a visit from the Division of Quality Assurance which was in relation to our self-report on the vent unit. No citations were issued and we were in compliance per the review.

   Mount View recently received good news on our appeal for being a nurse aide training site. Per verbal confirmation, the State has agreed to let us continue being a clinical site for nursing assistant training through the Northcentral Technical College. We are just awaiting the written documentation before setting up clinical rotations.
5) **Regulatory Update Pine Crest:** Pine Crest had an anonymous complaint about staffing on weekends in December. The State came to follow-up on the complaint which resulted in no citations being issued and we were found to be in compliance for this review as well.

6) **Employee Engagement Updates:** In December we continued our holiday spirit by having special dress up days in both facilities. A holiday party was held for both buildings with a potluck and was enjoyed by all.
MEMORANDUM

DATE: January 23rd, 2020
TO: North Central Community Services Program Board
FROM: Jarret Nickel, Operations Executive
RE: Monthly Operations Report

The following items are general updates and communications to support the Board on key activities and/or updates of Information Services since our last meeting:

1. **2019 Annual Employee Reviews**: With our new HRIS software UltiPro implemented, the 2019 annual reviews will be administered utilizing this software. Annual reviews provide a time for managers, supervisors and peers to reflect on the body of work completed by our employees through written and verbal feedback. Merit increases are also impacted by the employees review encouraging a culture of high performance. For 2020 an individualized approach will be taken for all Senior Managers to align with NCHC’s individual programs dashboards.

2. **Recruitment Update**: Towards the end of 2019 we saw a decrease in the number of applicants and hires as a result of resource allocation to Pine Crest & Lincoln Industries transitions. Having a down month in recruitment is not uncommon in any organization however, recognizing this before it becomes a trend is crucial. We’ve reallocated resources back to recruitment efforts and aligned our Senior Management team to increase recruitment efforts across all programs.

3. **Changing of Safety Landscape**: For many years we’ve operated our safety efforts through one committee, our Safety Committee. Healthcare as an industry has transitioned over time and identifies safety in two ways; emergency management and environment of care. In order to effectively lead both we’ve created committees for both and dissolved the Safety Committee. Our Emergency Management Committee has already identified the need for a large change within our organization in transitioning our emergency codes to plain language. First responders already use plain language along with a large amount of healthcare providers which will allow for a more effective communication during emergency events. This transition is not one that can be implemented overnight as it will likely take all of 2020 to complete.

4. **Orientation Overhaul**: Every quarter we host feedback sessions from new employees on how their experience has been and ways we can improve. Through these sessions, along with recruitment needs, a change in the way we deliver our orientation was needed. Five methods of orientation were proposed and reviewed by the Executive Team. The selected method will be implemented for our March orientation which will include a shift from in-person training hours to online training hours.
<table>
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<tr>
<th>PRIMARY OUTCOME GOAL</th>
<th>TARGET</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
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<th>JUN</th>
<th>JUL</th>
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<td><strong>PEOPLE</strong></td>
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<td>Vacancy Rate</td>
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<td>5 - 7%</td>
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<td>97.8%</td>
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<td>Readmission Rate</td>
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<td>Nursing Home Star Rating</td>
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<td>Adverse Event Rate</td>
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<td>0.65</td>
<td>0.53</td>
<td>0.39</td>
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<td>0.48</td>
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<td>NCHC EMP: 3.31 - 3.51</td>
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<td>Hospital Days</td>
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<td>735 or less per month</td>
<td>770</td>
<td>667</td>
<td>821</td>
<td>715</td>
<td>768</td>
<td>930</td>
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<td>Access Rate</td>
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<td>Direct Expense/Gross Patient Revenue</td>
<td>⬇️</td>
<td>60 - 64%</td>
<td>64.9%</td>
<td>68.0%</td>
<td>73.3%</td>
<td>65.5%</td>
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<td>73.9%</td>
<td>75.8%</td>
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<td>Indirect Expense/Direct Expense</td>
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<td>36 - 38%</td>
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<td>33.0%</td>
<td>31.1%</td>
<td>43.3%</td>
<td>33.9%</td>
</tr>
<tr>
<td>Net Income</td>
<td>⬆️</td>
<td>2 - 3%</td>
<td>1.3%</td>
<td>-1.6%</td>
<td>-12.4%</td>
<td>0.2%</td>
<td>-9.2%</td>
<td>-1.1%</td>
<td>-7.0%</td>
<td>-5.5%</td>
<td>-4.1%</td>
<td>-7.8%</td>
<td>-5.7%</td>
<td>1.2%</td>
<td>-4.1%</td>
</tr>
</tbody>
</table>

Higher rates are positive
Lower rates are positive
<table>
<thead>
<tr>
<th><strong>DASHBOARD MEASUREMENT OUTCOME DEFINITIONS AND DETAILS</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PEOPLE</strong></td>
<td></td>
</tr>
<tr>
<td>Vacancy Rate</td>
<td>Total number of vacant positions as of month end divided by total number of authorized positions as of month end.</td>
</tr>
<tr>
<td>Retention Rate</td>
<td>Annualized number of employees onboard on January 1st who remain employed divided the number of employees onboard on January 1st.</td>
</tr>
<tr>
<td><strong>SERVICE</strong></td>
<td></td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Mean score of responses to the overall satisfaction rating question on the survey.</td>
</tr>
<tr>
<td><strong>CLINICAL</strong></td>
<td></td>
</tr>
<tr>
<td>Readmission Rate</td>
<td>Number of residents re-hospitalized within 30 days of admission to nursing home / total admissions. Percent of patients who are readmitted within 30 days of discharge from the Inpatient Behavioral Health hospital for Mental Health primary diagnosis. Benchmark: American Health Care Association/National Center for Assisate Living (AHCA/NCAL) Quality Initiative.</td>
</tr>
<tr>
<td>Nursing Home Star Rating</td>
<td>Star rating as determined by CMS Standards.</td>
</tr>
<tr>
<td>Adverse Event Rate</td>
<td>Patients: # of actual harm events that reached patients/number of patient days x1000  Employees: # of OSHA Reportables x 200,000/hours worked</td>
</tr>
<tr>
<td>Total Hospital Days</td>
<td>Total Hospital days that all patients spend hospitalized for psychiatric stabilization or evaluation either in our inpatient unit or at external diversion sites. The current figure totals the NCHC current month hospital days to out of facility hospital days from the previous month. This lag is due to the processing time of invoices from other facilities.</td>
</tr>
<tr>
<td><strong>COMMUNITY</strong></td>
<td></td>
</tr>
<tr>
<td>Access Rate</td>
<td>• Adult Day Services - within 2 weeks of receiving required enrollment documents</td>
</tr>
<tr>
<td></td>
<td>• Aquatic Services - within 2 weeks of referral or client phone requests</td>
</tr>
<tr>
<td></td>
<td>• Birth to 3 - within 45 days of referral</td>
</tr>
<tr>
<td></td>
<td>• Community Corner Clubhouse - within 2 weeks</td>
</tr>
<tr>
<td></td>
<td>• Community Treatment - within 60 days of referral</td>
</tr>
<tr>
<td></td>
<td>• Outpatient Services</td>
</tr>
<tr>
<td></td>
<td>- within 4 days following screen by referral coordinator for counseling or non-hospitalized patients,</td>
</tr>
<tr>
<td></td>
<td>• within 4 days following discharge for counseling/post-discharge check</td>
</tr>
<tr>
<td></td>
<td>• 14 days from hospital discharge to psychiatry visit</td>
</tr>
<tr>
<td></td>
<td>• Prevocational Services - within 2 weeks of receiving required enrollment documents</td>
</tr>
<tr>
<td></td>
<td>• Residential Services - within 1 month of referral</td>
</tr>
<tr>
<td></td>
<td>• Post Acute Care % of eligible referred residents admitted within 48 hours</td>
</tr>
<tr>
<td></td>
<td>• Long Term Care % of eligible referred residents admitted within 2 weeks</td>
</tr>
<tr>
<td></td>
<td>• CBRF % of eligible patients admitted within 24 hours</td>
</tr>
<tr>
<td></td>
<td>• MMT % of eligible patients admitted within 60 days of UPC</td>
</tr>
<tr>
<td></td>
<td>• Crisis Services % of individuals with commitments and settlement agreements enrolled in CCS or CSP programs for eligible individuals within 60 days of referral</td>
</tr>
<tr>
<td></td>
<td>• Inpatient Services</td>
</tr>
<tr>
<td></td>
<td>- within 4 days following discharge for counseling/post-discharge check</td>
</tr>
<tr>
<td></td>
<td>• 14 days from hospital discharge to psychiatry visit</td>
</tr>
<tr>
<td></td>
<td>• Ratio of patient days served at NCHC vs. Out of County placements</td>
</tr>
<tr>
<td><strong>FINANCE</strong></td>
<td></td>
</tr>
<tr>
<td>Direct Expense/Gross Patient Revenue</td>
<td>Percentage of total direct expense compared to gross revenue.</td>
</tr>
<tr>
<td>Indirect Expense/Direct Revenue</td>
<td>Percentage of total indirect expenses compared to direct expenses.</td>
</tr>
<tr>
<td>Net Income</td>
<td>Net earnings after all expenses have been deducted from revenue.</td>
</tr>
</tbody>
</table>
Quality Executive Summary
January 2020

Organizational Outcomes

People

- **Vacancy Rate**
  The Vacancy Rate target range for 2019 was 5.0–7.0%. The rate was 9.6% for December. The 2019 year average was 9.6%, slightly higher than 2018 at 9.5%. The 2020’s Vacancy Rate target has been set at 7.0–9.0%. Recruitment numbers fell towards the end of 2019 in large part due to resources allocated towards Pine Crest acquisition. The Vacancy Rate performance in 2020 will be a key for NCHC’s future success.

- **Employee Retention Rate**
  The Employee Retention Rate target range for 2019 was 80.0–82.0%. The rate was 84.9% for December. We improved year over year in 2019 and exceeded our target with an average rate of 85.1%. For 2020 the Retention Rate target has been set at 82.0–84.0%.

Service

- **Patient Experience**
  NCHC Patient Experience target range for 2019 was 88.3–90.5. We are measuring patient experience via mean score of responses to the overall satisfaction question on the patient experience surveys. This month, we were in target at 90.4. Overall year to date, the measure is at 88.9 which is slightly above the target at 88.3.

Quality

- **Readmission Rate**
  The Readmission Rate is a combined measure consisting of the total number of residents re-hospitalized within 30 days of admission and the percent of patients who are readmitted within 30 days of discharge from the inpatient behavioral hospital for mental health primary diagnosis. After multiple admits of a few high acuity patients in November that drove the high number of 24.6% readmissions, the number decreased in December to 7.1%. BHS’s readmission rate for 2019 was 11.1% which is 1.1% over the target. The nursing home showed a decrease in December with a rate of 17.9%. For 2019, the YTD Readmission Rate for Mount View Care Center was 12.3%. We continue to struggle with some clinically complex residents. A case study is being presented in January at the Aspirus Post-Acute network to do some problem-solving ways to avoid readmissions. Our target for 2019 is 8-10% total readmission rate. The combined rate YTD is 11.3

- **Nursing Home Star Rating**
  For 2019, we reported the Nursing Home Star Rating as determined by CMS Standards with a target of 4 stars. The current rating as of November remains a 2 star. This is due to the Payroll Based Journal audit that brought some discrepancies in our report based on paid lunches accounting. We have corrected the reporting parameters to comply with the new guidance we received from the audit. We have recently been notified and have submitted additional information to ensure that the problem has been corrected for the next reporting periods. This penalty is for 90 days and should be removed in January 2020.
Adverse Event Rate
For 2019, we measured adverse events for both patients and employees. Our definition of “adverse” is actual harm that reached the patient or the employee. This measure will not include “near misses” or events that could have had the potential for harm, although this data will be collected, measured, and analyzed for quality process improvement efforts.

For 2019, the target range for Patient Adverse Events was .71-.73 per 1,000 patient days. The overall rate improved from the previous month to be within target range in December and YTD was .63. For November, Mount View showed a rate of 2.40 which was back in target.

The target range for Employee Adverse Events was 3.31 - 3.51 per 200,000 hours worked. For December, NCHC was within target at 1.90. Our 2019 rate met our target range at 3.47. Most of the recent injuries occurred while performing patient care duties. 2019 overall trended downward after a high number of injuries in the beginning of the year due to inclement weather.

Total Hospital Days
This measure includes the total number of days that all patients spend hospitalized for psychiatric care or evaluation either in our inpatient unit or at diversion sites. The data for diversion days will be at a one month lag. Our target for 2019 is 735 or less total hospital days per month. In December, NCHC had a low hospital utilization month at 668 days. Fluctuations in this number can be caused by a variety of factors. For 2019, the average number of hospital days was 783, which is 48 days over target. BHS has experienced a high number of placement issues in the second half of 2019. Placement issues have been related to geriatric psychiatry, ongoing housing unavailability, or highly complex patient needs.

Community
Access Rate for Behavioral Health Services
The target range for this measure for 2019 is 90-95%. In 2019, NCHC was under target by 19.1%. The year to date rate was 79.9%, which is well below the target rate of 90%. The NCHC board was recently educated about the concerns with this measure; the residential program had previously reported 100% access to the housing programs. However, this doesn’t take into account the system that is built to handle referrals for recovery-focused housing. Since the demand is so high, and the availability so low, case managers are alerted to vacancies by the Community Living Director. This creates a reverse-referral process, which is not accounted for in this measure. The ongoing demands for residential supportive housing remains high.

Finance
Direct Expense/Gross Patient Revenue
This measure looks at percentage of total direct expense to gross patient revenue. The 2019 target is 60-64%. This measure for December is 73.5% and the overall for the year is 71.7%. Expenses overall continue to be above target, with significant items continuing to be health insurance, diversions and physician onboarding. Overtime and call time continue to be up due to vacant position. There are also holidays in December, which does increase salary expense.

Indirect Expense/Direct Expense
Indirect Expense/Direct Expense is the percentage of total indirect expenses compared to direct expenses and the 2019 target is 36-38%. The percentage for December is 43.3% and the overall for the year is 33.9%. There is an entry for $290,000 included in December for the settlement on the building that was previously leased for Community Treatment. This does show up in an indirect program, which is the reason this percentage is high in December. Overall for the year, this target is better than target. With expenses in the direct areas running over budget, support programs helped all year with keeping some of the expenses down.
Net Income

Net Income is the net earnings after all expenses have been deducted from revenue. The target for 2019 is 2-3%. December shows a small gain for the month, with the percentage being at 1.2%. This is better than the past several months but is still below the target of 2-3%. The overall percent for the year is -4.1%. There are year-end settlements for the CCS and WIMCR programs included in December that contribute to the gain for the month. The loss for the year is mostly a result of the direct expenses being over targets.

Program-Specific Outcomes - items not addressed in analysis above

The following outcomes reported are measures that were not met at the program-specific level. They do not represent all data elements monitored by a given department/program, only the targets that were not met for the month.

Human Service Operations

Behavioral Health Services (Inpatient, MMT, CBRF, Crisis):

- The BHS Vacancy Rate decreased in December to 12.5%, however, this is still over target of 5.8% to 7.8%. Crisis staff have had significant turnover and there are several vacancies we have yet to fill. Attention is being paid to onboarding, training, and orientation of staff to prevent future turnover. Candidates are being screened more selectively with reworked interview questions as well as in-interview realistic job preview discussions. The stressors of the job are a driving factor in retention.

- Patient experience increased from previous months for the highest score in 2019 in December. The department ended with a mean score of 87.2. This brings the overall YTD number to 83.6. Patient surveys are reporting dissatisfaction with the current programming in the hospital, a desire to have more staff education and interaction, and better facility space. As such, clinical leaders in that area have changed programming to enhance treatment. Also, an emphasis is being made on reducing computer-based workloads for the nurses, so that there is more opportunity for them to interact with patients on the floor.

- Readmissions decreased dramatically in December from the previous month. Patients with complex needs are now the focus of weekly care coordination meetings. The goal of these meetings is to better meet the needs of the patients that are readmitting frequently or are staying on our unit or at external hospital systems for more than 10 days.

- Patient Adverse Event Rate is over target. The measure has a target of 0.71 to 0.73 and currently BHS ended the year over target. This is driven by aggressive patient behaviors.

- Hospital Days: Our target for 2019 is 735 or less total hospital days per month. In December, NCHC had a low hospital utilization month at 668 days.

- Direct Expense/Gross Patient Revenue, BHS had an increase from last month at 98.9% with a target of 64-69%. The unit is over target, and the focus has been to decrease diversions, reduce the use of PRN staffing, and manage turnover in the crisis department. Acuity and associated no-roommate status have been a primary contributor to diversions; these are being evaluated daily for necessity. PRN overtime is being addressed.

Birth to 3

- Birth to 3 transferred to the Marathon County Special Education in June. Measures will no longer be reported for this program.
Community Living (Residential/ADS/PreVoc):
- Vacancy Rate is trending up, and the 2019 YTD ended slightly over target. Community Living has had some retirements and turnover in direct care staff.
- Patient Adverse Event Rates: While this measure is over target overall, the rate did decrease from the previous two months. December’s rate was 0.19, which is excellent.
- Access Rate: There is ongoing and increasing demand for residential housing for individuals in substance use treatment and recovery.

Outpatient/Community Treatment/Community Corner Clubhouse:
- Vacancy Rate: While this service line did not meet the YTD target of 5.6% or lower, they missed it by 0.3%. November and December results were within target range.
- Access Rate: The access rate for this service line was at 29.7% increasing slightly from last month. In October and November, there was turnover in provider staffing, which greatly impacts our ability to provide outpatient services in Antigo. It also impacts services for other counties, as we flex providers to cover gaps.
- Direct Expense/Gross Patient Revenue: The Outpatient/Community Treatment service line has not met its financial goal since January 2019. This has been an identified issue within the outpatient area. We are working to address critical access issues that are also impacting no-shows and turnover, which impacts the bottom line. Production continues to struggle in outpatient and is further complicated by recent counseling vacancies in Langlade County. Reduction in case loads for outpatient staff should improve provider and client satisfaction and no show rates. Decreasing no shows will positivity impact the financials and will impact readmissions, which is a system financial benefit.

Nursing Home Operations

Aquatic Services:
- Vacancy Rate for the month is 0%.
- Access was at 95.7% for December and was 96.2% YTD which exceeded target.
- Direct Expense Budget/Gross Patient Revenue is 51-56%. December was at 52.2% and YTD just missed target at 57.5%.

MVCC Overall:
- Vacancy Rate for the month of December showed a slight improvement at 14.2% with a target range of 6.4-8.4%. Per review of 2018 Wisconsin Data direct caregiver vacancy in the State of Wisconsin is at 19%. YTD we are at 14.1% which is below the state average but did not meet our target. In an effort to give employees flexibility in their schedules, this causes changes in FTE statuses. The nursing home Vacancy and Retention Committee meets weekly and is working to impact this outcome. Food service showed some improvement in December. We continue to struggle in our dietary, housekeeping and laundry departments to attract qualified candidates.
- Readmission Rate target for 2019 is 8-10%. In December the readmission rate was 17.9% which was a slight improvement from November. In December we had 5 readmissions in the 30-day timeframe which were unavoidable readmissions. With the reduction in the number of admissions this number drives the percentage up. Our YTD is at 12.3%. National average is at 22.2% so even though we are over are target internally we still remain under the national average. Continued education and training is ongoing.
- Adverse Event Rate for December was 2.4 events per 1,000 patient days which puts us in target. YTD we are at 2.70; slightly over target. We saw a significant decline in falls in December with the lowest in a number of years.
• Access Rate for December was at 100%. The short term target for 2019 is for a referral to have an admission within 48 hours after acceptance. This goal has been revised to measure when the facility accepts a referral versus actual referral date.
• Direct Expense/Gross Patient Revenue for December showed a slight improvement at 61.9% with a target of 46-51%. Our census showed a decline in December which contributed to our loss. Team is continuing to focus on payer mix, reduction of overtime, and supply management. Write-offs remain in line at .14% for YTD.

Support Programs
  ❖ **APS:**
    • Vacancy rate was at 0% for another month as APS is fully staffed. Overall rate dropped to 6.1%. Retention rate remains at 62.5% - there have been no resignations since July 2019.
    • APS patient experience remains over target – 80.6 for December and 91.2 overall.

  ❖ **Information Management (IMS):**
    • Direct Expense Budget target is $191,668 - $201,251 per month. December came in over budget at $243,565. This is due to multiple maintenance contracts coming due at the end of the year. The yearly overall IMS monthly average was $185,684 which is below budget.

  ❖ **Patient Financial Services:**
    • Direct Expense Budget target is $66,088-$69,393 per month. Expenses for December were within target but the overall expenses for the year are over target. This is due to collection expenses. There is an increase in revenue which offsets the increased expense.

  ❖ **Pharmacy:**
    • The Direct Expense/Gross Patient Revenue for December is at 40.7% with a target range of 37-41%. This year to date is 42.1 % which remains off target. Factor influencing this is drug costs more than budget. Pharmacy is continuing to review better pricing for drugs and also reviewing changing off hours contract to assist in reduction of cost.
<table>
<thead>
<tr>
<th>Department</th>
<th>Domain</th>
<th>Outcome Measure</th>
<th>2018</th>
<th>Target Level</th>
<th>2019 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>People</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vacancy Rate</td>
<td>9.5%</td>
<td>5 - 7%</td>
<td>9.6%</td>
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<tr>
<td></td>
<td></td>
<td>Retention Rate</td>
<td>82.0%</td>
<td>80 - 82%</td>
<td>84.9%</td>
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<tr>
<td><strong>Service</strong></td>
<td></td>
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<tr>
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<td>Patient Experience: % Top Box Rate</td>
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<td>88.3 - 90.5</td>
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<tr>
<td><strong>Quality</strong></td>
<td></td>
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</tr>
<tr>
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<td></td>
<td>Readmission Rate</td>
<td>11.3%</td>
<td>8 - 10%</td>
<td>11.5%</td>
</tr>
<tr>
<td></td>
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<td>Nursing Home Star Rating</td>
<td>★★</td>
<td>4+ Stars</td>
<td>★★</td>
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<td></td>
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<td>Adverse Event Rate</td>
<td>0.75</td>
<td>PAT: 0.71 - 0.73</td>
<td>0.63</td>
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<td>3.77</td>
<td>NCHC EMP: 3.31 - 3.51</td>
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<tr>
<td></td>
<td></td>
<td>Hospital Days</td>
<td>N/A</td>
<td>&lt;= 735 / month</td>
<td>783</td>
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<tr>
<td><strong>Community</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
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<td>Access Rate</td>
<td>88.3%</td>
<td>90 - 95%</td>
<td>70.9%</td>
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<tr>
<td></td>
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<td>Direct Expense/Gross Patient Revenue</td>
<td>68.2%</td>
<td>60 - 64%</td>
<td>71.7%</td>
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<td>Indirect Expense/Direct Expense</td>
<td>35.5%</td>
<td>36 - 38%</td>
<td>33.9%</td>
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<tr>
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<td>Net Income</td>
<td>0.7%</td>
<td>2 - 3%</td>
<td>-4.1%</td>
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<td></td>
<td></td>
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<tr>
<td></td>
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<td>BHS Vacancy Rate</td>
<td>5.8%</td>
<td>5.8 - 7.8%</td>
<td>15.0%</td>
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<td>BHS Retention Rate</td>
<td>8%</td>
<td>80 - 82%</td>
<td>82.5%</td>
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<tr>
<td></td>
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<td>BHS Patient Experience</td>
<td>88.3%</td>
<td>88.3 - 90.5</td>
<td>83.6</td>
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<td><strong>Quality</strong></td>
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<td>BHS Readmission Rate</td>
<td>8%</td>
<td>8 - 10%</td>
<td>11.1%</td>
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<td>BHS Adverse Event Rate</td>
<td></td>
<td>PAT: 0.71 - 0.73</td>
<td>3.97</td>
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<td>NCHC EMP: 3.31 - 3.51</td>
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<tr>
<td></td>
<td></td>
<td>BHS Access</td>
<td>90%</td>
<td>90 - 95%</td>
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<tr>
<td><strong>Finance</strong></td>
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<tr>
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<td>BHS Budgeted Direct Expense/Gross Patient Revenue</td>
<td>64%</td>
<td>64 - 69%</td>
<td>84.1%</td>
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<tr>
<td></td>
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<td>BHS Write-Offs</td>
<td>0.69%</td>
<td>0.69%</td>
<td>1.75%</td>
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### COMMUNITY LIVING

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<th>2019 YTD</th>
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<tbody>
<tr>
<td>People</td>
<td>People</td>
<td>Community Living Access Rate</td>
<td>↑</td>
<td>90 - 95%</td>
</tr>
<tr>
<td>Service</td>
<td>Service</td>
<td>Community Living Patient Experience</td>
<td>↑</td>
<td>88.3 - 90.5</td>
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<tr>
<td>Quality</td>
<td>Quality</td>
<td>Community Living Adverse Event Rate</td>
<td>↓</td>
<td>PAT: 0.73 - 0.75</td>
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<tr>
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<td>Community</td>
<td>Community Living Access Rate</td>
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<td>90 - 95%</td>
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<tr>
<td>Finance</td>
<td>Finance</td>
<td>Community Living Direct Expense/Gross Patient Revenue</td>
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<td>56 - 61%</td>
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<tr>
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<td>Community Living Write-Offs</td>
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### OP/CT/CLUBHOUSE

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<th>Domain</th>
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<tbody>
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<td>OP/CT/Clubhouse</td>
<td>OP/CT/Clubhouse Vacancy Rate</td>
<td>↓</td>
<td>3.3 - 5.3%</td>
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<tr>
<td>Service</td>
<td>OP/CT/Clubhouse</td>
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<td>↑</td>
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</tr>
<tr>
<td>Quality</td>
<td>OP/CT/Clubhouse</td>
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<tr>
<td>Community</td>
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### AQUATIC

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<td>Aquatic Patient Experience</td>
<td>↑</td>
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<tr>
<td>Community</td>
<td>Aquatic</td>
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<td>Domain</td>
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<td></td>
<td>Service</td>
<td>NCHC Overall Patient Experience</td>
<td>↑ 88.3 - 90.5</td>
<td>88.9</td>
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<td></td>
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<td>Org Dev Retention Rate</td>
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<td>100.0%</td>
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<td></td>
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<td>NCHC Overall Patient Experience</td>
<td>↑ 88.3 - 90.5</td>
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<td>PATIENT ACCESS SERVICES</td>
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<td></td>
<td>People</td>
<td>Patient Access Services Retention Rate</td>
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<td>100.0%</td>
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<tr>
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<td>Service</td>
<td>NCHC Overall Patient Experience</td>
<td>↑ 88.3 - 90.5</td>
<td>88.9</td>
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<td>Quality</td>
<td>Support Program Overall Adverse Event Rate</td>
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<tr>
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<td>Patient Access Services Direct Expense Budget</td>
<td>↓ $50,225 - $52,737 per month</td>
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<tbody>
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<td>People</td>
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<td>100.0%</td>
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<tr>
<td></td>
<td>Service</td>
<td>NCHC Overall Patient Experience</td>
<td>↑ 88.3 - 90.5</td>
<td>88.9</td>
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<td></td>
<td>Quality</td>
<td>Support Program Overall Adverse Event Rate</td>
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<td>↓ $66,088 - $69,393 per month</td>
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<td>People</td>
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<td></td>
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<td>NCHC Overall Patient Experience</td>
<td>↑ 88.3 - 90.5</td>
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<tr>
<td></td>
<td>Quality</td>
<td>Support Program Overall Adverse Event Rate</td>
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<td>Finance</td>
<td>Pharmacy Budgeted Direct Expense/Gross Patient Revenue</td>
<td>↓ 37 - 41%</td>
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<td>People</td>
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<td>Finance</td>
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<td>↓ $18,643 - $19,575 per month</td>
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## Department: TRANSPORTATION

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<tr>
<td>People</td>
<td>Transportation Vacancy Rate</td>
<td>↓ 3.7 - 5.7%</td>
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<td></td>
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<td>↑ 80 - 82%</td>
<td>100.0%</td>
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<tr>
<td>Service</td>
<td>NCHC Overall Patient Experience</td>
<td>↑ 88.3 - 90.5</td>
<td>88.9</td>
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<tr>
<td>Quality</td>
<td>Support Program Overall Adverse Event Rate</td>
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</tr>
<tr>
<td></td>
<td>Access: On-Time Arrivals</td>
<td>↑ 90 - 95%</td>
<td>94.8%</td>
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<td>Finance</td>
<td>Transportation Direct Expense Budget</td>
<td>↓ $32,062 - $33,665 per month</td>
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## Department: VOLUNTEER SERVICES

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<tr>
<td>People</td>
<td>Volunteer Services Vacancy Rate</td>
<td>↓ 16.1 - 18.1%</td>
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<td></td>
<td>Volunteer Services Retention Rate</td>
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<td>Service</td>
<td>NCHC Overall Patient Experience</td>
<td>↑ 88.3 - 90.5</td>
<td>88.9</td>
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<td>Quality</td>
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<td>3.47</td>
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<tr>
<td>Finance</td>
<td>Volunteer Services Direct Expense Budget</td>
<td>↓ $9,453 - $9,926 per month</td>
<td>$9,891</td>
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</table>
Proposed modifications to the Medical Staff Bylaws, as recommended by the Medical Executive Committee on November 21, 2019, and voted on by the Medical Staff are enclosed for your review. These recommended changes have been in review and consideration for several months in collaboration with Medical Staff membership and leadership. The last time they were reviewed and modified was in 2015. All “Active” members of the Medical Staff were given the opportunity to vote on the adoption of the proposed amendments, which have now been conferred as of January 24, 2020.

Once conferred by the Medical Staff, the amendments shall only be effective when approved by the NCHC Board of Directors. While the Medical Staff has individual rights and responsibilities, these are afforded and delegated by the NCCSP Board. The NCCSP Board, in its ultimate authority over the quality of care and the Organized Medical Staff, does have the ability to approve, modify or not approve these proposed amendments individually and/or collectively.

The document is a fairly detailed and lengthy document, but all substantive changes are identified through the document markup and review function.

If you have any questions about this process or the substance of the proposed modifications, please contact me directly.
Medical Staff Bylaws

Approved: April 17, 2014
Last Revision: July 3, 2015

PROPOSED MODIFICATIONS
RECOMMENDED BY MEC
November 21, 2019
# MEDICAL STAFF BYLAWS

## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Article</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preamble</td>
<td>14</td>
</tr>
<tr>
<td>Definitions</td>
<td>14</td>
</tr>
<tr>
<td><strong>ARTICLE I: CREATION AND NAME</strong></td>
<td>55</td>
</tr>
<tr>
<td>1.1 CREATION OF MEDICAL STAFF</td>
<td>55</td>
</tr>
<tr>
<td>1.2 NAME</td>
<td>56</td>
</tr>
<tr>
<td><strong>ARTICLE II: PURPOSES AND RESPONSIBILITIES</strong></td>
<td>66</td>
</tr>
<tr>
<td>2.1 PURPOSES</td>
<td>66</td>
</tr>
<tr>
<td>2.2 RESPONSIBILITIES</td>
<td>66</td>
</tr>
<tr>
<td>2.3 POWERS RESERVED TO THE BOARD OF DIRECTORS</td>
<td>72</td>
</tr>
<tr>
<td><strong>ARTICLE III: MEDICAL STAFF MEMBERS</strong></td>
<td>98</td>
</tr>
<tr>
<td>3.1 NATURE OF MEDICAL STAFF MEMBERS</td>
<td>98</td>
</tr>
<tr>
<td>3.2 BASIC QUALIFICATIONS FOR MEDICAL STAFF MEMBERS</td>
<td>111</td>
</tr>
<tr>
<td>3.3 BASIC RESPONSIBILITIES OF INDIVIDUAL MEDICAL STAFF MEMBERS</td>
<td>111</td>
</tr>
<tr>
<td>3.4 DURATION OF APPOINTMENT</td>
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</tr>
<tr>
<td>3.5 PROFESSIONAL PRACTICE EVALUATION</td>
<td>1242</td>
</tr>
<tr>
<td>3.6 CONTRACT PRACTITIONERS</td>
<td>1242</td>
</tr>
<tr>
<td>3.7 LEAVE OF ABSENCE</td>
<td>1343</td>
</tr>
<tr>
<td>3.8 RESIGNATION</td>
<td>1414</td>
</tr>
<tr>
<td><strong>ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF</strong></td>
<td>1515</td>
</tr>
<tr>
<td>4.1 ACTIVE STAFF</td>
<td>1515</td>
</tr>
<tr>
<td>4.2 PROVISIONAL STAFF</td>
<td>1614</td>
</tr>
<tr>
<td>4.3 COURTESY STAFF</td>
<td>1712</td>
</tr>
<tr>
<td>4.4 CONSULTING STAFF</td>
<td>1712</td>
</tr>
<tr>
<td>4.5 IN-TRAINING STAFF</td>
<td>1818</td>
</tr>
<tr>
<td>4.6 LIMITATION OF PREROGATIVES</td>
<td>1818</td>
</tr>
<tr>
<td>4.7 WAIVER OF QUALIFICATIONS</td>
<td>1818</td>
</tr>
<tr>
<td><strong>ARTICLE V: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT</strong></td>
<td>2020</td>
</tr>
<tr>
<td>5.1 GENERAL PROCEDURE</td>
<td>2020</td>
</tr>
<tr>
<td>5.2 APPLICATION FOR INITIAL APPOINTMENT</td>
<td>2040</td>
</tr>
<tr>
<td>5.3 EFFECTS OF APPLICATION</td>
<td>2323</td>
</tr>
<tr>
<td>5.4 PROCESSING THE APPLICATION</td>
<td>2747</td>
</tr>
<tr>
<td>5.5 REAPPOINTMENT PROCESS</td>
<td>3044</td>
</tr>
<tr>
<td>5.6 REQUESTS FOR MODIFICATIONS OF TERMS OF APPOINTMENTS</td>
<td>3131</td>
</tr>
<tr>
<td><strong>ARTICLE VI: DETERMINATION OF CLINICAL PRIVILEGES</strong></td>
<td>3242</td>
</tr>
<tr>
<td>6.1 EXERCISE OF PRIVILEGES</td>
<td>3242</td>
</tr>
<tr>
<td>6.2 DELINEATION OF PRIVILEGES IN GENERAL</td>
<td>3242</td>
</tr>
<tr>
<td>6.3 PRIVILEGES</td>
<td>3242</td>
</tr>
<tr>
<td>6.4 INTERIM, CASE LIMITED, TIME LIMITED OR TEMPORARY PRIVILEGES</td>
<td>3242</td>
</tr>
<tr>
<td>6.5 EMERGENCY PRIVILEGES</td>
<td>3242</td>
</tr>
<tr>
<td>6.6 DISASTER PRIVILEGES</td>
<td>3434</td>
</tr>
<tr>
<td>6.7 RIGHTS ASSOCIATED WITH TEMPORARY, INTERIM, CASE LIMITED, TEMPORARY, EMERGENCY AND DISASTER PRIVILEGES</td>
<td>3434</td>
</tr>
<tr>
<td><strong>ARTICLE VII: CORRECTIVE ACTION</strong></td>
<td>3548</td>
</tr>
<tr>
<td>7.1 PROCEDURE</td>
<td>3548</td>
</tr>
<tr>
<td>7.2 PRECAUTIONARY SUSPENSION</td>
<td>3747</td>
</tr>
<tr>
<td>7.3 AUTOMATIC SUSPENSION</td>
<td>3848</td>
</tr>
<tr>
<td>7.4 SUMMARY ACTION</td>
<td>4040</td>
</tr>
<tr>
<td><strong>ARTICLE VIII: INTERVIEWS, HEARINGS, AND APPELLATE REVIEW</strong></td>
<td>4242</td>
</tr>
</tbody>
</table>
8.1 INTERVIEWS ........................................................................................................... 4242
8.2 HEARING AND APPELLATE REVIEW .................................................................... 4242
8.3 REMOVAL OF CHIEF MEDICAL OFFICER OR MEDICAL DIRECTOR .......... 4242
ARTICLE IX: FAIR HEARING PLAN ........................................................................... 4444
  9.1 SPECIAL DEFINITIONS ..................................................................................... 4444
  9.2 RIGHT TO HEARING ......................................................................................... 4444
  9.3 REQUEST FOR HEARING .................................................................................. 4949
  9.4 HEARING PREREQUISITES ................................................................................ 4949
  9.5 HEARING PROCEDURE ...................................................................................... 5050
  9.6 HEARING COMMITTEE REPORT AND FURTHER ACTION ......................... 5454
  9.7 INITIATION AND PREREQUISITES OF APPELLATE REVIEW ..................... 5555
  9.8 APPELLATE REVIEW PROCEDURE ................................................................. 5555
  9.9 FINAL DECISION OF THE BOARD ................................................................... 5757
  9.10 GENERAL PROVISIONS ............................................................................... 5858
ARTICLE X: OFFICERS .............................................................................................. 6060
  10.1 OFFICERS ........................................................................................................ 6060
  10.2 QUALIFICATIONS ............................................................................................. 6060
  10.3 NOMINATIONS .................................................................................................. 6060
  10.4 ELECTION .......................................................................................................... 6060
  10.5 TERM OF OFFICE ............................................................................................. 6161
  10.6 VACANCIES AND REMOVAL FROM OFFICE .............................................. 6161
  10.7 RESPONSIBILITIES .......................................................................................... 6161
ARTICLE XI: COMMITTEES ....................................................................................... 6464
  11.1 MEDICAL EXECUTIVE COMMITTEE (MEC) ..................................................... 6464
  11.2 QUALITY COMMITTEES ................................................................................... 6868
  11.3 MULTIDISCIPLINARY COMMITTEES ................................................................. 6969
ARTICLE XII: MEDICAL STAFF MEETINGS ............................................................. 7070
  12.1 REGULAR STAFF MEETINGS ......................................................................... 7070
  12.2 SPECIAL STAFF MEETINGS .......................................................................... 7070
  12.3 QUORUM / VOTING / RECORD KEEPING .................................................... 7070
  12.4 CLOSED MEETINGS / EXECUTIVE SESSIONS .......................................... 7070
ARTICLE XIII: PRIVILEGE AND IMMUNITY / CONFIDENTIALITY ......................... 7171
  13.1 PRIVILEGES AND IMMUNITIES ..................................................................... 7171
  13.2 AUTHORIZATIONS AND CONDITIONS ......................................................... 7171
  13.3 CONFIDENTIALITY OF INFORMATION ....................................................... 7272
  13.4 IMMUNITY FROM LIABILITY ......................................................................... 7272
  13.5 ACTIVITIES AND INFORMATION COVERED .............................................. 7373
  13.6 RELEASES ....................................................................................................... 7474
  13.7 CUMULATIVE EFFECT .................................................................................... 7474
ARTICLE XIV: RULES, REGULATIONS, POLICIES and FORMS ................................. 7575
ARTICLE XV: CONFLICT RESOLUTION .................................................................. 7676
ARTICLE XVI: DUES AND ASSESSMENTS ............................................................... 7878
ARTICLE XVII: HISTORIES & PHYSICALS ............................................................... 7979
ARTICLE XVIII: BYLAWS AMENDMENTS / REVISIONS AND ADOPTION ........... 8080
  18.1 MEDICAL STAFF RESPONSIBILITY ................................................................. 8080
  18.2 METHODOLOGY ............................................................................................ 8080
BYLAWS OF THE MEDICAL STAFF
NORTH CENTRAL HEALTH CARE
Wausau, Wisconsin

PREAMBLE

WHEREAS, the Medical Staff is responsible for structuring itself to provide a uniform standard of quality of patient care, treatment and services; and

WHEREAS, it is recognized that the Medical Staff of North Central Health Care (NCHC) is responsible for the quality of the medical care in all programs and services provided, and must accept and discharge this responsibility, subject to the ultimate authority of the North Central Community Services Program (NCCSP) Board, NCHC’s governing body, and that the cooperative efforts of the Medical Staff, the Chief Executive Officer (CEO) and the governing body are necessary to fulfill the organization’s obligation to its patients;

WHEREAS, the Medical Staff is responsible for: the ongoing evaluation of competency of all Practitioners who are Privileged; delineating the scope of Privileges that will be granted to Practitioners; and providing leadership in performance improvements activities related to the provision of medical care and services;

THEREFORE, the Practitioners practicing at NCHC hereby organize themselves into an organized Medical Staff in conformity with these Bylaws.

DEFINITIONS

ALLIED HEALTH PRACTITIONER. Advanced Practice Providers means an individual, other than a licensed Physician, Dentist, or Podiatrist who exercises independent judgment within the area of his or her competence or who is qualified to render direct or indirect medical or dental care under the supervision of, or in a collaborative agreement with, a member of the Active Medical Staff; and whose clinical care activities require that the authority to perform specified patient care services be processed through the Medical Staff channels or with involvement of Medical Staff representatives. Such allied Health Practitioners Advanced Practice Providers shall include, but shall not be limited to, clinical psychologists, Advanced Practice Registered Nurses, Physician Assistants, or other legally permissible physician extenders.

APPLICATION COMPLETE means (1) all blanks on the application form are filled and necessary additional explanations and attachments are provided; (2) verification of the information is complete; that is, all information necessary to properly evaluate an applicant’s qualifications has been received including reports from the National Practitioner Data Bank, the Federation of State Medical Boards, and Office of Inspector General (OIG) Exclusion List and (3) as required, responsive letters of reference and information from past hospitals and other affiliations have been received including letters from department/program medical director or other physicians who have worked with or observed the applicant.
BOARD OF DIRECTORS or BOARD means the governing body of NCHC, and duly created committees of the Board performing duties delegated by the Board.

BYLAWS or MEDICAL STAFF BYLAWS means these Bylaws of the Medical Staff of NCHC.

Chief Executive Officer (CEO) is the individual appointed by the Board to act on its behalf in the overall management of the organization.

Chief Medical Officer (CMO) is a member of the Executive Management Team of NCHC who in collaboration with the Chief Executive Officer, provides administrative oversight to all members of the Medical Staff, including appointed Medical Directors. Clinical responsibilities are defined as those involving professional capability as a Physician such as to require the exercise of clinical judgment with respect to patient care.

COLLABORATIVE AGREEMENT means a process in which an Advanced Practice Registered Nurse nurse prescriber works with a Physician, in each other’s presence when necessary, to deliver health care services within the scope of the Practitioner’s training, education, and experience. The Advanced Practice Registered Nurse nurse prescriber shall document this relationship in formally executed collaborative agreement.

CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Practitioner to render specific diagnostic, therapeutic, or medical services.

DAYS refers to calendar days.

EX-OFFICIO means service as a member of a body by virtue of an Officer or position held and, unless otherwise expressly provided, means without voting rights.

FAIR HEARING PLAN means the procedure set forth in Article IX.

GOOD STANDING means the Medical Staff member is not under a suspension of his/her appointment or admitting privileges.

HOSPITAL means any licensed Inpatient Psychiatric Hospital in Wausau, Wisconsin managed by NCHC.

MALICE means the dissemination of a known falsehood or of information with a reckless disregard for whether it is true or false, or the absence of a reasonable belief that an action, statement or recommendation is warranted by the facts.

MEDICAL EXECUTIVE COMMITTEE or MEC means the CEO and Medical Staff Officers.

MEDICAL DIRECTOR means a Practitioner Physician employed by, or otherwise serving NCHC, on a full or part-time basis, whose duties include responsibilities, some of which are purely administrative in nature, some purely clinical in nature, and some both administrative and clinical in nature. Any appointed Medical Director provides guidance and leadership on the use of medicine in a healthcare organization for a specific program or service. Clinical responsibilities are defined as those involving professional capability as a Practitioner Physician such as to require the exercise of clinical judgment with respect to patient care.
Director devises the protocols and guidelines for the clinical staff and evaluates them while they are in use.

MEDICAL STAFF means the Medical Staff of NCHC as created pursuant to these Medical Staff Bylaws.

NCHC means North Central Health Care and its services and programs.

PATIENT means any resident, client, and/or consumer receiving services through all Programs at North Central Health Care.

PHYSICIAN means an individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is fully licensed to practice medicine in the State of Wisconsin.

PRACTITIONER means, unless otherwise expressly limited, any Physician or Advanced Practice Provider applying for or exercising clinical privileges at NCHC.

PREROGATIVES means a participatory right granted, by virtue of the staff category or otherwise, to a staff member or allied health practitioner exercising subject to the conditions imposed in these Bylaws and in other NCHC and Medical Staff policies.

PROCTOR means an individual who holds active, provisional or consulting staff status within the Medical Staff of NCHC. This individual is appointed by the Medical Director. Responsibilities of the proctor are:

1) To coordinate in a reasonable manner with the individual to be proctored an agreed upon schedule for patient/case review.

2) Observe the appropriate number of specified patients/cases as delineated by the Chief Medical Officer, and fulfilling Bylaws requirements:
   a) It is permissible that the proctor may provide first assistant services;
   b) It is permissible that the proctor may intervene in the event of an unanticipated outcome;
   c) It is not anticipated that the proctor provides formal educational services during a proctoring sequence, but may provide anecdotal advice/insight.

3) The proctor shall provide a written result to the Chief Medical Officer upon completion of the proctoring responsibility. Said report shall include: a) patient identifier; b) date of proctoring; c) general description of proctoring event; d) patient outcome; and e) recommendations/conclusions.

PROFESSIONAL REVIEW ACTIVITY shall mean any activity of NCHC with respect to an individual Practitioner (i) to determine whether an Applicant or Medical Staff Appointee may have clinical privileges at NCHC or membership on the Medical Staff; (ii) to determine the scope of conditions of such privileges or membership; or (iii) to change or modify such privileges or membership.

PROFESSIONAL REVIEW BODY shall mean as appropriate to the circumstances, the Board of Directors, MEC, any Ad Hoc Investigation Committee, any Hearing Committee, any Appellate
Review Committee, the CEO and other Officers of NCHC, the President of the Medical Staff, the Chief Medical Officer, any department/program Medical Director and any other person, committee or entity having authority to make an adverse recommendation or take any adverse action with respect to or propose an action against any Applicant or Medical Staff Appointee when assisting the Board of Directors in a Professional Review Activity.

PROGRAMS means all inpatient, outpatient, residential, skilled nursing, and community-based services provided in Langlade, Lincoln and Marathon Counties.

QUORUM means those members present who are eligible to vote at any regular or special general staff meeting or any department, program, or committee meeting. Ex-officio members shall not be counted in determining the presence of a quorum.

REPRESENTATIVE means a Board and any director or committee thereof; a Chief Executive Officer or his/her designee; a Medical Staff organization and any member, Officer, department/program or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

SPECIAL NOTICE means written notification sent by certified mail, return receipt requested.

THIRD PARTIES means both individuals and organizations providing information to any representative.
ARTICLE I: CREATION AND NAME

1.1 CREATION OF MEDICAL STAFF

There is hereby established within NCHC a Medical Staff which shall consist of all Practitioners who have been granted the right to exercise clinical privileges within NCHC’s Programs. No Physician Practitioner may admit or provide health-related services to any patients of NCHC’s Programs unless he or she has been appointed by the Medical Staff Board of Directors, or granted partial or temporary privileges. The Board of Directors shall, in the exercise of its discretion, delegate to the Medical Staff the responsibility for providing appropriate professional care to NCHC patients. The Medical Staff shall conduct a continuing review and appraisal of the quality of professional care rendered in NCHC Programs and facilities and shall report such activities and their results to the Board of Directors.

1.2 NAME

The name of the Medical Staff shall be the “Medical Staff of North Central Health Care (NCHC).”
ARTICLE II: PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of the Medical Staff are to:

2.1-1 Be the formal organizational structure through which:

(a) The benefits of membership on the staff may be obtained by individual Practitioners; and

(b) The obligations of staff membership may be fulfilled.

2.1-2 Serve as the primary means for accountability to the Board for the appropriateness of the professional performance and ethical conduct of Medical Staff members and allied health practitioners, and to strive toward assuring that the pattern of patient care at NCHC is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available.

2.1-3 Provide a means through which the Medical Staff may participate in the organization’s policy making and planning process.

2.1-4 Provide an educational setting that will maintain scientific standards and lead to continuous advancement in professional knowledge and skill.

2.1-5 Cooperate with affiliated medical schools and other educational institutions in undergraduate, graduate, and post graduate education.

2.2 RESPONSIBILITIES

The Medical Staff shall be responsible to the Board of Directors for the quality of all medical care provided to patients of NCHC and for the ethical and professional practices of members of the Medical Staff. The responsibilities of the Medical Staff, to be fulfilled through the actions of its Officers, departments, and committees include:

2.2-1 Accountability

The accounting of quality and appropriateness of patient care rendered by all Practitioners and allied health practitioners authorized to practice at NCHC through the following measures:

(a) A credentials program, including mechanisms for appointment and reappointment, and the matching of clinical privileges to be exercised or of specified services to be performed, with the verified credentials and current demonstrated performance of the applicant, staff member, or allied health practitioner.

(b) A continuing education program, fashioned at least in part on the needs demonstrated through the quality/utilization management program.
(c) A utilization review program to allocate inpatient and outpatient medical and health services based upon patient specific determinations of individual medical needs.

(d) An organizational structure that allows continual monitoring of patient care practices.

(e) A program to assist the impaired practitioner in receiving professional help through NCHC and that provides an appropriate monitoring system is in place.

2.2-2 Recommendation to Board

To recommend to the Board action with respect to appointments, reappointments, staff category, departmental assignments, clinical privileges and corrective action.

2.2-3 Quality/Utilization Management

To account to the Board for the quality and efficiency of patient care rendered to patients at NCHC through regular reports and recommendations concerning the implementation, operation and results of the quality/utilization management activities.

2.2-4 Corrective Action

To initiate and pursue corrective action with respect to practitioners and allied health practitioners, when warranted.

2.2-5 Compliance with Bylaws, Rules & Regulations

To develop, administer and seek compliance with these Bylaws, the Rules and Regulations of the Medical Staff and other patient care related NCHC policies.

2.2-6 Identification of Needs and Goals

To assist in identifying community health needs and in setting appropriate organizational goals and implementing programs to meet those needs.

2.2-7 Authority

To exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

2.3 POWERS RESERVED TO THE BOARD OF DIRECTORS

2.3-1 The property and business of NCHC shall be managed by a Board of Directors which shall be responsible for establishing policy, assessing the quality of patient care, appointing and evaluating the performance of the offices as well as evaluating the performance of the Board of Directors and Medical Staff, assuring the fiscal integrity of NCHC, providing for institutional management and planning.
and assuring the provision of an appropriate level of patient care in the various Programs and services of NCHC. The Board of Directors shall have and exercise full power and authority to do all things deemed necessary and expedient in the governance, management and control of the business and affairs of NCHC. All Officers, Organized Medical Staff members, limited health practitioners, employees and agents are subject to the control, direction and removal by the Board. All practitioners are subject to appointment, termination or modification of their Medical Staff Membership and/or clinical privileges by the Board of Directors, based on factors deemed relevant by the Board of Directors. Actions taken by the Board of Directors may, but need not, follow the procedures outlined in the Medical Staff Bylaws and related documents.

2.3-2 The Board of Directors may at any time after considering the recommendation of the Medical Executive Committee direct that specific procedures or clinical practices not be performed at NCHC if the Board of Directors determines that such practices or procedures are not medically acceptable, cannot be properly performed at NCHC, are inconsistent with the mission, operations or principles of NCHC, or for any other reason determines that the procedures or services should not be performed in NCHC. There shall be no appeal or hearing with regard to any decision by the Board of Directors that any practices or procedures are not permitted to be performed in NCHC.
ARTICLE III: MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of NCHC shall be extended only to professionally competent Physicians Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws.

Appointment to and membership on the Medical Staff shall confer on the staff member only such clinical privileges and prerogatives as have been granted by the Board in accordance with these Bylaws, and shall include staff category and department.

No Practitioner shall admit or provide medical or other health related services to patients of any NCHC Program unless he/she has been appointed by the Medical Staff or has been granted temporary privileges. Medical Staff appointment shall confer a privilege in the nature of a license to exercise only such clinical privileges as are specifically granted by the Board of Directors. A Medical Staff member is neither an employee nor an independent contractor of NCHC unless such a relationship is separately and independently established. These Bylaws shall not create a contract between the Medical Staff or any individual member of the Medical Staff Practitioner and NCHC.

In the event of any conflict between the language of these Medical Staff Bylaws or the Appointment and Corrective Procedures or Fair Hearing Procedure and a specific contract between the Healthcare EntityNCHC and a Medical Staff Appointee, the language of the contract shall control.

3.2 BASIC QUALIFICATIONS FOR Medical Staff MEDICAL STAFF MEMBERSHIP

3.2-1 Basic Qualifications

Only Physicians Practitioners licensed to practice in the State of Wisconsin who meet the following requirements will be eligible for appointment and/or clinical privileges:

(a) Document their experience, background, training, demonstrated ability, and their physical and/or mental health status, with sufficient adequacy to demonstrate to the staff and the Board that they will provide care to patients at the generally recognized professional level of quality, and utilization standards in effect at NCHC;

(b) Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others relating to patient care, and to be willing to participate in the discharge of staff responsibilities; and

(c) Possess a current unrestricted license to practice in the State(s) where the Practitioner currently provides care for patients with no past or present restriction(s) or adverse action(s).

(d) Have satisfactorily completed approved postgraduate training relevant to the specialty in which the applicant is seeking to practice, as further
defined on specialty-specific privilege forms.

(e) Possess DEA certification with no record of past or present restriction(s), sanction(s), or voluntary relinquishment.

(f) Possess appropriate professional liability insurance coverage specific to privileges requested, as applicable, without prior history of restriction or reduction of coverage.

(g) Have no record of conviction of Medicare, Medicaid, or insurance fraud and abuse, payment of civil money penalties for the same, or exclusion from such programs.

(h) Have no record of conviction of, or plea of guilty or no contest to, any felony or misdemeanor related to violence, controlled substances, third-party reimbursement or the Practitioner’s professional practice.

(i) Have no record of denial, revocation, relinquishment or termination of appointment, affiliation, or clinical privileges at any healthcare facility for reasons related to professional competence or conduct.

A waiver of a criterion may infrequently be granted solely by the Board of Directors upon the recommendation of the MEC when exceptional circumstances exist. The individual requesting the waiver bears the burden of demonstrating that exceptional circumstances exist.

3.2-2 Effect of Other Affiliations

No physician Practitioner is entitled to membership on the staff or to the exercise of particular clinical privileges solely because he/she is licensed to practice in this or in any other state, or because he/she is a member of any professional organization, or is certified by any clinical Board or presently or formerly held staff membership or privileges at another healthcare facility or in another practice setting.

3.2-3 Nondiscrimination

Staff membership or particular clinical privileges shall not be granted or denied on the basis of any physical or mental condition or other criterion unrelated to the efficient delivery of patient care at the generally recognized professional level of quality in NCHC, including, but not limited to race, creed, color, handicap, marital status, sex, national origin, ancestry, sexual orientation, gender identity, arrest record, conviction record, membership in armed forces, use or non-use of lawful products off NCHC premises.

3.2-4 Administrative and Medical Directors

All program Medical Directors must be a member of the Medical Staff, achieving his/her status by the procedure provided in accordance with Article VI. The Medical Staff membership and clinical privileges of any Medical Director shall not
be contingent on his/her continued occupation of that position, unless otherwise provided in his/her employment agreement.

3.3 BASIC RESPONSIBILITIES OF INDIVIDUAL MEDICAL STAFF MEMBERS

The responsibilities of all members of the Medical Staff are to:

3.3-1 Provide his/her patients with care at the generally recognized professional level of quality and efficiency and utilization standards at NCHC.

3.3-2 Abide by the Bylaws rules, regulations, and associated policies of the Medical Staff and NCHC, Principles and Codes of Medical Ethics of the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or the American Nurses Credentialing Center, as applicable based on each member’s credential.

3.3-3 Provide emergency medical care for any patient following accepted guidelines of his/her respective specialty society. Any individual with delineated clinical privileges may provide emergency care to any patient in a life-threatening emergency or a situation that threatens serious harm, provided that the care provided is within the scope of the individual's license.

3.3-4 Agree to and recognize NCHC’s obligation to query and report adverse actions to the National Practitioner Data Bank as established by federal statute. Information obtained by query of the Data Bank will be used in evaluating the Practitioner's qualification for initial and/or continued membership, and if applicable, Privileges.

3.3-5 Provide appropriate and timely care to those patients for whom they are assigned as attending physician, or to ensure that this care is provided by an appropriate level of Physician Practitioner coverage.

3.3-6 Make appropriate arrangements for coverage of patients to ensure continuous care, ensuring that such arrangements are effectively communicated to NCHC and Medical Staff, to NCHC, the Medical Staff, other NCHC staff and clinicians outside of NCHC as appropriate.

3.3-7 Maintain personal, professional medical malpractice insurance coverage in accordance with Wisconsin regulations.

3.3-8 Inform the Medical Staff in a timely manner of any changes made, or formal action initiated, including pending criminal charges or convictions, that could result in a change to license, state or federal controlled substance registration, professional liability insurance coverage, and voluntary or involuntary reduction of clinical privileges at other health care institutions. Final judgments or settlements for any malpractice activity must be reported.

3.3-9 Work with other individuals and organizations in a cooperative, professional and civil manner and refraining from any activity that is disruptive of NCHC or Medical Staff operations.
3.3-10 Cooperate with and participate in performance improvement and peer review activities, whether related to self or others.

3.3-11 Complete in a timely fashion all medical records for the patients to whom care is provided at NCHC.

3.3-12 Refuse to engage in improper inducements for patient referral or any other unethical behavior, adhering to NCHC’s Corporate Compliance Code of Conduct.

3.3-13 Exercise privileges only as specifically granted by the Board of Directors which includes refraining from practice of all or any privilege until appropriately granted as stipulated by the Medical Staff Bylaws, by the Board.

3.3-14 Assume medical and legal responsibility for allied health practitioners delegated to performing duties on behalf of the Practitioner via an employed or contracted relationship with the Practitioner.

3.3-15 Appropriately supervise residents and students rendering patient care under his or her authority and credentials.

3.3-16 Reflect NCHC’s customer person-centered service ideals, as reflected in its Mission, Vision, and Values statements.

3.3-17 To ensure that all hospitalized patients are visited daily by their attending physician or by another Medical Staff member designated by the attending physician, unless otherwise exempted by other Rules and Regulations of the Medical Staff.

Compliance with the above is necessary to apply for or maintain membership, and for applicable privileges, with the Medical Staff.

3.4 DURATION OF APPOINTMENT

3.4-1 Appointment to the staff shall be for a period of two (2) years.

3.5 PROFESSIONAL PRACTICE EVALUATION

3.5-1 The granting of initial clinical privileges, as well as the addition of new privileges for existing members, is subject to focused professional practice evaluation (Provisional Status).

3.5-2 Provisional Status automatically concludes when an appropriate Medical Staff leader concludes that competency has been verified, but not less than a one year period.

3.5-3 Upon the conclusion of Provisional Status, each individual with clinical privileges is subject to Peer Review as described in the Medical Staff Peer Review Policy.

3.6 CONTRACT PRACTITIONERS PHYSICIANS
The staff appointment of any staff member who has a contractual relationship with NCHC, or is either an employee, partner or principal of, or in any entity that has a contractual relationship with NCHC, relating to providing services to patients at NCHC shall be governed by the terms and conditions of the contract. If at any time the contracting staff member’s individual competence or fitness is questioned, he/she shall be entitled to due process rights otherwise provided to practitioners under Article VIII or Article IX or both. In no event shall contracting staff members be entitled to due process rights not afforded to non-contracted staff members under similar circumstances.

3.7 LEAVE OF ABSENCE

3.7-1 Leave Status

(a) A staff member may request a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC, which states the period of time for the leave, which may not exceed the remainder of the current staff appointment. A leave of absence request may be granted by the MEC, subject to such conditions or limitations as the MEC shall determine to be appropriate. During the period of a leave of absence the staff member’s privileges and prerogatives shall not be exercised.

(b) A leave of absence shall occur automatically when the MEC determines that a Practitioner requires treatment for impairment and such is agreed to by the Practitioner. The impaired Practitioner must agree to enroll in a long-term treatment program approved by the MEC.

3.7-2 Termination of Leave

A staff member on a leave of absence from the Medical Staff, which is less than six (6) months, may request to return from leave by providing fifteen (15) days written notice to the CEO. If the leave is for six (6) months or more, sixty (60) days written notice to the CEO is required.

As provided in the above paragraph, the staff member may request reinstatement of his/her privileges and prerogatives by submitting a written notice to that effect to the CEO for transmittal to the MEC. The staff member shall submit a written summary of his/her relevant activities during the leave, if the MEC or the Board so requests. The MEC shall make a recommendation to the Board concerning the reinstatement of the member’s privileges and prerogatives. Thereafter, the procedure provided in Sections 6.4-4 and 6.4-9 shall be followed.

Failure without good cause to request reinstatement or to provide a requested summary of activities as above provided before termination of the leave shall result in automatic termination of staff membership, privileges, and/or prerogatives, without right of hearing or appellate review. A request for staff membership subsequent to termination received from a staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointment.

13
If a staff member Practitioner is denied return from a leave of absence, it shall be considered a suspension and the right to a fair hearing shall apply.

3.8 RESIGNATION

In the event a physician Practitioner wishes to resign from the Medical Staff, he/she shall present in writing to the Chief Executive Officer president of the staff, for transmittal to the Medical Staff President Medical Director, a statement to that effect noting the date of termination. If a physician Practitioner leaves the community or otherwise discontinues practice and does not notify the Medical Director Chief Executive Officer, an effort will be made on behalf of the MEC to reach the physician Practitioner by special notice to determine his/her wishes. If he/she does not respond, termination will be automatic thirty (30) days after the special notice has been sent. The physician Practitioner will be notified of this action with no hearing or appellate rights.
ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be divided into Provisional, Active, and Courtesy the following categories:

4.1 ACTIVE STAFF

4.1-1 Qualifications

The active staff shall consist of Physicians Practitioners who average eight (8) or more practice hours per week for a year, including on-call time, each of whom:

(a) Meet the basic qualifications set forth in Section 3.2-1

(b) Have completed their status as provisional staff members and have been recommended for advancement to active staff status.

(c) Regularly admit patients to, or are otherwise regularly involved in the care of patients at NCHC.

4.1-2 Prerogatives

The prerogatives of an active staff member shall be to:

(a) Exercise of clinical privileges as granted pursuant to Article VI.

(b) Eligibility to hold office, Eligibility to hold Medical Staff office, as defined in Article X Officers.

4.1-3 Responsibilities

The responsibilities of the active staff shall include:

(a) Meet the basic responsibilities set forth in Section 3.3.

(b) Retain responsibility within his/her area of professional competence for the care and supervision of each patient at NCHC for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.

(c) Actively participate in quality/utilization management activities required of the staff, in monitoring new appointees of his/her same profession, in discharging such other functions as may from time to time be required by the MEC.

(d) Attend a minimum of fifty percent (50%) of scheduled Medical Staff meetings.

4.1-4 A majority of the members of the Active Staff shall be licensed Physicians.
4.2 PROVISIONAL STAFF

4.2-1 The Provisional Medical Staff shall consist of Physicians–Practitioners who, following their initial appointment, are being considered for advancement to the Active Medical Staff. The duration of Provisional Medical Staff status shall be for one (1) year from such applicant’s initial appointment to the Medical Staff. During this time, the Provisional Medical Staff Appointee’s performance will be monitored by the Medical Director of the Department in which such individual is assigned to determine eligibility of such Provisional Medical Staff Appointee for appointment to the Active Medical Staff. Reappointments to the Provisional Medical Staff may not exceed one (1) full Medical Staff year, at which time the failure to remove such provisional status shall be deemed a termination of his or her Medical Staff appointment. A Provisional Medical Staff member whose membership is so terminated shall have the rights accorded by the Appointment and Corrective Action Procedures to an Active Medical Staff member who has failed to be reappointed to the Active Medical Staff.

The Provisional Medical Staff shall be appointed to a specific Department and shall be eligible to serve on Medical Staff committees. They shall be ineligible to hold office in the Medical Staff and shall have no voting rights on Medical Staff matters so long as they are a Provisional Medical Staff Appointee. They shall be required to attend Medical Staff meetings.

4.2-2 Before the MEC makes recommendations on the Provisional Medical Staff Appointee’s advancement to the Active Medical Staff, the MEC shall have as a minimum a written report from the appropriate Department Medical Director regarding the rendering of proper patient care. The report shall be based on adequate sampling of records, observation and consultation. The report shall contain an evaluation of both professional and ethical conduct.

4.3 COURTESY STAFF

4.3-1 Qualifications

The courtesy staff shall consist of physicians–Practitioners who:

(a) Practice less than an average of 8 hours per week over a one year period.

(b) Meet the basic qualifications set forth in Section 3.2-1.

4.3-2 Prerogatives

The prerogatives of the courtesy staff member shall be to:

(a) Serve as a member of committees, with the exception of quality review committees.

(b) Courtesy staff members shall not be eligible to vote, except when serving as a member of a committee.
4.3-3 Responsibilities

The responsibilities of the courtesy staff shall include:

(a) Discharge the basic responsibilities specified in Section 3.3.

(b) Retain responsibility within his/her area of professional competence for the care and the supervision of each patient at NCHC for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.

4.4 CONSULTING STAFF

4.4-1 Qualifications

The Consulting Staff will consist of members of the Medical Staff who:

(a) Demonstrate professional ability and expertise and provide services not otherwise available on the Active Staff.

(b) Provide services at NCHC only at the request of active members of the Medical Staff.

(c) Maintain membership to the active medical staff at another Hospital, unless their clinical specialty does not support an active inpatient practice and the Board makes an exception to this requirement.

(d) At each reappointment time, provide quality data and other information to assist in an appropriate assessment of current clinical competence as set forth in NCHC policies for credentialing.

4.4-2 Prerogatives

The prerogatives of the consulting staff member shall be to:

(a) Evaluate and treat (but not admit) patients in conjunction with active members of the Medical Staff.

(c) Consulting staff members shall not be eligible to attend meetings of the Medical Staff and applicable committee meetings or hold Medical Staff office, as defined in Article X Officers.
(a) Discharge the basic responsibilities specified in Section 3.3.
(b) Retain responsibility within his/her area of professional competence for the care and the supervision of each patient at NCHC for whom he/she is providing services.

4.5 IN-TRAINING STAFF RESIDENTS

Residents In-Training Staff shall consist of all Physicians Practitioners who are in recognized training programs under the direction of the faculty of an approved residency or advanced practice provider training program and shall be eligible for Medical Staff committee membership and to participate in Medical Staff committees, conferences, seminars and teaching programs. They shall not be members of the Medical Staff, attend Medical Staff meetings, nor entitled to the rights, privileges, duties, and obligations of staff membership. Residents In-Training Staff will function in accordance with responsibilities and expectations described in the Residency’s training program’s curriculum.

4.5-1 Resident Supervision

To safeguard patient care and to enhance graduate medical education by setting standards for In-Training Staff supervision, the Medical Staff has the following supervision requirements:

(a) Licensed practitioners with appropriate clinical privileges must supervise residents In-Training staff in their patient care responsibilities.

(b) The admitting or attending physician must countersign co-sign all orders written by residents and In-Training Staff who are unlicensed physicians as applicable.

(c) Medical Staff members may write patient care orders on patients who are cared for in part by In-Training staff.

(d) The Director of the Residency Training Program will annually communicate through the Medical Executive Committee, to the governing body of NCHC, a report on the performance of the residents, any identified patient safety issues, the quality of care provided by the residents and the educational needs of the residents.

4.6 LIMITATION OF PREROGATIVES

The prerogatives set forth under each staff category are general in nature and may be subject to limitations by special conditions attached to a physician’s staff appointment recommended by the MEC, through other sections of these Bylaws, the Rules and Regulations of the staff, or by policies of NCHC.

4.7 WAIVER OF QUALIFICATIONS
Any qualifications, requirements, or limitations in this article or any other article of these Bylaws, not required by law or governmental regulations, may be waived in the discretion of the Board, in consultation with the MEC, upon determination that such waiver will serve the best interests of the patients and of NCHC.
ARTICLE V: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

5.1 GENERAL PROCEDURE

The Medical Staff through its Officers shall investigate and consider each application for appointment and reappointment to the staff and each request for modification of staff membership status and shall adopt and transmit recommendations thereon to the Board. The Medical Staff shall perform these same investigations, evaluations and recommendations in connection with any allied health practitioner.

5.2 APPLICATION FOR INITIAL APPOINTMENT

5.2-1 Application Form

Each application for appointment to the staff shall be in writing, and signed by the applicant. All written requests for application forms shall be acted upon promptly, and a copy of the staff Bylaws, Rules and Regulations and policies shall be furnished to each such person.

5.2-2 Content

The application form shall include such provisions as are necessary to secure information useful for evaluation of the applicant. In addition the form shall include a statement that the applicant has been furnished a copy of the Bylaws, Rules and Regulations and policies of the Medical Staff, and that he/she agrees to be bound by the terms thereof during the time the application is under consideration and, if staff appointment is granted, while a member of the staff.

5.2-3 Application Processing Fee

The Board may establish an application processing fee in consultation with the MEC.

5.2-4 Pre Application Procedure

The Board in consultation with the MEC may have developed a pre-application procedure for initial applicants. Such shall be a The screening process will determine if the applicant meets the Board’s qualifications for Medical Staff membership, or if there are reasons apart from the qualifications for membership (e.g., inability of NCHC to accommodate a particular subspecialty) which would result in an inability to appoint the applicant. No application for appointment shall be provided to a Practitioner, nor shall an application be accepted from a proposed applicant, if NCHC CEO or Board of Directors determines based on information from a pre-application questionnaire or any other source that:

(a) NCHC does not have the ability to provide adequate facilities or services for the applicant or the patients to be treated by the prospective applicant.

(b) The prospective applicant has interests or activities that are inconsistent with the needs, mission, operations and plans of NCHC and the communities it serves, including any medical staff development plan.
(c) NCHC has contracted with an individual or group to provide the clinical services sought by the prospective applicant on an exclusive basis, and the prospective applicant will not be associated with the individual or contracted group.

(d) The prospective applicant has been excluded from participation in Medicare or Medicaid.

(e) The prospective applicant does not meet the requirements relating to licensure and registration, professional liability insurance, board certification, or reapplication after adverse decision or resignation while under investigation or to avoid an investigation.

(f) The prospective applicant is not a type of Allied Health Care Professional Practitioner approved by the Board of Directors to provide patient care services in NCHC.

(g) The Practitioner does not have a valid unrestricted state license, or is subject to any form of counseling, monitoring, supervision, educational requirement or any other ongoing review, condition, requirement or restriction of any kind.

(h) The Practitioner has been convicted of a felony or convicted of a misdemeanor related to the Practitioner’s fitness to practice medicine.

(i) The prospective applicant has provided materially false or misleading information on any pre-application questionnaire or in connection with any pre-application review process. No application for reappointment shall be provided to a Practitioner who is currently a member of the Medical Staff or holds clinical privileges if the Practitioner has not provided requested information or documents or not responded to requests for comments concerning peer review or quality improvement matters or the Practitioner’s qualification for Medical Staff membership and privileges, provided the staff member has been notified in writing of the requested information and has had a reasonable opportunity to respond [has not responded within thirty (30) calendar days].

(j) Any other reason that is not related to the qualifications of any potential applicant.

The applicant or prospective applicant shall be advised of the information relied on as grounds for not providing an application and the applicant or prospective applicant shall have a reasonable opportunity to submit information or evidence that the information relied on is not accurate. No individual shall be entitled to a hearing or any other procedural rights as a result of a refusal by NCHC to provide the individual an application form for initial appointment or reappointment.

5.2-5 Application Form
Once the completed pre-application form indicating that applicant meets the minimum criteria has been returned, the receipt of this pre-application form shall be logged in the office of the CEO and the requesting individual shall be sent a letter enclosing the appropriate application form, supplemental application which should be returned in a separately sealed envelope and a copy of these Medical Staff Bylaws, as well as the Appointment Procedure. If the completed pre-application form indicates that the requesting individual does not meet the minimum criteria, the individual shall be notified. The application form shall include, but not be limited to, the following:

(a) Qualifications. Detailed information concerning applicant’s credentials.

(b) Location of Practice. The geographic location of applicant’s practice.

(c) Requests. Specific requests stating the appointment category and clinical privileges for which applicant wishes to be considered.

(d) References. The names and current addresses of at least three active Practitioners who have had significant work experience with applicant and observed his or her professional performance in the recent past and who can provide reliable, non-confidential information as to applicant’s training, clinical experience and ability, ethical character, ability to work with others and other qualifications for staff appointment.

(e) Institutional Affiliations. The names and complete addresses of the chairpersons of each department of any and all hospitals or other institutions at which the applicant has worked or trained (i.e., the individuals who served as chairpersons at the time the applicant worked in the particular department).

(f) Revocation of Privileges. Information as to whether applicant’s staff appointment and/or clinical privileges have ever been terminated (whether voluntarily or involuntarily), denied, revoked, suspended, reduced or not renewed at any healthcare entity, and whether any proceeding is pending or has been instituted which, if decided adversely to applicant, would result in any of the foregoing.

(g) Withdrawal of Application. Information as to whether applicant has ever withdrawn his or her application for appointment, reappointment or clinical privileges, or resigned from a Medical Staff before final decision by a healthcare entity’s governing body.

(h) Professional Sanctions. Information as to whether any of the following have ever been suspended, revoked or denied, restricted or terminated (whether voluntary or involuntary) and whether any proceeding is pending or has been instituted which, if decided adversely to applicant, would result in any of the following being suspended, revoked or denied restricted or terminated: (1) licensure or registration with any local, state or federal agency or body to practice his or her profession; (2) appointment or fellowship in a local, state or national professional
organization; (3) any specialty board certification; or (4) applicant’s narcotics registration certificate.

(i) Professional Liability Insurance. Information documenting that applicant carries professional liability insurance coverage in an amount at least equal to the minimum amount of coverage required by NCHC for the privileges requested and information as to applicant’s malpractice claims history and experience and applicant’s involvement in any professional liability actions (including out-of-court settlements) during the past five years, including a consent to the release of information by his or her present and any past insurance carriers and a waiver of any privilege relating thereto.

(j) Health Status. Information on the applicant’s physical and mental health, in the manner and to the extent permitted by applicable laws and regulations.

(k) Criminal Charges. Information as to whether the applicant has ever been named as a defendant and/or convicted in a criminal action and details about any such instances.

(l) Citizenship. Information on the citizenship and visa status of the applicant.

(m) Participation in Reimbursement Programs. Information regarding whether the applicant has ever been sanctioned by, or excluded or suspended from participation in Medicare, Medicaid or any other governmental reimbursement programs.

(n) Other Information. Such other information as the Board of Directors or MEC may require.

(o) Pledge of Patient Care. A statement whereby applicant pledges to provide or arrange for the provision of continuous care for his or her patients if granted staff appointment and clinical privileges.

(p) Acknowledgment. A statement that applicant has received and read the Medical Staff Bylaws, appointment procedure and the Rules and Regulations of the Medical Staff and (1) if granted staff appointment and/or clinical privileges, agrees to be bound by the terms of such documents, and (2) without regard to whether or not the application is granted, agrees to be bound by the terms thereof in all matters relating to consideration of the application.

5.3 EFFECTS OF APPLICATION

By applying for appointment to the Medical Staff, the applicant:

5.3-1 Signifies his/her willingness to appear for interviews in regard to his/her application.
5.3-2 Authorizes NCHC representatives to consult with others who have been associated with him/her and/or may have information bearing on his/her competence and qualifications.

5.3-3 Consents to the inspection by NCHC representatives of all records and documents that may be material to an evaluation of his/her interpersonal and professional qualifications and ability to carry out the clinical privileges he/she requests as well as of his/her ethical qualifications for staff membership.

5.3-4 Releases from any liability all NCHC representatives for acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials.

5.3-5 Releases from all liability all individuals and organizations who provide information, including otherwise privileged or confidential information to NCHC representatives in good faith and without malice concerning the applicant’s ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges.

5.3-6 Pledges to maintain an ethical practice and provide continuous care to his/her patients.

5.3-7 Agrees that any lawsuit brought by the applicant against an individual or organization providing information to a NCHC representative, or against a NCHC representative shall be brought in a court, federal or state, in the state in which the defendant resides or is located.

For purposes of this Section, the term “NCHC Representative” includes the members of the Board of Directors, all Officers, employees, and agents of NCHC, and all members and Officers of the Medical Staff, its departments and committees, and any outside reviewers, who have responsibility for collecting, providing or evaluating information concerning the applicant’s credentials or making recommendations or acting on any application for Medical Staff membership or clinical privileges, the Board, its directors and committees, the CEO or designee, all Medical Staff members, Divisions and committees which have responsibility for collecting or evaluating the applicant’s credentials or acting upon his/her application, and any authorized representative of any of the foregoing.

5.3-8 Agrees to maintain professional liability insurance providing coverage for the entire time the member has privileges at NCHC with an insurer approved by NCHC Board of Directors the CEO in no less than the minimum amount and in such form as may be required from time to time by the Board of Directors, or provide such other evidence of financial responsibility as the Board of Directors may approve.

5.3-9 Acknowledges that any material misstatement or omission on any application, or made at any time during the appointment or reappointment process, or after medical staff membership and/or clinical privileges have been granted, shall be grounds for immediate denial of the application for appointment or
reappointment, or summary suspension and termination of Medical Staff membership and clinical privileges if the misstatement or omission is discovered after the Practitioner is appointed or reappointed.

5.3-10 Acknowledges that the failure to provide complete and accurate information in connection with any investigation concerning the Practitioner’s Medical Staff membership, or clinical privileges, shall be grounds for immediate suspension and termination of Medical Staff membership and clinical privileges.

5.3-11 Absolutely and unconditionally releases from any and all liability NCHC and all NCHC Representatives for all actions performed in connection with providing, obtaining or reviewing information and evaluating or making recommendations or decisions concerning the applicant and the applicant’s credentials.

5.3-12 Absolutely and unconditionally releases from any liability all individuals and organizations who provide information to NCHC and NCHC Representatives, including otherwise privileged or confidential information, relating to the applicant’s ability, background, conduct, professional ethics, character, physical and mental health, emotional stability, and other matters relating to the applicant’s qualifications for staff appointment and clinical privileges.

5.3-13 Authorizes and consents to NCHC, its Officers, agents employees Medical Staff members and its representatives providing other hospitals, medical associations, licensing boards, the National Practitioner Data Bank and other health care organizations concerned with provider performance, conduct, and the quality, appropriateness, and efficiency of patient care, with any information or opinions related to such matters which NCHC or any of its Officers, agents, employees Medical Staff members or representatives may have concerning the Practitioner, and absolutely and unconditionally releases NCHC and its Officers, agents employees, Medical Staff members and representatives from any and all liability for providing such information.

5.3-14 Agrees to provide, upon request by the CMO, Medical Director and/or Medical Executive CommitteeMEC, access to and copies of the Practitioner’s office charts and records relating to the treatment of patients who have been treated by the Practitioner in NCHC or any related facility if deemed necessary for the review of the Practitioner’s professional activities and current clinical competence.

5.3-15 Agrees to immediately notify the CEO in writing of any change in the Practitioner’s home or office addresses or telephone numbers so that NCHC has current addresses and telephone numbers at all times. The Practitioner further agrees that any notice delivered to the home or office address of the Practitioner which is on file in the CEO shall be conclusively deemed to have been received by the Practitioner. Any notice sent by regular mail shall be conclusively deemed to have been received on the second business day after the date the notice was mailed.

5.3-16 Agrees to submit any reasonable evidence of current health status which may be reasonably requested by the DepartmentProgram Medical Director CMO or the Medical Staff Executive CommitteeMEC, and to submit to such mental or
physical examination, including providing blood, urine, or other samples, as the Medical Staff Executive Committee (MEC) might require at any time and for any reason, including random, unannounced drug screens without cause.

5.3-17 Acknowledges that a practitioner who fails or refuses to provide any requested evidence of current health status, including providing blood, urine or other samples for testing for drug or alcohol use, shall be deemed to be no longer qualified for medical staff membership and clinical privilege, in which event the medical staff membership and clinical privileges shall be automatically terminated for administrative reasons and the practitioner shall not be entitled to a hearing.

5.3-18 Agrees that if at any time, an adverse ruling is made or action taken with respect to the practitioner's membership, staff status, and/or clinical privileges, the applicant shall be required to exhaust all remedies afforded by these Bylaws and the Fair Hearing and Appellate Review Plan, before resorting to formal legal action.

5.3-19 Agrees to notify the Department/Program Medical Director (CMO, MEC and CEO NCHC President/CEO) immediately in writing upon learning that the applicant or Practitioner:

1. Is the subject of a complaint or investigation by, or has been charged with misconduct by, any licensing or disciplinary authority of any state or federal agency or professional organization;

2. Has been charged with a misdemeanor, excluding traffic offenses, or a felony;

3. Has been notified that their professional liability insurance carrier intends to cancel, not renew, restrict or impose any conditions or deductibles on their professional liability insurance for any reason related to the Practitioner's clinical practices or claims history;

4. Has been notified of the loss of their DEA number or exclusion from the Medicaid or Medicare program, is under investigation by Medicaid or Medicare, or has been subjected to any fine, penalty or sanction by Medicare or Medicaid;

5. Is or has been the subject of any actual or proposed disciplinary action, including any modification of clinical privileges, restriction of clinical privileges, or placing of conditions on clinical privileges (including any form of monitoring or review), by any other hospital or health care facility or organization;

6. Is or has been the subject of any actual or proposed disciplinary action by any regulator, licensing or disciplinary authority or professional organization, including any form of reprimand or sanction;

7. Has voluntarily relinquished, agreed not to exercise, or involuntarily lost any licensure, certification, registration, medical staff membership or clinical privileges at any healthcare facility;
(8) Has entered into a contract or agreement with any impaired physicians committee or similar entity as a result of any substance abuse or other disease or disorder; or

(9) Has developed any mental or physical illness or sustained any injury which could have an effect on the exercise of the individual’s clinical privileges.

5.4 PROCESSING THE APPLICATION

5.4-1 Applicant’s Burden

The applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, and physical and mental health status, and of resolving any doubts about these or any of the other basic qualifications specified in Section 3.2-1. The application shall not be considered complete until (1) all blanks and spaces are completed on the application form; (2) verification of all information has been completed; (3) all required supporting information has been provided by the application; and (4) information from references, past hospitals and other external sources has been received.

5.4-2 Verification of Information

The applicant shall submit a completed application to the CEO or designee, who shall, within thirty (30) days, seek to collect or verify the references, licensure, and other qualification evidence submitted. The CEO shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant’s obligation to obtain the information. When collection and verification is accomplished the CEO or designee shall transmit the application and all supporting materials to the MEC. The MEC may also conduct an interview of the applicant.

5.4-3 MEC Action

At its next regular meeting, the MEC shall consider the application and such other relevant information available to it. The committee shall then forward to the Board of Directors a written report and recommendations on the prescribed form as to staff appointment and, if appointment is recommended, as to staff category, and any special conditions to be attached to the appointment. The committee may also defer action on the application pursuant to Section 5.4-4(a). The MEC may defer action and request evaluation of the applicant through the Medical Staff process in instances where there is doubt about an applicant’s ability to perform the requested privileges. The reasons for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the committee, all minority views shall also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

5.4-4 Effect of MEC Action
(a) Deferral: Action by the MEC to defer the application for further consideration must be followed up within thirty (30) days with a stated recommendation from the MEC for provisional appointment with specified clinical privileges, or for rejection for staff membership.

(b) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, it shall promptly be forwarded to the Board together with all supporting documentation. For the purposes of this Section 5.4-4(b) “all supporting documentation” includes the application form and its accompanying information.

(c) Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the CEO shall within thirty (30) days inform the Practitioner by special notice and he/she shall be entitled to the procedural rights as provided in Article VIII and in the Fair Hearing Plan. For the purpose of this Section 5.4-4(c) an “adverse recommendation” by the MEC is defined in the Fair Hearing Plan.

5.4-5 Board Action

(a) On Favorable MEC Recommendation: The Board of Directors shall, in whole or in part, adopt or reject a favorable recommendation of the MEC or refer the recommendation back to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the Board’s action is adverse to the applicant as defined in the Fair Hearing Plan, the CEO shall within thirty (30) days so inform the applicant by special notice and he/she shall be entitled to the procedural rights as provided in Article IX and in the Fair Hearing Plan.

(b) Without Benefit of MEC Recommendation: If the Board does not receive a MEC recommendation within the time period specified in Section 5.4-3, it may take action on its own initiative. If such action is favorable, it shall become effective as the final decision of the Board. If such action is adverse, as defined in the Fair Hearing Plan, the CEO shall promptly so inform the applicant by special notice and he/she shall be entitled to the procedural rights as provided in Article VIII and in the Fair Hearing Plan.

(c) Procedural Rights: In the case of an adverse MEC recommendation pursuant to Section 5.4-4(c) or an adverse Board decision pursuant to Section 5.4-5(a) or (b), the Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Article VIII and in the Fair Hearing Plan Article IX. Action thus taken shall be the conclusive decision of the Board except that the Board may defer final determination by referring the matter back for further recommendation. Any such referral back shall state the reasons, therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new
evident in the matter, if any, the Board shall make a final decision either to appoint the applicant to the staff or to reject him/her for staff membership.

5.4-6 Conflict Resolution

Whenever the Board’s proposed decision will be contrary to the MEC’s recommendation, the Board shall submit the matter to a joint conference of equal numbers of Medical Staff and Board members for review and recommendation before making its final decision and giving notice of final decision required by Section 5.4-7.

5.4-7 Notice of Final Decision

(a) Notice of the Board’s final decision shall be given within thirty (30) days through the CEO, to the MEC, and to the applicant by means of Special Notice.

(b) A decision and notice to appoint shall include:

(1) The staff category to which the applicant is appointed;

(2) The clinical privileges he/she may exercise; and

(3) Any special conditions attached to the appointment.

5.4-8 Reapplication after Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of one (1) year. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the staff or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.

5.4-9 Time Period for Processing

Applications for staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and except for good cause, shall be processed within the time periods specified in this Section. The staff upon completing the information collection and verification tasks, usually within thirty (30) days after receiving the application. The MEC shall review the application and endeavor to make its recommendation to the Board at its next meeting after receiving the application. The Board or the appropriate committee thereof shall then endeavor to take the final action on the application at its next regular meeting. The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the Practitioner to have the application processed within those periods.
5.5 REAPPOINTMENT PROCESS

5.5-1 Information Form for Reappointment

The CEO or designee shall, at least 120 days prior to the expiration date of the present staff appointment of each Medical Staff member, provide such staff member with reappointment forms for use in considering his/her reappointment. Each staff member who desires reappointment shall, at least ninety (90) days prior to such expiration date, send his/her reappointment forms to the CEO or designee. Failure without good cause to so return the form shall be deemed a voluntary resignation from the staff and shall result in automatic termination of membership at the expiration of the member’s current term.

5.5-2 Verification of Information

The CEO or designee shall, within thirty (30) days seek to collect or verify the additional interval information regarding the staff member’s professional activities, performance and conduct at NCHC. The CEO or designee shall promptly notify the staff member of any problems in obtaining the information required. The staff member shall then have the same burden of producing adequate information and resolving doubts as provided in Section 5.4-1. When collection and verification are accomplished, the CEO or designee shall transmit the information form and supporting materials to the Medical Director of each Department/Program, Chief Medical Officer in which the staff member requests privileges and to the MEC.

5.5-3 MEC Action

The MEC shall review each information form and all other relevant information available to it and shall, on the prescribed form, transmit to the Board its report and recommendation that appointment be either renewed, renewed with modified staff category, Department affiliation and/or clinical privileges, or terminated. The committee may also defer action. Each such report shall satisfy the requirements of Section 5.5-5. Any minority views shall also be reduced to writing and transmitted with the majority report.

5.5-4 Final Processing and Board Action

Thereafter, the procedure provided in Sections 5.4-4 through 5.4-9 shall be followed. For purposes of reappointment, the terms “applicant” and “appointments” as used in those Sections shall be read, respectively, as “staff member” and “reappointment.”

5.5-5 Basis for Recommendation

Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon such member’s professional ability and clinical judgment in the treatment of patients, his/her professional ethics, his/her discharge of staff obligations, his/her health status, his/her compliance with the Medical Staff Bylaws, Rules and Regulations
and policies and other matters bearing on his/her ability and willingness to contribute to quality patient care at NCHC.

5.5-6 Time Periods for Processing

The time periods specified herein are to guide the acting parties in accomplishing their tasks. If a reappointment application has not been returned timely, or sufficiently complete to enable processing, or the required processing, peer review and approval has not been completed by the expiration date of the reappointment, the staff member's appointment will expire at the end of the current appointment term. No appointment to be the Medical Staff may exceed two (2) years.

5.6 REQUESTS FOR MODIFICATIONS OF TERMS OF APPOINTMENTS

5.6-1 Request Status Modification

A staff member may, either in connection with reappointment or at any other time, request modification of his/her staff category, specialty or division assignment, or clinical privileges by submitting a written application to the CEO on the prescribed form. Such application shall be processed in substantially the same manner as provided in Section 5.5 for reappointment.

5.6-2 Request New Privileges

The applicant presents in writing the described new privilege being sought. This is directed to the MEC. This application shall be accompanied by a certificate or other documents from a recognized training facility which grants AMA Category I CME credits, or credits deemed appropriate by the MEC in the absence of a recognized program.

During the performance of the requested privilege the performance is assessed in one of two methods:

(a) By a Medical Staff member who has experience in this technique; or

(b) By outcome assessment if no Medical Staff member has experience in this technique.

The appropriate preparation by the privilege seeking applicant will be determined by the specialty or division of which he/she is a member. Based on current literature no less than five (5) cases should be assessed before the specialty representative will sign off at the conclusion of "a" or "b". Then permanent privileges can be recommended to the MEC.
ARTICLE VI: DETERMINATION OF CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

Every Practitioner or other professional providing direct clinical services at NCHC by virtue of Medical Staff membership or otherwise shall, in connection with such practice and except as otherwise provided in Section 6.4, be entitled to exercise only those clinical privileges or specified services specifically granted to him/her by the Board.

6.2 DELINEATION OF PRIVILEGES IN GENERAL

6.2-1 Requests

Each applicant for appointment or reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a staff member pursuant to Section 5.6 for a modification of privileges must be supported by documentation of additional training and/or experience supportive of the request.

6.2-2 Basis for Privilege Determination

Requests for clinical privileges shall be evaluated on the basis of the Practitioner’s education, training, experience and demonstrated ability and judgment. The basis for privilege determination to be made in connection with periodic reappointment or otherwise shall include observed clinical performance and the documented results of quality review and evaluation activities required by these Bylaws to be conducted at NCHC. Privilege determination shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a Practitioner exercises clinical privileges. This information shall be added to and maintained in the staff file established for a staff member.

6.2-3 Procedure

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article V.

6.3 PRIVILEGES

6.3-1 A Physician applicant for Medical Staff appointment seeking privileges must have completed the number of years of residency sufficient to satisfy the specialty board requirements of the American Board of Medical Specialties or the American Osteopathic Association for eligibility to become certified, in effect at the date application for staff appointment is requested to be effective.

6.4 INTERIM, CASE LIMITED, TIME LIMITED OR TEMPORARY PRIVILEGES

6.4-1 Circumstances

Upon the written concurrence of the Medical Director/CMO (or designee), the CEO (or designee) may grant interim privileges in the following circumstances:
(a) Interim Privileges

Pendency of Application: Class I privileges may be granted for thirty (30) days, only if the applicant’s credentials file is complete and ready to be forwarded to the MEC. An extension not to exceed ninety (90) days may be granted upon the recommendation of the Medical Director/CMO. Requests for Class IV privileges, accompanied with documentation of training and experience will be reviewed by the CEO and Medical Director/CMO prior to being granted as interim privileges. In exercising such privileges the applicant shall act under the supervision of the Medical Director/CMO and in accordance with the conditions specified in Section 6.2.

(b) Case Limited Privileges

Care of Specific Patients: Upon receipt of a written request for specific case limited privileges an appropriately licensed Practitioner of documented competence who is not an applicant for membership may be granted such privileges for the care of one or more specific patients. Such privileges shall be restricted to the treatment of not more than five (5) patients in any one year by any Practitioner, after which the Practitioner shall be required to apply for membership on the Medical Staff as Consulting Staff before being allowed to attend to additional patients.

(c) Temporary Privileges

Upon receipt of a written request an appropriately licensed Practitioner may, without applying for membership on the staff, be granted temporary privileges for an initial period of thirty (30) days. Such privileges may be extended for a period of time not to exceed ninety (90) days.

(d) Time Limited Privileges

As defined by contract or employment agreement.

6.4-2 Conditions

Interim, case limited, time limited, or temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting Practitioner’s qualifications, ability and judgment to exercise the privileges requested, and only after the Practitioner has provided evidence of professional liability insurance coverage in the amount consistent with Wisconsin state statutes or other evidence of financial responsibility in accordance with the Medical Staff Bylaws, Section 3.2-1(c). SpecialBylaws. Special requirements of consultation and reporting may be imposed by the Medical Director/CMO. Before interim, case limited, time limited, or temporary privileges are granted, the Practitioner must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, and the Rules and Regulations.
and that he/she agrees to be bound by the terms thereof in all matters relating to his/her privileges.

6.4-3 Termination

On the discovery of any information or the occurrence of any event of a nature which raises question about a Practitioner’s professional qualifications or ability to exercise any or all of the privileges granted, the CEO, after consultation with the Medical DirectorCMO, may terminate any or all of such Practitioner’s privileges, provided that when the life or well-being of a patient is determined to be endangered by continued treatment by the Practitioner, the termination may be effected by any person entitled to impose summary suspension action under the Medical Staff Bylaws, Article VII. In the event of any such termination, the Practitioner’s patients receiving care through NCHC shall be assigned to another Practitioner by the Medical DirectorCMO. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner. The terminated Practitioner shall confer with the substitute Practitioner to the extent necessary to safeguard the patient.

6.4-4 Rights of the Practitioner

A Practitioner shall not be entitled to the procedural rights afforded by the Medical Staff Bylaws, Article VIII or Article IX because his/her request for interim, case limited, time limited, or temporary privileges is refused or because all or any portion of such privileges are terminated or suspended.

6.5 EMERGENCY PRIVILEGES

For the purposes of this Section, an “emergency” is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any Practitioner, to the degree permitted by his/her license and regardless of staff status, or clinical privileges, shall be permitted to do, and shall be assisted by NCHC personnel in doing everything possible to save the life of a patient or to save a patient from serious harm. A Practitioner utilizing emergency privileges shall promptly provide the Medical Executive Committee in writing a statement explaining the circumstances giving rise to the emergency.

6.6 DISASTER PRIVILEGES

For the purpose of this section a “disaster” is defined as any officially declared emergency whether it is local, state or national, and that creates healthcare demands that exceed the capabilities of NCHC and/or the Medical Staff. A Practitioner providing patient care in the event of a disaster must be granted privileges by the Chief Executive Officer or designee, prior to providing patient care. Such privileges shall be valid only for the duration of the disaster and shall automatically terminate at the end of needed services.

6.7 RIGHTS ASSOCIATED WITH TEMPORARY, INTERIM, CASE LIMITED, TEMPORARY, EMERGENCY AND DISASTER PRIVILEGES
The granting of temporary, interim, case limited, temporary, emergency or disaster privileges shall not confer Medical Staff membership on any Practitioner, nor shall Practitioners holding such privileges be considered to be members of the medical staff or have any of the rights provided to Medical Staff members by these Bylaws or otherwise except as expressly stated herein. The refusal to grant, or termination or withdrawal of, temporary, locum tenens, emergency or disaster privileges shall not entitle the Practitioner involved to a hearing or any other procedural rights or review unless the action is reportable to the National Practitioner Data Bank.
ARTICLE VII: CORRECTIVE ACTION

7.1 PROCEDURE

7.1-1 Criteria for Initiation

Whenever the activities or professional conduct of any Practitioner with clinical privileges are, or are reasonably likely to be, detrimental to patient safety or to the delivery of quality care, or if there is doubt about a Practitioner’s ability to perform within the privileges granted, corrective action against such Practitioner will be initiated within five (5) days by any Officer of the Medical Staff, by the leadership of a division or standing committee of the Medical Staff, the CMO, a Medical Director, by the MEC, by the CEO, or by the Board.

7.1-2 Requests and Notices

All requests for corrective action shall be in writing, submitted to the MEC, and supported by reference to the specific conduct or activities which constitute the grounds for the request. The President of the Medical Staff shall promptly notify the CEO in writing of all requests for corrective action received by the committee and shall continue to keep the CEO fully informed of all action taken in connection therewith.

7.1-3 Investigation

After consideration of the request, the MEC shall either reject the request and report the reasons for its decision to the CEO, or forward the request either to the program/department head in which the questioned activities or conduct occurred, or to an ad hoc committee appointed by the President of the Medical Staff to conduct an investigation. The staff member who is under investigation may be invited to appear before the investigating committee. Any such appearance shall be informal in nature and not constitute a hearing. As soon as possible and in any event no longer than fifteen (15) days after the receipt of the request, the CMO, the Program/Department Medical Director, or the investigating committee shall forward a written report of the investigation to the MEC.

7.1-4 MEC Action

As soon as possible and in any event no longer than seven (7) days following receipt of the report of the investigation, the Medical Executive Committee shall take action upon the request. Such action may include, without limitation:

(a) Rejecting the request for corrective action.
(b) Issuing a warning, a letter of admonition, or a letter of reprimand.
(c) Recommending terms of probation or requirements of consultation.
(d) Recommending reduction, suspension, or revocation of clinical privileges.
(e) Recommending reduction of staff category or limitation of any staff prerogatives directly related to patient care.

(f) Recommending suspension or revocation of staff appointment.

7.1-5 Procedural Rights

Any action by the Medical Executive Committee pursuant to Section 7.1-4(c); 7.1-4(d); 7.1-4(e); or 7.1-4(f), or any combination of such actions, shall entitle the Practitioner to the procedural rights as provided in Article VIII, and the matter shall be processed in accordance with the provisions of Article IX.

7.1-6 Other Action

If the Medical Executive Committee’s recommended action is as provided in Section 7.1-4(a) or 7.1-4(b), such recommendation, together with all supporting documentation, shall be transmitted to the Board. Thereafter, the procedure to be followed shall be as provided in sections 5.4-5 through 5.4-7 as applicable.

7.2 PRECAUTIONARY SUSPENSION

7.2-1 Criteria for Initiation

The President of the Medical Staff, the Administrator On-Call, the CEO, CMO or the executive committee of either the Medical Staff or of the Board shall have the authority to suspend the Medical Staff membership status or all or any portion of the clinical privileges of a Practitioner, whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual.

Such precautionary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended individual but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility to the situation that caused the suspension.

The President of the Medical Staff, Administrator On-Call, CEO, CMO or executive committee of either the Medical Staff or the Board will place a request for corrective action, followed by investigation as appropriate, as outlined in 7.1.3.

7.2-2 MEC Action

As soon as possible and in any event no longer than five (5) days after such precautionary suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may modify, continue or terminate the terms of the precautionary suspension.

7.2-3 Procedural Rights

Unless the MEC recommends immediate termination of the suspension and cessation of all further corrective action, the staff member shall be entitled to the
procedural rights as provided in Article XIII, and the matter shall be processed in accordance with the provisions of Article IX. The terms of the precautionary suspension as sustained by the MEC shall remain in effect pending a final decision by the Board.

If the MEC recommends termination of the suspension and cessation of all further corrective action, the suspension shall remain in effect until the Board has reviewed the recommendation and taken action to terminate the suspension. If the Board, after such review, decides to continue the suspension, the staff member shall be entitled to the procedural rights provided in Article VIII, and the matter shall be processed in accordance with the provisions of Article IX.

If the MEC recommends less restrictive terms of suspension, the original suspension shall remain in effect until the Board has reviewed the recommendation and taken action to terminate the suspension. If the Board, after such review, decides to continue the suspension, either original or as modified; the staff member shall be entitled to the procedural rights as provided in Article VIII, and the matter shall be processed in accordance with the provisions of Article IX.

7.3 AUTOMATIC SUSPENSION

7.3-1 License

If a staff member’s license to practice his/her profession in the State of Wisconsin is revoked or suspended, or the licensing agency imposes limitation of practice on the Practitioner, such staff member shall immediately and automatically be suspended from practicing at NCHC.

7.3-2 A Medical Staff appointee fails to report to NCHC any restriction or condition imposed on or probation with respect to his or her license by the Licensure Board within thirty (30) days of the imposition of such restriction, condition or probation.

7.3-3 A Medical Staff appointee who has been requested to appear at a meeting of any committee of the Medical Staff or healthcare entity in order to discuss proposed corrective action and fails to appear.

7.3-4 Drug Enforcement Administration (DEA) Number

A Practitioner whose DEA number is revoked, suspended or is voluntarily relinquished shall immediately and automatically be divested of his/her right to prescribe medications covered by such number. Within seven (7) days of such automatic suspension, the MEC shall convene to review and consider the facts under which the DEA number was revoked, suspended, or relinquished. The MEC may then recommend such further corrective action as appropriate to the facts disclosed in its investigation.

7.3-5 Failure to Satisfy Special Appearance Requirements
A Medical Staff appointee fails to report to NCHC any restriction or condition imposed on or probation with respect to his or her license by the Licensure Board within thirty (30) days of the imposition of such restriction, condition or probation.

7.3-6 Medical Records

An automatic suspension shall be imposed for failure to complete medical records in a timely fashion or in the manner required under the Rules and Regulations of the Medical Staff or policies and procedures of NCHC after receiving a written warning of non-compliance.

7.3-7 Failure to Practice Actively

At the time of reappointment when a member of the staff with admitting privileges has not admitted a patient to NCHC or has not provided professional services to any patient at NCHC for two (2) years, he/she shall be given special notice that in thirty (30) days his/her staff appointment will be automatically reviewed by the MEC unless he/she either admits a patient to NCHC or provides services to a patient at NCHC during that thirty (30) day period.

7.3-8 Impairment

When a Practitioner has been judged to be impaired by the MEC and refuses appropriate treatment (to be determined by the MEC), the CEO and/or President of the Medical Staff, or their designees, after consultation may initiate immediate and automatic suspension. The Practitioner is afforded all rights of appeal as provided by the Medical Staff Bylaws.

7.3-9 Exclusion or Withdrawal from Federal Health Care Programs

A staff member who is excluded or who voluntarily withdraws from participation in the Medicare, Medicaid, or other federal health care programs, shall be immediately and automatically divested of his/her right to treat, care for, or order studies for any beneficiary of such programs. Within seven (7) days of such automatic suspension, the MEC shall convene and consider the facts under which exclusion or withdrawal occurred. The MEC may then recommend such further corrective action as appropriate to the facts disclosed in the investigation.

7.3-10 A Medical Staff appointee who has his or her right to prescribe or administer any controlled substances revoked or suspended in any manner.

7.3-11 A Medical Staff appointee who has his or her name placed on any list of providers excluded from billing Medicare, Medicaid, or any other federal or state healthcare program.

7.3-12 A Medical Staff appointee who fails to maintain the minimum professional liability insurance coverage established from time to time by NCHC, as required by the Medical Staff Bylaws, unless the Medical Staff Appointee has timely requested a waiver or reduction of such coverage and is awaiting final action on such request.
7.3-13 A Medical Staff appointee whose contractual arrangement with healthcare entity is terminated pursuant to such contract.

7.3-14 Procedural Rights

A staff member under automatic suspension by operation of Section 7.3-4 shall be entitled to the procedural rights provided in Article VIII and Article IX.

A staff member whose appointment or privileges has been automatically suspended or revoked by operation of Sections 7.3-1, 7.3-2, 7.3-3 and 7.3-4 may request a hearing by a committee appointed by the Board to present evidence to establish that the automatic suspension or revocation was invoked in error. The hearing and any subsequent proceedings shall be conducted in accordance with provisions of Article IX. The invoking of an automatic suspension does not preclude initiation of corrective action pursuant to Section 7.1.

7.4 SUMMARY ACTION

The Medical Executive Committee (MEC), the Department/Program Medical Director (CMO), and the President of the Medical Staff or CEO may summarily suspend, restrict or place conditions or requirements on all or any portion of the clinical privileges of any Practitioner in accordance with this section. Any such suspension, restrictions, conditions or requirements shall be effective immediately and shall remain in effect until terminated by CEO or the Board of Directors after considering the recommendations of the Medical Executive Committee (MEC). Grounds for imposition of summary suspension, restriction or conditions shall include, but not be limited to, the following:

a. the conduct of a Practitioner creates a reasonable possibility of injury or damage to any patient, employee or person present in NCHC or to NCHC;

b. a Practitioner is charged with the commission of a crime which may relate to the Practitioner’s suitability for Medical Staff membership;

c. a Practitioner engages in or is charged with unlawful or unethical activity related to the practice of medicine or nursing;

d. a Practitioner engages in any dishonest, unprofessional, abusive or inappropriate conduct which is or may be disruptive of NCHC operations and procedures;

e. the Practitioner has had any medical staff membership, clinical privileges, certification, licensure or registration terminated, suspended, restricted, limited, reduced or modified in any way, has resigned from any other medical staff in order to avoid an investigation or proposed action concerning medical staff membership or clinical privileges, or has voluntarily surrendered or agreed not to exercise any clinical privileges while under investigation or to avoid an investigation;

f. it is determined that the Practitioner made a material misstatement or omission on any pre-application or application for appointment or reappointment, or at any time provided incorrect information or otherwise deceived or attempted to deceive or mislead the Medical Staff and/or NCHC;
g. a Practitioner has falsified or inappropriately destroyed or altered any medical record;

h. a Practitioner refuses to submit to evaluation or testing relating to the Practitioner’s mental or physical status, including refusal to submit to any testing related to drug or alcohol use;

i. a Practitioner abandons a patient or wrongfully fails or refuses to provide care to a patient;

j. a Practitioner fails to maintain appropriate malpractice insurance or a current, unrestricted active state license to practice medicine;

k. a Practitioner fails to adhere to the requirements of the NCHC compliance program;

l. a Practitioner fails to comply with the Rules and Regulations of the Medical Staff or any policies and procedures of NCHC;

m. a Practitioner engages in clinical activities outside the scope of the Practitioner’s approved clinical privileges.
ARTICLE VIII: INTERVIEWS, HEARINGS, AND APPELLATE REVIEW

8.1 INTERVIEWS

When the MEC, other relevant committee, or the Board or any appropriate committee thereof receives or is considering initiating an adverse recommendation concerning a Practitioner, the Practitioner may be afforded an interview. The interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The Practitioner shall be informed of the general nature of the circumstances and may present information relevant thereto. A record of such interview shall be made.

8.2 HEARING AND APPELLATE REVIEW

8.2-1 Adverse MEC Recommendation

When any Practitioner receives special notice of an adverse recommendation of the MEC, he/she shall be entitled upon request, to a hearing before an ad hoc committee of the Medical Staff appointed by the President of the staff. Said individuals shall not be in direct economic competition with the physician involved. If the recommendation of the MEC following such hearing is still adverse to the Practitioner, he/she shall then be entitled, upon request, to an appellate review by the Board before a final decision is rendered.

8.2-2 Adverse Board Decision

When any Practitioner receives special notice of an adverse decision by the Board taken either contrary to a favorable recommendation by the MEC under circumstances where no right to a hearing existed, or on the Board's own initiative without benefit of a prior recommendation by the MEC such Practitioner shall be entitled, upon request, to a hearing by an ad hoc hearing committee appointed by the Board. If such hearing does not result in a favorable recommendation, he/she shall then be entitled upon request, to an appellate review by the Board before a final decision is rendered.

8.2-3 Procedure and Process

All hearings and appellate reviews shall be in accordance with the procedure and safeguards set forth in Article IX.

8.2-4 Exceptions

The denial, termination or reduction of temporary privileges or any other actions, except those specified in Article IX, shall not give rise to any right to a hearing or appellate review.

8.3 REMOVAL OF CHIEF MEDICAL OFFICER OR MEDICAL DIRECTOR

8.3-1 General Manner of Removal
Removal from office of the Chief Medical Officer or Medical Director for grounds unrelated to his/her professional clinical capability or to his/her exercise of clinical privileges may be accomplished in accordance with the usual personnel policies of NCHC or the terms of such Officer’s employment agreement, contract, or other arrangements if any. To the extent that the grounds for removal would require a report to the National Practitioner Data Bank relating to competence in performing professional clinical tasks, in supervising the professional activities of Practitioners under his/her direction or in exercising clinical privileges, resolution of the matter shall be in accordance with Articles VIII and IX and the Fair Hearing Plan.

8.3-2 Statement of Grounds

Prior to removal of a Chief Medical Officer or Medical Director, the Board, through the CEO, shall transmit to such Medical Director and to the MEC a written notice of the proposed removal from office together with a statement specifying the grounds for removal. The extent that such grounds explicitly relate to professional clinical capability or to the exercise of clinical privileges, the notice to the Officer whose removal is sought shall take the form of a special notice, and for hearing purposes, the proposed removal shall be deemed equivalent to an adverse recommendation of the MEC. If the stated grounds for dismissal are based solely on nonclinical matters, the procedure specified in Section 8.3-3 shall apply at the discretion of the CEO in consultation with the Officers of the Medical Staff.

8.3-3 Joint Conference Committee

Within thirty (30) days of receipt by the MEC of the notice as provided in Section 8.3-2, a Joint Conference Committee of equal members from the Medical Staff and the Board shall be convened. Up to five (5) Board members shall be selected by the Chair of the Board and up to five (5) Medical Staff members by the President of the Medical Staff.

This Joint Conference Committee shall review the statement of dismissal and conduct such other inquiry as it may deem appropriate for the purpose of rendering an advisory opinion on the categorization of the grounds for removal. The Joint Conference Committee may, but is not required to interview the medical director/Chief Medical Officer or Medical Director. Within ten (10) days of its deliberations, the Joint Conference Committee shall, by written memorandum to the MEC and to the Board, submit its opinion on the matter. The advisory panel’s deliberations shall not be deemed a hearing as that term is used in Section 8.2 and shall not be conducted as such, but a record shall be kept.

8.3-4 Board Decision

After considering the Joint Conference Committee’s opinion, the Board shall make its final decision as to the categorization of the grounds for dismissal. Removal of the Officer shall be effected in the manner appropriate to the Board’s final categorization and consistent with Section 8.3-1.
9.1 SPECIAL DEFINITIONS

For the purpose of this Article, the following definitions shall apply:

9.1-1 APPELLATE REVIEW BODY: means the group designated pursuant to section 9.2 of these Bylaws to hear a request for appellate review properly filed and pursued by a Practitioner.

9.1-2 HEARING COMMITTEE: means the committee appointed pursuant to section 9.4-3 of this plan to hear a request for evidentiary hearing properly filed and pursued by a Practitioner.

9.1-3 PARTIES: means the Practitioner who requested the hearing or appellate review and the body or bodies upon whose adverse action a hearing or appellate review request is predicated.

9.2 RIGHT TO HEARING

Unless waived, an applicant or Medical Staff appointee shall be entitled to a hearing if any professional review body proposes to make a recommendation that any of the following actions (to the extent they are considered to be adversely affecting an applicant or Medical Staff appointee as defined under the Health Care Quality Improvement Act of 1986) be taken with respect to him or her for reasons other than failure to meet minimum objective criteria specified in the Medical Staff Bylaws or Appointment and Corrective Action Procedures:

1. Denial of a completed application for initial appointment of reappointment to the Medical Staff for any reason, except where: (i) the application does not meet the minimum objective requirements set forth in the Medical Staff Bylaws or appointment and corrective action procedures; or (ii) the applicant is requesting clinical privileges in a department, subspecialty or service in which the number of appointees has been limited in accordance with the Medical Staff Bylaws.

2. Summary suspension or termination from the Medical Staff in accordance with the Appointment and Corrective Action Procedures.

3. Revocation or termination of appointment to the Medical Staff, except where continued appointment to the Medical Staff was contingent upon the continuance of a contractual relationship with the healthcare entity.

4. Denial of requested advancement or requested change in Medical Staff category, except for any denial resulting from failure to meet the minimum objective criteria for the requested category.

5. Reduction in Medical Staff category, other than (i) a change from Active Medical Staff to Courtesy Medical Staff for failure to meet any patient care requirements set forth in these Medical Staff Bylaws; (ii) a change from Active Medical Staff to Courtesy Staff for failure to meet the meeting attendance requirements set forth in these Medical Staff Bylaws; or (iii) any other change in category resulting from
a failure to meet the minimum objective criteria for a particular Medical Staff Category.

(6) Denial of requested clinical privileges or requested change in clinical privileges, except where (i) the applicant or Medical Staff appointee is requesting clinical privileges in a department/program or service area in which the number of Medical Staff Appointees has been limited; or (ii) the applicant or Medical Staff appointee fails to meet the minimum objective criteria for the requested privileges.

(7) Reduction in, restriction of, or failure to renew clinical privileges, other than (i) a temporary restriction in accordance with the Appointment and Corrective Action Procedures; or (ii) where the Medical Staff Appointee no longer meets the minimum objective criteria for such privileges.

(8) Revocation or suspension (summary or otherwise) of clinical privileges, other than (i) a temporary suspension as provided by the Appointment and Corrective Action Procedures; or (ii) where the Medical Staff appointee no longer meets the minimum objective criteria for such privileges.

(9) Any other action or recommendation “adversely affecting” (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act of 1986) any applicant or Medical Staff appointee.

9.2-1 When Deemed Adverse

A recommendation or action listed in Section 9.2 shall be deemed adverse action only when it has been:

(a) Recommended by the MEC; or

(b) A suspension continued in effect after review by the MEC and/or the Board; or

(c) Taken by the Board contrary to a favorable recommendation by the MEC under circumstances where no prior right to a hearing existed; or

(d) Taken by the Board on its own initiative without benefit of a prior recommendation by the MEC; or

(e) Imposed automatically.

9.2-2 Actions Not Giving Rise to Hearing Right

A professional review body shall not be deemed to have made a proposal for an adverse recommendation or action, or to have made such a recommendation to or have taken such action, and a hearing right under this Section shall not have arisen in any of the following circumstances:

(a) The appointment of an ad hoc investigation committee;
(b) The conduct of an investigation into any matter;

(c) The restriction or suspension of a Medical Staff appointee’s clinical privileges for a period of no longer than fourteen (14) days while an investigation is pending;

(d) The formulation and presentation of any preliminary report of any ad hoc investigation committee to the CEO, CMO, Medical Director, to the Officers of the Medical Staff Board or any committee of the Board;

(e) The making of a request or issuance of a directive to an applicant or Medical Staff appointee to appear at an interview or conference before the MEC, any ad hoc investigation committee, the CEO, the Board or any other professional review body in connection with any investigation prior to a proposed adverse recommendation or action;

(f) The denial of or refusal to accept an application for initial appointment or reappointment to the Medical Staff (i) where the application is incomplete; (ii) where the application reflects that the applicant does not meet the minimum objective requirements for appointment or reappointment; or (iii) where the applicant is requesting clinical privileges in a department, specialty or service in which the number of Medical Staff appointees has been limited in accordance with the Medical Staff Bylaws;

(g) The denial or revocation of temporary privileges in accordance with the Appointment and Corrective Action Procedures;

(h) The appointment of a newly-appointed Medical Staff appointee to the provisional staff;

(i) Automatic termination as provided by the Appointment and Corrective Action Procedures;

(k) The imposition of supervision or observation on a Medical Staff appointee which supervision or observation does not restrict the clinical privileges of the Medical Staff appointee or the delivery of professional services to patients;

(l) The issuance of a letter of warning, admonition or reprimand;

(m) Corrective counseling;

(n) A recommendation that the Medical Staff appointee be directed to obtain retraining, additional training, or continuing education;

(o) The denial of a request for a waiver or reduction of the required minimum liability insurance coverage as provided in the Medical Staff Bylaws;

(p) Any change in Medical Staff category resulting from the failure of a Medical Staff appointee to meet the minimum objective criteria for a specific category; or
(q) Any recommendation or action not “adversely affecting” (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act of 1986) any applicant or Medical Staff appointee, or which is not based upon a subjective determination of the professional competency or conduct of the applicant or Medical Staff appointee.

9.2-3 Notice of Adverse Recommendation or Action

A Practitioner against whom adverse action defined under Section 9.2 above has been proposed shall be provided within written notice of the proposed adverse action by the CEO. The notice shall indicate that the Practitioner may request a hearing in accordance with the Medical Staff Bylaws.

The written notice shall indicate that a professional review action has been proposed against the Practitioner, the reasons for the proposed action, a description of the proposed adverse action, a summary of the hearing rights available to the affected provider that the Practitioner has a period of thirty (30) days from receipt of the notice within which to request a hearing on the proposed action, and that the Practitioner shall be deemed to waive hearing rights if hearing is not requested within such thirty (30) day period. The notice further shall indicate that: A) if a hearing is requested on a timely basis, the hearing shall be held before a hearing Officer or panel of individuals appointed pursuant to the Bylaws who are not in direct economic competition with the Practitioner; B) the right to a hearing may be forfeited if the Practitioner, without good cause, fails to appear; C) in the hearing the Practitioner has a right (1) to representation by an attorney or other person of the Practitioner’s choice, (2) to have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof; (3) to call, examine and cross examine witnesses; (4) to present evidence determined to be relevant by the hearing Officer or panel, regardless of its admissibility in a court of law; and (5) submit a written statement at the close of the hearing. The notice further shall indicate that the Practitioner, upon completion of the hearing, has a right: (1) to receive the written recommendation of the Officer or panel, including the statement of the basis for the recommendations, and (2) to receive a written decision of the health care entity, including a statement of the basis for the decision.

9.2-4 Actions for Which No Hearing Is Required

No Practitioner shall be entitled to hearing rights in the event any Practitioner is summarily suspended for:

(a) Failure to maintain appropriate malpractice insurance;

(b) Failure to maintain a current, active, unrestricted appropriate state license;

(c) Exclusion from participation in Medicare or Medicaid; or
(d) Failure to maintain a current, active DEA certification (if required for the Practitioner’s specialty), the Practitioner shall be notified of the suspension and the basis of the suspension by regular and certified mail, and given ten (10) calendar days to produce clear and convincing evidence that the facts relied on in taking summary action are not correct. If NCHC does not receive such evidence from the member within ten (10) calendar days, the individual shall be deemed to be no longer qualified for Medical Staff membership and/or clinical privileges shall automatically terminate, in which event the Practitioner shall not be entitled to a hearing as set forth elsewhere in these Bylaws or the Fair Hearing and Appellate Review Plan.

9.2-5 No Practitioner shall be entitled to a hearing as a result of any action which is recommended or taken which is not reportable to the state or the National Practitioner Data Bank, including, but not limited to the following:

(a) Letters of warning, reprimand, or admonition;

(b) Imposition of monitoring, proctoring, review or consultation requirements;

(c) Requiring provision of information or documents, such as office records, or notice of events or actions;

(d) Imposition of educational or training requirements;

(e) Placement on probationary or other conditional status;

(f) Appointment or reappointment for less than two (2) years;

(g) Failure to place a Practitioner on any on-call or interpretation roster, or removal of any Practitioner from any such roster;

(h) Continuation of provisional appointment;

(i) The refusal of the Board of Directors to grant a request for a waiver or extension of time regarding the Board certification requirements set forth in these Bylaws;

(j) Termination of Medical Staff membership and/or clinical privileges as a result of matters which are not related to the Practitioner’s professional qualifications, competence or conduct such as:

   (1) Failure to pay dues or assessments;

   (2) Failure to meet any objective requirement imposed on all staff members that specific numbers of procedures be performed to maintain or demonstrate clinical competence; or

   (3) NCHC elects to enter into an exclusive contract for the provision of certain services.
If any action is taken which does not entitle the Practitioner to a hearing, the Practitioner shall be offered the opportunity to submit a written statement or any information which the Practitioner wishes to be included in the Practitioner’s peer review records along with the documentation regarding the action taken.

9.3 REQUEST FOR HEARING

A Practitioner shall have at least thirty (30) and not more than forty-five (45) days following the receipt of a notice pursuant to Section 9.2-3 to file a written request for a hearing. Such request shall be deemed to have been made when delivered to the CEO in person or when sent by certified mail to the CEO.

9.3-1 Waiver by Failure to Request a Hearing

A Practitioner who fails to request a hearing within the time and in the manner specified waives any right to hearing with respect to the recommended adverse action, the imposition of the recommendation action and to any appellate review to which he/she might otherwise have been entitled. Such waiver in connection with:

(a) An adverse action by the Board shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board.

(b) An adverse recommendation by the MEC shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board. The Board shall consider the committee’s recommendation at its next regular meeting following the waiver. In its deliberations, the Board shall review all the information and material considered by the committee and may consider all other relevant information received from any source. If the Board’s action on the matter is in accord with the MEC’s recommendation such action shall constitute a final decision by the Board. If the Board’s action has the effect of changing the MEC’s recommendation, the matter shall be submitted to the Joint Conference Committee as provided in this plan. The Board’s action on the matter following receipt of the Joint Conference Committee’s recommendation shall constitute its final decision.

The CEO shall promptly send the Practitioner a special notice informing him/her of each action taken pursuant to this section and shall notify the President of the Medical Staff of each such action.

9.4 HEARING PREREQUISITES

9.4-1 Notice of Time and Place of Hearing

Upon receipt of a timely request for hearing, the CEO shall deliver such request to the President of the Medical Staff or to the Board, depending on whose recommendation or action prompted the request for a hearing. At least thirty (30) days prior to the hearing, the CEO shall send the Practitioner special notice of the time, place and date of the hearing and a list of witnesses the Medical Staff
or Board expects to call. The hearing date shall not be less than thirty (30) days from the date of notice of the hearing; unless the Practitioner voluntarily waives in writing the thirty (30) day period, whereupon the CEO and the Practitioner shall endeavor to mutually agree on a hearing date. In the event an agreed upon date cannot be reached the date contained in the notice shall be the hearing date.

9.4-2 State of Issues and Grounds

The notice of hearing provided shall contain a concise statement of the Practitioner’s alleged acts or omissions, a list by number of the specific or representative patient record in question and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing.

9.4-3 Appointment of the Hearing Committee

(a) By Medical Staff: A hearing occasioned by a medical executive or MEC recommendation pursuant to Section 9.2-1 shall be conducted by a hearing committee appointed by the CEO and composed of five (5) members of the active staff. One of the members so appointed shall be designated as chair.

(b) By Board: A hearing occasioned by an adverse action of the Board pursuant to section 9.2-1 or upon a request pursuant to section 9.3 shall be conducted by a hearing committee appointed by the chair of the Board and composed by five (5) persons, including two (2) active staff members chosen with advice from the president of the staff shall be included on this committee when issues concern professional competence or performance. One of the appointees to the committee shall be designated as chair.

(c) A Medical Staff or Board member shall be disqualified from serving on a hearing committee if he/she participated in initiating, investigating, or has an economic interest in the underlying matter at issue. In no event shall a member of the body whose adverse recommendation or action occasioned the hearing serve on the hearing committee.

9.5 HEARING PROCEDURE

9.5-1 Personal Presence

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 9.3-1.

9.5-2 Presiding Officer

Either the hearing Officer, if one is appointed, pursuant to Section 9.10-1, or the chair of the hearing committee shall be the presiding Officer. The presiding Officer shall act to maintain decorum and to assure that participants in the
hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

9.5-3 Representation

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the Medical Staff in good standing or by a member of his/her local professional society. The MEC or the Board, depending on whose recommendation or action prompted the hearing shall appoint an individual to represent it at the hearing to present the facts in support of its adverse recommendation or action and to examine witnesses. Representation of either party by an attorney at law shall be governed by the provisions of section 9.54(a) and section 9.10-2.

9.5-4 Rights of Parties

During a hearing, each of the parties shall have the right to:

(a) Be represented by an attorney or other representative; however, the Hearing Committee has the right to define the role of counsel for the Practitioner or Committee;

(b) Have a record of the proceedings made according to Section 9.5-8 and to obtain a copy of the record upon payment of a reasonable charge;

(c) Call, examine, and cross-examine witnesses;

(d) Present relevant evidence;

(e) Submit a written statement at the close of the hearing;

(f) Receive any written recommendation based on the hearing, including the basis for the recommendation; and

(g) Receive a written final decision, including the basis for the decision.

9.5-5 Procedure and Evidence

The hearing shall not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. The hearing committee may require one or both parties to prepare and submit to the committee, written statements of their position on the issues, prior to, during, or after, the hearing. The hearing committee may establish rules of procedure, including, but not limited to, requiring the submission prior to the hearing of lists of proposed witnesses and
exhibits. The presiding Officer, may but shall not be required to order that oral evidence be taken only on oath or affirmation administered by any person designed by him/her/her and entitled to notarize documents in the State of Wisconsin.

9.5-6 Evidentiary Notice

In reaching a decision, the hearing committee may take note, for evidentiary purposes, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Wisconsin. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be recited in the hearing record. Any party shall be given opportunity on timely request, or request that a matter be evidentiary noticed and to refute the evidentiary noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing committee. The Committee shall also be entitled to consider any pertinent material contained on file at NCHC, and all other information that can be considered, pursuant to the Medical Staff Bylaws, in connection with applications for appointment or reappointment to the staff and for clinical privileges.

9.5-7 Sequence of Presentation

Whenever a hearing relates solely to a (i) a denial of appointment or reappointment to the Medical Staff; (ii) requested clinical privileges; or (iii) requested advancement in Medical Staff category, the applicant or Medical Staff appointee shall present his or her evidence first. In all other cases, the representative of the professional review body shall present his or her evidence first. After the first party to present evidence has completed, the other party shall present his or her evidence. The initial party shall then have the opportunity to rebut the evidence presented by the opposing party. The hearing committee may in its discretion request or allow opening statements, which if made will be presented by the parties in the same sequence as provided for presentation of evidence.

9.5-8 Documentary Evidence

Documentary evidence may be received in the form of original or copies. Excerpts of documents may also be received, in the discretion of the Moderator. Upon request, parties shall be given an opportunity to compare a copy with the original. Each party shall be responsible for properly identifying any exhibits sought to be introduced into evidence. If authority is challenged by the opposing party, such party shall also be responsible for proving authenticity of the exhibit. The identification of authenticity of any exhibit shall be a matter for determination by the Moderator.

9.5-9 Official Notice

The Hearing Committee may, in the course of the proceedings, indicate that it will take official notice of any matters as to which it believes there can be no
reasonable dispute. Official notice may also be taken of generally recognized technical or scientific facts within the hearing committee members’ specialized knowledge. Upon challenge of the propriety of taking such official notice, the Hearing Committee shall set forth in writing and provide the participants to the hearing a brief statement of the basis for such official notice of technical or scientific facts. Any party to the hearing is entitled upon a request made within a reasonable time thereafter to be heard as to the propriety of taking official notice.

9.5-10 Burden of Proof

When a hearing relates to an adverse action or recommendation set forth in section 9.2 (1)-(9) of the provisions above entitled Right to Hearing, the Practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that such basis or the conclusions drawn therefrom are arbitrary, unreasonable, and capricious. In all other cases, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof, but the Practitioner shall thereafter have the burden of proving, by a preponderance of credible evidence, that the grounds for such action or recommendation lack any substantial factual basis of that such basis or the conclusions drawn therefrom are arbitrary, unreasonable, and capricious.

9.5-11 Record of Hearing

A record of the hearing shall be kept that is of sufficient accuracy to assure that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Hearing Committee chair, unless his/her decision is reversed by a majority vote of the Hearing Committee, shall select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. A Practitioner requesting an alternate method shall bear the cost thereof. The Practitioner is entitled to a copy of the record of the hearing.

9.5-12 Postponement

Requests for postponement of a hearing shall be granted by the hearing committee only upon a showing of good cause.

9.5-13 Presence of Hearing Committee Members and Vote

All members of the Hearing Committee must be present throughout the hearing and deliberations. If a committee member is absent from any part of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision.

9.5-14 Recesses and Adjournment

The Hearing Committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the
purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee, shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of its deliberations, the hearing shall be declared finally adjourned.

9.6 HEARING COMMITTEE REPORT AND FURTHER ACTION

9.6-1 Hearing Committee Report

Within ten (10) days after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations specifically addressing each charge made in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing. All findings and recommendations by the hearing committee shall be supported by reference to the hearing record and the other documentation considered by it.

9.6-2 Action on Hearing Committee Report

Within thirty (30) days after receipt of the report of the Hearing Committee, the MEC or the Board, as the case may be, shall consider the same and affirm, modify or reverse its recommendation.

9.6-3 Notice and Effect of Result

(a) Notice: The CEO shall promptly send a copy of the result to the Practitioner by special notice, to the President of the Medical Staff, and to the Board.

(b) Effect of Favorable Result:

(1) Adopted by the Board: If the Board’s result pursuant to Section 9.6-2 is favorable to the Practitioner, such result shall become the final decision by the Board and the matter shall be considered finally closed.

(2) Adopted by MEC: If the MEC’s result pursuant to Section 9.6-2 is favorable to the Practitioner, the CEO shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting MEC’s result in whole or in part, or by referring the matter back to the MEC for further reconsideration. Any such referral shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The CEO shall promptly send the Practitioner special notice pursuant to Section 9.5-4(g) informing
him/her of each action taken. Favorable action shall become the final decision of the Board, and the matter shall be considered finally closed. If the Board’s action is adverse in any of the respects listed in Section 9.2, the special notice shall inform the Practitioner of his/her right to request an appellate review by the board as provided in Section 9.8 of this plan.

(c) Effect of Adverse Result: If the result of the MEC or of the Board continues to be adverse to the Practitioner in any of the respects listed in this Plan, the special notice required above shall inform the Practitioner of his/her right to request an appellate review by the Board as provided in this Plan.

9.7 INITIATION AND PREREQUISITES OF APPELLATE REVIEW

9.7-1 Request for Appellate Review

A Practitioner shall have thirty (30) days following his/her receipt of a notice as provided in 9.6-3 above to file a written request for an appellate review. Such request shall be delivered to the CEO either in person or by certified mail. The CEO shall forward a copy to the Practitioner of the report and record of the Hearing Committee and all other material, favorable or unfavorable, if not previously forwarded, that was considered in marking the adverse action or result.

9.7-2 Waiver by Failure to Request Appellate Review

A Practitioner who fails to request an appellate review within the time and in the manner specified in section 9.7-1 waives any right to such review. Such waiver shall have the same force and effect as that provided in section 9.3-1.

9.7-3 Notice of Time and Place of Appellate Review

Upon receipt of a timely request for appellate review, the CEO shall deliver such request to the Board. As soon as practical, the Board shall schedule and arrange for an appellate review which shall be not less than ten (10) days nor more than thirty (30) days from the date of receipt of the appellate review request; provided, however, that an appellate review for a Practitioner who is under suspension then in effect shall be held as soon as arrangements for it may reasonably be made, but not later than forty (40) days from the date of receipt of the request for review. At least ten (10) days prior to the appellate review, the CEO shall send the Practitioner special notice of the time, place, date of the review and a list of witnesses the Board will call. The time for the appellate review may be extended by the appellate review body for good cause.

9.7-4 Appellate Review Body

The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee composed of five (5) members of the Board appointed by the chair. If a committee is appointed, one of its members shall be designated as chair.
9.8 APPELLATE REVIEW PROCEDURE

9.8-1 Nature of Proceedings

The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee, that committee's report, and all subsequent results and action thereon. The appellate review body shall also consider the written statements, if any, submitted as provided below and such other material as may be presented and accepted within the terms of this plan.

9.8-2 Written Statements

The Practitioner seeking the review may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review body through the CEO at least seven (7) days prior to the scheduled date of the appellate review, except if such time limit is waived by the appellate body. A written statement in reply must be submitted to the MEC or by the board, and if submitted, the CEO shall provide a copy thereof to the Practitioner at least two (2) days prior to the scheduled date of the appellate review.

9.8-3 Presiding Officer

The chair of the appellate review body shall be the presiding Officer. He/she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

9.8-4 Oral Statement

The appellate review body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be subject to answer questions put to him/her by any member of the appellate review body.

9.8-5 Consideration of New or Additional Matters

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only in the discretion of the appellate review body, following an explanation by the party requesting the consideration of such matter or evidence as to why it was not presented earlier.

9.8-6 Powers

The appellate review body shall have all powers granted to the Hearing Committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.
9.8-7 Presence of Members and Vote

All members of the appellate review body must be present throughout the review and deliberations. If a member of the review body is absent from any part of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision.

9.8-8 Recesses and Adjournment

The appellate review body may recess and review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of these deliberations, the appellate review shall be declared finally adjourned.

9.8-9 Action Taken

The appellate review body may recommend that the Board affirm, modify or reverse the adverse result or action taken by the MEC or by the Board, or in its discretion, may refer the matter back to the hearing committee for further review and recommendation to be returned to it within fifteen (15) days and in accordance with its instructions. Within fifteen (15) days after receipt of such recommendation after referral, the appellate review body shall make its recommendation to the Board as provided in this section.

9.8-10 Conclusion

The appellate review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

9.9 FINAL DECISION OF THE BOARD

9.9-1 Board Action

Within thirty (30) days after the conclusion of the appellate review, the board shall render its final decision in the matter in writing and shall send notice to the President of the Medical Staff, and to the Medical Executive or MEC as appropriate. If this decision is in accord with the MEC's last recommendation in the matter, if any, it shall be immediately effective and final. If the Board's action has the effect of changing the MEC's last such recommendation, if any, the Board shall refer the matter to a Joint Conference review as provided below. The Board's action on the matter following receipt of the Joint Conference recommendation shall be immediately effective and final.

9.9-2 Joint Conference Review

Within thirty (30) days of its receipt of a matter referred to it by the Board pursuant to the provisions of this Plan, a Joint Conference of equal number of
Medical Staff and Board members shall convene to consider the matter and shall submit its recommendation to the Board. The Joint Conference shall be composed of a total of ten (10) members selected in the following manner: the Board representatives shall be appointed by the Board; the Medical Staff representatives shall be appointed by the President of the Medical Staff with MEC approval.

9.10 GENERAL PROVISIONS

9.10-1 Hearing Officer Appointment and Duties

The use of a hearing Officer to preside at an evidentiary hearing is optional. The use and appointment of such Officer shall be determined in discretion of the Board after consultation with the president of the Medical Staff. A hearing Officer may or may not be an attorney at law but must be experienced in conducting hearings. He/she shall act in an impartial manner as the presiding Officer of the hearing. If requested by the hearing committee, he/she may participate in its deliberations and act as its legal advisor, but he/she shall not be entitled to vote.

9.10-2 Attorneys

If the affected Practitioner desires to be represented by an attorney at any hearing or at any appellate review appearance pursuant to section 9.5-3, his/her request for such hearing or appellate review must so state. The request for hearing shall identify the name and contact information of the attorney for the affected Practitioner. The MEC or the Board may also be represented at the hearing or appellate review by an attorney. The foregoing shall not be deemed to limit the Practitioner or the Board in the use of legal counsel in connection with preparation for a hearing or an appellate review.

9.10-3 Waiver

If at any time after receipt of special notice of an adverse recommendation, action or result, a Practitioner fails to make a required request or appearance or otherwise fails to proceed or to comply with this Fair Hearing Plan, will be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws then in effect or under this Fair Hearing Plan with respect to the matter involved.

9.10-4 Number of Reviews

Notwithstanding any other provision of the Medical Staff Bylaws or of this Plan, no Practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to an adverse recommendation or action.

9.10-5 Extensions

Stated time periods and limits for actions, notices, requests, submissions of material and scheduling in Article IX may be extended upon the agreement of the parties and, when necessary, the hearing committee or appellate review body.
9.10-6 Release

By requesting a hearing or appellate review under Article IX, a Practitioner agrees to be bound by the provisions in Article XIII of the Medical Staff Bylaws and by the laws of the State of Wisconsin relating to immunity from liability.

9.6-7 Reports to the National Practitioners Data Bank

The healthcare entity or its authorized representative, The CEO shall report all adverse actions, as defined in the Healthcare Quality Improvement Act of 1986, to the National Practitioners Data Bank only upon the adoption by the Governing Body of such adverse action as being a final action of the Governing Body, or as otherwise required by law. The Governing Body’s adoption of such adverse action as a final action shall only occur after the hearing process set forth in the Fair Hearing Procedure has been followed.

9.6-8 Arbitration

Any controversy, dispute or disagreement arising out of or relating to, the Medical Staff Bylaws, the Appointment Procedure, the Fair Hearing Procedure, rights arising thereunder or the breach thereof (except for any Hearing Procedure requested by a Physician-Practitioner in connection with matters with respect to which the adequate notice and hearing provisions of the Health Care Quality Improvement Act of 1986, as amended from time to time, apply) shall be settled exclusively by arbitration, which shall be conducted in Wausau, Wisconsin in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.
ARTICLE X: OFFICERS

10.1 OFFICERS

10.1-1 Identification

The Officers of the Medical Staff shall be:

(a) President
(b) Vice President
(c) Secretary

10.2 QUALIFICATIONS

Candidates for Medical Staff Officers candidates must be Physicians and should have a proven track record of distinguished leadership and service to the medical community and be willing to commit to a program of further leadership development. All Medical Staff Officers must possess and maintain the qualifications defined below. Failure to do so shall automatically remove the member from the office involved:

10.2-1 Members of the Active Medical Staff in good standing at NCHC at time of nomination and election and throughout the entire term of office.

10.2-2 Have affirmatively established that they possess competence through the credentialing process.

10.2-3 Willing and able to discharge faithfully the duties and responsibilities of the position to which the individual aspires.

10.2-4 Willing and able to utilize email and other electronic means of communication to carry out their responsibilities.

10.3 NOMINATIONS

The MEC will act as a Nominating Committee of the Medical Staff for purposes of identifying qualified candidates for Medical Staff Officer positions. The MEC shall annually review members of the Active Staff demonstrating proven leadership capability and meeting the qualifications described in this Article to determine a slate of at least one nominee for each vacant position. Potential nominees must be recommended to a Nominating Committee member at least fourteen (14) calendar days prior to the annual meeting of the Medical Staff. The MEC is responsible to bring forward the final slate.

10.4 ELECTION

Officers of the Medical Staff shall be elected at the annual meeting of the Medical Staff. Only Physician members of the active Medical Staff shall be entitled to vote.

10.5 TERM OF OFFICE
All Officers shall serve terms of two (2) years or until their successor is duly elected. Officer terms shall commence on January 1 following election.

10.6 VACANCIES AND REMOVAL FROM OFFICE

10.6-1 Vacancies

Should any Officer resign their position prior to fulfillment of their term, such resignation must be tendered in writing to the CEO and to the MEC.

Vacancies in these offices shall be addressed by recommendation of the remaining Officers, following approval of the MEC and voted upon by the Medical Staff at a special election held for that purpose. The special election shall be initiated within fourteen (14) calendar days of the MEC approval and will follow the standard election process described in these Bylaws. The recommendation may modify the number of Officers serving and/or the responsibilities of each Officer, as described in section 7 of this article.

Service in an amended role due to unanticipated vacancy shall not count toward the term limitations described in these Bylaws.

10.6-2 Removal from Office

Any Officer of the Medical Staff may be removed at the discretion of the Board of Directors. The MEC by a seventy-five percent (3/4) vote, may remove any Medical Staff Officer for conduct detrimental to the interests of NCHC as defined by the MEC, or if the individual is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office. Notice of the meeting at which such action shall be decided must be given in writing to the affected individual at least fourteen (14) calendar days prior to the meeting. The Officer shall be afforded the opportunity to speak prior to a final decision concerning removal.

Any Medical Staff Officer who is found by the Board, in consultation with the MEC, to no longer meet the qualifications for the position set forth in these Bylaws shall automatically relinquish his/her office. Medical Staff Officers will automatically be removed from office upon loss of clinical privileges with NCHC or upon loss of licensure.

10.7 RESPONSIBILITIES

Unless amended as described in section 6 of this article, the following are the responsibilities of Medical Staff Officers.

10.7-1 Officers

While these responsibilities are primarily those of the President of the Medical Staff, they are also expectations of the other Medical Staff Officers. All Officers shall:
(a) Be accountable to the Board of Directors in conjunction with the MEC, for the quality and efficiency of clinical services and performance within NCHC and for the effectiveness of quality review and evaluation functions delegated to the Medical Staff by means of regular reports and recommendations based on results of these activities;

(b) Communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Board of Directors, the CEO, the CMO and other officials of the Medical Staff;

(c) Act in coordination and cooperation with the CEO in all matters of mutual concern with respect to NCHC Programs and the Hospital;

(d) Develop and implement, in cooperation with the Chief Medical Officer leadership, methods for quality review activities including ongoing monitoring of practice, credentials review, delineation of privileges and specified services, continuing education and utilization review; and,

(e) Be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner.

10.7-2 The President shall:

(a) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

(b) Chair the MEC, assuming oversight authority of the responsibilities of the MEC;

(c) Appoint members to Committees (except for the MEC) as described in these Bylaws;

(d) Be the spokesperson for the Medical Staff in its external professional and public relations; and,

(e) Receive and interpret the policies of the Board of Directors to the Medical Staff and report to the Board of Directors on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibilities to provide medical care.

10.7-3 The Vice President shall:

(a) Assume all the responsibilities and have the authority of the President in the absence of the President in the event of his/her temporary inability to perform due to illness, absence from the community or unavailability for any other reason;
(b) Perform such responsibilities as assigned by the President.

10.7-4 The Secretary shall:

(a) Perform such responsibilities as assigned by the President;

(b) Ensure accurate and complete records of Medical Staff meetings as appropriate; and

(c) Attend to all correspondence and perform such other responsibilities as pertain to the functions of Secretary.

(d) Assure that proper notice is given of all general and special meetings of the Medical Staff.
ARTICLE XI: COMMITTEES

Committees of the Medical Staff will be designated by the MEC. All meetings of the Medical Staff shall be considered peer review meetings. Thus all minutes and correspondence of a peer review committee shall be confidential and all members and personnel of the peer review committee shall enjoy all the rights, responsibilities, and protections of the Wisconsin peer review statute. The President of the Medical Staff may attend any meeting of the Medical Staff. The Chairs of Medical Staff Committees shall usually be Active Staff members, meeting the same qualifications as Medical Staff Officers. They will be appointed annually by the President of the Medical Staff subject to the approval of the MEC. The MEC composition is explicitly defined in Section 1 of this Article. Committee members may also be appointed by the President, subject to MEC approval, unless otherwise described in these Bylaws. Committee members are expected to utilize email and other means of electronic communication in order to fulfill their responsibilities.

Each committee will ensure rules, regulations and policies document committee responsibilities, meeting frequency, attendance requirements, if any, quorum, voting mechanisms, record keeping, and other key elements, if not already defined in the Bylaws. Consent Agendas are encouraged. A Board member appointed by the Chair of the Board may serve on administrative committees without voting right. When requested by Medical Staff Leadership Officers, non-Medical Staff members may serve as members of Committees without vote.

11.1 MEDICAL EXECUTIVE COMMITTEE (MEC)

11.1-1 Composition

The Medical Executive Committee (MEC) shall be a standing committee of the Medical Staff. The MEC shall consist of the Officers of the Medical Staff and the CEO. At minimum, a majority of the Clinician members of the MEC shall be licensed Physicians who are members of the Active Staff of the Medical Staff.

11.1-2 Chair and Oversight

The MEC is chaired by the President of the Medical Staff and has primary authority for activities related to self-governance of the Medical Staff, and oversight of Allied Health practitioners, to ensure the quality of medical care, treatment, and services and for performance improvement of the professional services provided by the Medical Staff, reporting to the NCHC Board of Directors. Their ultimate priority is to support the Medical Staff’s provision of safe and quality patient care, placing the best interests of patients first in all matters.

The MEC shall coordinate the activities and general policies of the Medical Staff and shall represent and act for the Medical Staff as whole, under such limitations as may be imposed by the Medical Staff. The Medical Staff may limit or expand the powers of the MEC by amending this Article using the Bylaws amendment process described in Article XVIII, and if necessary, the conflict resolution process described in Article XV.

The Chair of the Board of Directors may serve as an ad hoc member of the MEC without vote.
All members of the organized Medical Staff of any discipline or specialty are eligible for membership on the MEC. No Medical Staff member actively practicing at NCHC is ineligible for membership on the MEC solely because of his/her professional designation or discipline.

In the absence of the President of the Medical Staff, the Vice President or the President’s appointee shall act as chair.

Individual members of the Medical Staff may attend the MEC as described in Article XII, Section 6.c.

11.1-3 Responsibilities:

The responsibilities of the MEC shall be to:

(a) Execute primary authority for activities related to self-governance of the Medical Staff and for performance improvement of the professional services provided by all licensed independent practitioners and other practitioners privileged through the Medical Staff process.

(b) Represent and to act on behalf of the Medical Staff, including the authority to act on behalf of the Medical Staff between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

(c) Recommend revisions to and updating of the Medical Staff Bylaws and all Medical Staff rules, regulations, policies, forms, and associated documents;

(d) Approve and coordinate the activities and general policies of the various Committees, receiving and acting upon reports and recommendations from Medical Staff Committees;

(e) Recommend those serving in Medical Staff leadership Officer positions for Board of Director confirmation;

(f) Establish Medical Staff Committees, or discontinue them when their purpose has been served, by a seventy-five (75) percent or three-quarters (3/4) vote;

(g) Implement rules, regulations, and policies and procedures of the Medical Staff based on the recommendations of Specialties, Divisions, and Committees;

(h) Recommend action to the Board of Directors on NCHC organizational management matters (e.g., long range planning);

(i) Fulfill the Medical Staff’s accountability to the Board of Directors for the medical care provided to patients;
(j) Be responsible for Medical Staff compliance with Wisconsin Department of Health Services regulations, accreditation standards of The Joint Commission, and other relevant accreditation-granting or regulatory organizations;

(k) Review all applicants, including Medical Staff, and where applicable Allied Health, for initial appointment-affiliation, reappointment-affiliation, and requested if applicable clinical privileges, as recommended by the MEC; and then to make recommendations to the Board of Directors for appointment-affiliation and delineation of Clinical privileges;

(l) Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, and where applicable Allied Health, including the initiation of and/or participation in collegial, disciplinary, or review measures when warranted;

(m) Lead the Medical Staff, and applicable Allied Health, in collaboration with the organization’s performance improvement activities, including measuring, assessing and improving processes that primarily depend on the activities of Medical Staff or Allied Health;

(n) Keep the Medical Staff, and applicable Allied Health, apprised of MEC activities on an ongoing basis and solicit input.

11.1-4 Exclusive Recommendations to the Board

The MEC shall make recommendations directly to the Board of Directors on at least the following matters:

(a) Medical Staff membership.
(b) Medical Staff structure.
(c) Process used to review credentials and delineate privileges.
(d) Delineation of privileges of each Practitioner privileged through the Medical Staff process.
(e) MEC’s review of and actions on reports of Medical Staff committees, departments, and other assigned activity groups.

11.1-5 MEC Meetings

The MEC shall meet on a regular basis, at least monthly or more frequently as warranted. The CEO of NCHC or his designee shall attend meetings of the MEC on an ex-officio basis but shall have no vote.

The MEC shall determine the time and date of each meeting. Fifty percent (50%) of members shall constitute a quorum. The committee has an attendance requirement of at least fifty percent (50%) of the meetings. Attendance by the Member at Large may be designated in the absence of the President or Vice President. Attendance by the Vice President or Member at Large may be designated in the absence of the President.
A simple majority of those present and voting at a meeting in which quorum is present shall be the action of the Committee except as described above. Use of Consent Agenda is encouraged. Ad hoc committees may be appointed as needed to complete special projects. Policies may be developed to further guide the work of the committee.

The President of the Medical Staff, the Vice President, Elector, the Secretary/Treasurer, or any three (3) or more members of the Committee may request a meeting. Such a request must be honored within a period of one (1) week following such notification to the President of the Medical Staff or designee. A record of all proceedings of the MEC shall be made and retained indefinitely.

11.1-6 Bylaws Review & Recommendation

Conduct a review of the Bylaws on at least on an annual basis and submit recommendations to the Board.

11.1-7 Miscellaneous

To review reports that are referred by other committees and respond as requested.

11.1-8 Mechanisms/Policy Development

(a) To approve and monitor the qualifications, criteria, and other policies and requirements for consideration of credentialing recommendations, as well as review and act upon requests for development of cross-specialty privilege criteria, as described in associated Medical Staff policies and in accordance with Articles V and VI of these Bylaws;

(b) To approve and monitor the mechanisms used to verify and evaluate information used in the formation of credentialing recommendations, in accordance with Article V & VI of these Bylaws;

(c) To recommend to the MEC the Specialties to be recognized by the Medical Staff for specific representation in the Medical Staff structure.

11.1-9 Credentialing Recommendations:

(a) To review the credentials of all applicants for appointment and reappointment and to make recommendations to the Board for membership and delineation of clinical privileges, if any requested, as described in Article V & VI of these Bylaws;

(b) To review at least biennially every two years the current competence of Medical Staff and as a result of such reviews to make recommendations to the Medical Staff Executive Committee for the granting of reappointment and renewed clinical privileges. Such review will include: Patient Care; Medical/Clinical Knowledge; Practice Based Learning and Improvement; Interpersonal and Communication Skills; Professionalism; and Systems Based Practices.
11.1-10 Whenever an applicant’s practice is in direct economic competition with the practice of a member of the MEC, the conflicting committee member shall abstain from voting during proceedings relating to the credentials of the conflicting party and such abstention shall be recorded in the minutes of the applicable proceeding.

11.1-11 Establishment of Written Criteria

The MEC shall time to time solicit recommendations from the clinical departments/programs at least every two years concerning written criteria for the granting of clinical privileges within each department/program. The MEC shall take such recommendations and prepare its own recommendations. Recommendations from the MEC regarding establishment of written criteria shall be forwarded to the Governing Body for final approval.

11.2 QUALITY COMMITTEES

At least one member of the Medical Staff shall serve on the NCHC Outpatient Human Services and Inpatient Service Line Nursing Home Operations Quality Committees to fulfill the following responsibilities.

11.2-1 Duties-Responsibilities

(a) Provide organization wide leadership, guidance, and oversight for the implementation of multidisciplinary clinical quality improvement initiatives.

(b) Ensure that quality care initiatives are consistent with current standards of practice and comparative performance data where available.

(c) Review results of all patient care outcomes and procedure efficacy.

(d) Ensure that quality initiatives are acted upon and reported in a timely fashion.

(e) Assist in the identification of and ensure the execution of new clinical care opportunities for improvement.

(f) Participate in decision-making for organizational quality of care issues (standards of care, conflict resolution, peer review process and/or external review, adverse occurrence/sentinel event issues, etc.)

(g) Provide consultation to service areas regarding report completeness, comprehensiveness, and continuity with process improvement initiatives.

(h) Work collaboratively to ensure an integrated approach to process improvement initiatives.

(i) Participate in the annual evaluation of organizational wide quality program structures, coordination, and effectiveness and make recommendations.
for improvement. Ensure annually that the Quality Plan is current and executed.

(j) Issues raised through the Medical Staff peer review process will be brought to the appropriate Quality Committee for evaluation and action as necessary.

11.2.2 Process Improvement Initiatives

Process improvement initiatives include, but are not limited to:

(a) Ongoing monitoring and evaluation of specific quality indicators.
(b) Clinical process improvement teams with focus on key aspects of care.
(c) Review and evaluation of clinical risk management trend data.
(d) Patient experience, customer satisfaction feedback and complaint management information.
(e) Key functions where continuous quality improvement shall be performed include but are not limited to: pharmacy and therapeutics and medication use, surveillance, control and prevention of infection, operative and invasive procedures, medical record review, clinical risk management, utilization management, patient care and assessment, patient rights and patient education, clinical care improvement.

11.3 MULTIDISCIPLINARY COMMITTEES

Multidisciplinary committees will be developed by the Medical Staff on an ongoing basis for designated purposes, with Medical Staff membership appointed by the President of the Medical Staff. Each committee will document its purpose and responsibilities in rules, regulations, and policies as appropriate, and retain a record of its proceedings for at least 10 years. Consent Agendas are encouraged.

The MEC will receive reports from these committees as necessary, provide leadership and resources, and approve business as related to their responsibilities. An official listing of these committees will appear on the annual Medical Staff Committee List.
ARTICLE XII: MEDICAL STAFF MEETINGS

12.1 REGULAR STAFF MEETINGS

The Medical Staff as a whole shall meet on a bi-monthly basis. The Medical Staff Officers may authorize additional general staff meetings including adequate notice specifying time, date, place, and business of meeting.

12.2 SPECIAL STAFF MEETINGS

Special meetings of the Medical Staff may be called at any time by a Medical Staff Officer or the MEC. Reasons for the special meeting shall be stated on the notice of meeting. The agenda shall be limited to the reading of the notice; calling the meeting; discussion of the business of which the meeting was called and adjournment.

12.3 QUORUM / VOTING / RECORD KEEPING

Quorum at a Regular or Special Meeting is those present. A simple majority of those present and voting, authorized to vote, at a meeting shall be the action of the Medical Staff. Attendance is strongly encouraged. Consent agendas are encouraged.

Record of Medical Staff meetings will be retained for ten (10) years. In lieu of meeting, use of mail, telephone, videoconference, email, fax, or other forms of electronic communication, to conduct business is encouraged.

12.4 CLOSED MEETINGS / EXECUTIVE SESSIONS

Medical Staff may move into closed session pursuant to Section 19.85(1)(c) Wis. Stats. for the purpose of considering employment and/or performance evaluation of any public employee over which the governmental body exercises responsibility, and Section 19.85(1)(f) Wis. Stats. for preliminary consideration of financial, medical, social or personal histories or disciplinary data of specific persons, which if discussed in public, would likely have a substantial adverse effect upon the reputation of any person referred to in such histories or data, including specific review of performance of employees and providers of service and review of procedures for providing services by Agency.

The President of the Medical Staff or Officer leader of any meeting of the Medical Staff or its Committees may invite or excuse any or all individuals who are not voting members of the unit, irrespective of their status.
ARTICLE XIII: PRIVILEGE AND IMMUNITY / CONFIDENTIALITY

13.1 PRIVILEGES AND IMMUNITIES

The Board, any committees of the Medical Staff and/or of the Board who conduct Professional Review Activities and any individuals within NCHC authorized to conduct Professional Review Activities, hereby constitute themselves as Professional Review Bodies as defined in the Health Care Quality Improvement Act of 1986 and in the Wisconsin Act. Each Professional Review Body hereby claims all privileges and immunities afforded to it by said federal and state statutes. Any action taken by a Professional Review Body pursuant to these Medical Staff Bylaws or the Appointment Procedure shall be in the reasonable belief that it is in furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at NCHC) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any applicant or Medical Staff Appointee, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.

13.2 AUTHORIZATIONS AND CONDITIONS

By applying for appointment or reappointment to the Medical Staff, or for advancement in Medical Staff category, or for particular clinical privileges or changes in clinical privileges, the affected applicant or Medical Staff Appointee:

(a) Authorizes NCHC and Medical Staff representatives to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on his or her credentials and agrees that any information so provided shall not be required to be disclosed to him or her if the third party providing such information does so on the condition that it be kept confidential.

(b) Authorizes third parties to release information, including otherwise privileged or confidential information, as well as reports, records, statements, recommendations and other documents in their possession, bearing on his or her credentials to any NCHC or Medical Staff representative, and consents to the inspection and procurement by any NCHC or Medical Staff representative of such information, records and other documents.

(c) Authorizes the NCHC or Medical Staff representatives to release such information, when requested by the applicant, to other healthcare entities and their agents, who solicit such information for the purpose of evaluating the individual’s professional qualifications pursuant to the individual’s request for appointment, reappointment or clinical privileges.

(d) Authorizes NCHC or Medical Staff representative to maintain information concerning the applicant’s or Medical Staff appointee’s age, training, board certification, licensure and other confidential information in a centralized physician Practitioner data base for the purpose of making aggregate physician Practitioner information available for use by NCHC or Medical Staff.
(e) Authorizes NCHC or Medical Staff to release confidential information, including peer review and/or quality assurance information, obtained from or about the applicant or Medical Staff appointee to peer review committees of NCHC and the Medical Staff and affiliates of NCHC for purposes of reducing morbidity and mortality and for the improvement of patient care.

(f) Agrees to appear for a personal interview at any reasonable time requested by any NCHC or Medical Staff representative.

(g) Consents to the reporting by any NCHC representative of information to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 which such representative believes in good faith is required by law to be reported.

(h) Releases from any liability (1) all NCHC and Medical Staff representatives for their acts performed in connection with evaluating his or her credentials or releasing information to other institutions for the purpose of evaluating his or her credentials, in compliance with the Medical Staff Bylaws; and (2) all third parties who provide information, including otherwise privileged or confidential information, to the NCHC representatives concerning his or her credentials, unless such information is false and the third party providing it knew it was false.

(i) Agrees that, if any adverse decision is made with respect to him or her, (1) he or she will follow and exhaust the administrative remedies afforded by the Medical Staff Bylaws and the Hearing Procedure as a prerequisite to any other action, and (2) he or she will have the burden of demonstrating that he or she meets the standards for appointment or continued appointment to the Medical Staff or for the clinical privileges requested.

(j) Agrees that the foregoing provisions are in addition to any agreements, understandings, covenants, waivers, authorizations or releases provided by law or contained in any application or request forms.

13.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any Practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or Medical Staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general NCHC records.

13.4 IMMUNITY FROM LIABILITY

13.4-1 For Action Taken

No representative of NCHC or Medical Staff shall be liable to a Practitioner for damages or other relief for any action taken or statement or recommendation
made within the scope of his/her duties as a representative, if such representative acts in good faith after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement or recommendation is warranted by such facts. Regardless of the provisions of state law, truth shall be an absolute defense in all circumstances.

13.4-2 For Providing Information

No representative of NCHC or Medical Staff and no third party shall be liable to a Practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of NCHC or Medical Staff or to any other health care facility or organization of health professionals concerning a Practitioner or allied health Practitioner who is or has been an applicant to or member of the staff or who did or does exercise clinical privileges or provided specified services at NCHC, provided that such representative or their party acts in good faith.

13.5 ACTIVITIES AND INFORMATION COVERED

13.5-1 Activities

The confidentiality and immunity provided by this article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility or organization's activities concerning, but not limited to:

(a) Applications for appointment, clinical privileges, or specified services;
(b) Periodic reappraisals for reappointment, clinical privileges or specified services;
(c) Corrective action;
(d) Hearings and appellate reviews;
(e) Utilization reviews; and,
(f) Other NCHC committee or staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

13.5-2 Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this article may relate to a Practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

13.5-3 Scope of Immunity
The scope of immunity provided hereunder shall extend to all Professional
Review Activity conducted by any Professional Review Body. Professional
Review Activities will include activities relating to any individual Practitioner to
determine whether such individual may have Medical Staff or clinical privileges or
to determine the scope of or any limitations or conditions to any such privileges
or membership. Professional Review Body(s) shall include any committee,
department, division or individual having any authority to make any adverse
determination or recommendations regarding any Practitioner.

13.5-4 Privileges of Immunities

The Board of Directors, any committees of the Medical Staff and/or of the Board
of Directors who conduct Professional Review Activities and any individuals
within NCHC authorized to conduct Professional Review Activities, hereby
constitute themselves as Professional Review Bodies as defined in the Health
Care Quality Improvement Act of 1986 and equivalent Wisconsin laws. Each
Professional Review Body hereby claims all privileges and immunities afforded to
it by said federal and state statutes. Any action taken by a Professional Review
Body pursuant to these Medical Staff Bylaws or the Appointment Procedure shall
be in the reasonable belief that it is in furtherance of quality health care (including
the provision of care in a manner that is not disruptive to the delivery of quality
medical care at the Healthcare EntityNCHC) only after a reasonable effort has
been made to obtain the true facts of the matter, after adequate notice and
hearing procedures are afforded to any applicant or Medical Staff
Appointee, and only in the reasonable belief that the action is warranted by
the facts known after a reasonable effort has been made to obtain the facts.

13.6 RELEASES

Each Practitioner shall, upon request of NCHC, execute general and specific releases in
accordance with the tenor and import of this Article, subject to such requirements,
including those of good faith, absence of malice and the exercise of a reasonable effort
to ascertain truthfulness, as may be applicable under the laws of Wisconsin. Execution
of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

13.7 CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations,
confidentiality of information and immunities from liability shall be in addition to other
protections provided by law and not in limitation thereof, and in the event of conflict, the
applicable law shall be controlling.
ARTICLE XIV: RULES, REGULATIONS, POLICIES and FORMS

The Medical Staff, through Committees, shall adopt such rules, regulations, policies and forms as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the MEC and Board. These shall relate to the proper conduct of Medical Staff and where applicable Allied Health, organizational activities, and the level of practice that is to be required of each Practitioner at NCHC. Such Rules, Regulations, Policies and Forms are attendant to these Bylaws.

Rules, Regulations, Policies and Forms may be created, deleted or modified by recommendation of the responsible Committee, following their established rules for quorum and voting, subject to the approval of the MEC and Board. The Medical Staff shall be informed of these activities via meetings, publications, posting or other efficient methods of information dissemination, and provided opportunity to comment for MEC consideration.

Applicants and members of the Medical Staff and Allied Health shall be governed by such Rules, Regulations, Policies and Forms as are properly initiated and adopted. If there is a conflict between the Bylaws and Rules, Regulations, Policies and Forms, the Bylaws shall prevail.
ARTICLE XV: CONFLICT RESOLUTION

15.1 This Article establishes mechanisms by which the Board will address:

15.1-1 A situation where the Medical Staff disagrees with an MEC action that is not related to a peer review action, which also includes new or revised policy, rules and/or regulations.

15.1-2 A request to revise the Medical Staff Bylaws that is brought by the Medical Staff directly to the Board.

15.1-3 A proposal to alter a Medical Staff policy or rule/regulation that is brought by the Medical Staff directly to the Board.

15.1-4 Conflict between the Medical Executive Committee and the Board of Directors that is not otherwise addressed in other sections of these Bylaws.

15.2 A Medical Staff concern regarding an action of the MEC or a new or revised policy, rule or regulation following MEC recommendation and Board approval:

15.2-1 The membership may appeal for MEC reconsideration by written petition of at least fifty-one percent (51%) of Active Staff members to the MEC, outlining specifically the concern(s) and recommended remedies. The MEC must review the request at their next regularly-scheduled meeting and respond to the request within sixty (60) days of the meeting.

15.2-2 If, following the above process, dissatisfaction persists, the petition may be presented to the Chair of the Board of Directors, or via the CEO with notice to the President of the Medical Staff. Within thirty (30) days of receipt of the petition, equal members from the Medical Staff and the Board shall be convened. Board members shall be selected by the Chair of the Board. For purposes of conflict resolution between the Medical Staff and MEC, Medical Staff members shall be selected by the petitioners to represent the concerns outlined in the written petition and one (1) will be a member of the MEC selected by the President of the Medical Staff.

15.2-3 The identified individuals (15.2-2) shall review the petition, MEC record, any related documentation, and conduct such other inquiry as it may deem appropriate for the purpose of rendering a recommendation to the Board. Within ten (10) days of its final deliberations, the identified individuals shall, by written memorandum to the MEC and to the Board, submit its recommendation on the matter. The recommendation will be considered by the Board at its next regularly-scheduled meeting and a final decision made within 30 days.

15.3 If the Medical Staff wish to propose a revision to the Medical Staff Bylaws, alter an existing policy, rule or regulation, or propose a new policy, rule, or regulation:

15.3-1 The Medical Staff should follow the customary processes outlined in these Bylaws and associated policies to request consideration. If following the customary processes additional consideration is desired, the written petition process to the MEC described in this article is the appropriate next step.
15.3-3 If following the petition process, dissatisfaction persists, the process described in 15.2-1 through 15.2-3 may be utilized and will result in a final determination by the Board.

15.4 Should conflict exist between the MEC and the Board of Directors that is not otherwise addressed in other sections of these Bylaws, a Joint Conference Committee of equal members from the MEC and the Board shall be convened. Board members shall be selected by the chair of the Board. Through the collaboration of the Board Chair and the Medical Staff President, a time table will be established for resolution.
ARTICLE XVI  DUES AND ASSESSMENTS

The MEC has the authority to levy fees, dues and assessments for applicants and each category of staff membership and Allied Health affiliation and to determine the manner of expenditure of funds received. The process of establishing and collecting dues and assessments is outlined in the Dues and Assessments policy.
ARTICLE XVII: HISTORIES & PHYSICALS

A complete History and Physical (H&P) is required for all inpatient admissions. This can be accomplished by dictation and/or an H&P documented directly in the chart.

The H&P may be accomplished no more than thirty (30) days prior to, or within twenty-four (24) hours after inpatient admission.

For an H&P that was completed within thirty (30) days prior to inpatient admission, an update documenting any changes in the patient’s condition is completed within twenty-four (24) hours of inpatient admission.

All Medical Staff members have clinical privileges may perform H&Ps. Additionally, H&P performance may be delegated to Physician Assistants must be have their documentations co-signed by a Medical Staff member within 30 days of patient discharge.

Commented [R15]: Physician Assistants would need a cosignature however APRNs may not. This should be clarified as it may not be happening now for the APRNs.
ARTICLE XVIII: BYLAWS AMENDMENTS / REVISIONS AND ADOPTION

18.1 MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board of Directors Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board of Directors. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining harmony of purpose and effort with the Board of Directors and with the community.

18.2 METHODOLOGY

The Medical Staff Bylaws may be adopted by the following combined action:

18.2-1 Upon recommendation of the MEC, the Medical Staff Bylaws may be amended and/or revised in the following manner:

(a) Proposed amendments shall be distributed by hand delivery, mail, fax, or other forms of electronic communication to members of the Active Staff. In the event of a vote outside of a Medical Staff Meeting, a ballot shall be enclosed with the proposed amendments that shall be returned to the designee of the President of the Medical Staff. A voting period of fourteen (14) calendar days from the date of distribution shall be established for return of ballots. In order for proposed amendments to be adopted, a simple majority of ballots returned from eligible voters approving adoption of the amendments must be attained; or

(b) Proposed amendments shall be distributed by hand delivery, mail, fax, or other forms of electronic communication to members of the Active Staff at least fourteen (14) days in advance of a Medical Staff meeting with notice that a vote will occur at the meeting. In order for proposed amendments to be adopted, a simple majority of those present and eligible to vote approving adoption of the amendments must be attained.

18.2-2 Amendments adopted by the Medical Staff pursuant to 18.2-1 above will be effective only after approval by the Board of Directors. The Medical Staff Bylaws may be adopted and revisions accepted by the Board of Directors via an affirmative vote of the majority of the Board. Neither the Board nor Medical Staff may unilaterally modify the Medical Staff Bylaws. Provided, however, that in the event the Medical Staff shall fail to exercise its responsibility and authority as required, and after notice from the Board of Directors to such effect, including a Joint Conference Committee as required in Article IX stipulated in these Bylaws, Section 9, the Board may use its legal initiative in formulating or amending Medical Staff Bylaws. In such event, Medical Staff recommendations and views shall be carefully considered by the Board during its deliberations and in its actions which shall be pursuant to this Section.
These Bylaws are adopted by the NCHC Board of Directors on the date set forth below:

REVISED: April 17, 2014

Adopted by the Medical Staff on: June 19, 2014

President, Medical Staff

Ratified by the NCHC Board of Directors on January 30, 2019:

Chairman, NCHC Board

Chief Executive Officer, NCHC
RULES AND REGULATIONS
of the
MEDICAL STAFF OF
NCHC NORTH CENTRAL HEALTH CARE
Wausau, Wisconsin

I. ADMISSION OF PATIENTS TO THE HOSPITAL

Patients shall be admitted to the facility hospital only on the recommendation of a Physician, licensed by the State and privileged by the facility to admit patients except where required by Wisconsin Statutes (involuntary detentions and commitments).

II. PRACTITIONER RESPONSIBILITY

1. Every patient shall be under the care of a Practitioner. Practitioners shall provide for an intensive treatment program.

2. A Physician shall be on duty or on call at all times.

3. If no physician on site is physically present, the "on call" physician will be contacted to provide/direct emergency care. Names and telephone numbers of physicians/medical service personnel available for emergency calls shall be posted at each nursing station and the emergency services department.

All Units—For those Physicians who are part of a group practice in which not all members of the practice have privileges at NCHC, and all members of the practice rotate on call, the attending Attending Physician will provide to NCHC the list of Physicians who will be on call. Orders received from such Physicians will be accepted as if from the attending Attending Physician.

4. Ensure individuals arriving at the facility for examination/treatment of Psychiatric/AODA conditions are appropriately screened to determine if whether an emergency medical condition exists. An emergency medical condition exists when a psychiatric and/or AODA condition manifests itself by acute symptoms of sufficient severity such that the absence of immediate attention could reasonably be expected to result in:

(a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) Serious impairment to any bodily functions; and/or

(c) Serious dysfunction of any bodily organ or part.

Screening may be delegated to appropriately designated and qualified staff including evaluating RN of the unit. For individuals with psychiatric conditions the medical records will indicate an assessment of suicide attempt or risk, and disorientation or assaultive behavior that indicates a danger to self or others. For individuals with alcohol related conditions the medical records will indicate an assessment of recent substance usage (including Breathalyzer test as indicated), incapacitation, risk for withdrawal and dangerousness to self and/or others.
Should an emergency medical condition be present the Physician (on site/on call) will be contacted to determine disposition, including, but not limited to examination/treatment by on site/on call Physician, transfer to Acute Care Hospital, or admission to NCHC Hospital unit.

a. All individuals coming to the NCHC and found to have an emergency medical condition will be either provided:

1) Stabilizing treatment within the capability of NCHC. Under the direction of the Physician, this treatment will be provided by members of the interdisciplinary treatment team (Medical, Nursing, Social, Dietary, and Rehab Services); or

2) Transfer per Physician order to another medical facility to meet the needs of the individual. Transfer will occur either with informed consent of the individual or certification written by Physician/RN designee after MD consultation. Certification shall state medical benefits of transfer outweigh the risks to individual.

5. In the event the Physician has reason to believe NCHC has received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of EMTALA (Emergency Medical Treatment and Labor Act) regulations, he/she will discuss with Administration appropriate action to be taken.

6. In compliance with Section I. 146.301(2) of the Wisconsin Statutes, NCHC will not refuse emergency treatment to any sick or injured person. Practitioners are expected to comply with this requirement.

Wisconsin law—(Section 146.301)—prohibits hospitals to delay emergency treatment to a sick or injured person until credit checks, financial information forms, or promissory notes have been initiated, completed, or signed if, in the opinion of one of the following, who is an employee, agent, or staff member of NCHC, the delay is likely to cause increased medical complication, permanent disability, or death:

(a) A Physician, Advanced Practice __registeredPractitioner, Registered Nurse, or emergency Emergency medical Medical technicianTechnician-Paramedic.

(b) A Licensedtrained Practical Nurse under the specific direction of a physician Practitioner or registered Registered Nurse.

(c) A physician’s assistant or any other person under the specific direction of a physician.

Further, the Omnibus Budget Reconciliation Act of Amendments of 1989 specifies that hospitals may not delay a medical screening examination or stabilizing treatment in order to inquire about the individual’s method of payment or insurance status.
III. **PHYSICIAN-PRACTITIONER ORDERS**

1. Any physician Practitioner desiring to establish routine nursing directives for his her patient may do so.

2. Orders written by the Physician or Advanced Practice Nurse Practitioner on the patient’s chart must be time, dated, and authenticated. Telephone or verbal orders from a Physician or Advanced Practice Nurse Practitioner may be obtained only by a Registered Nurse, Licensed Practical Nurse, Certified Physician Assistant, or another Practitioner.

3. All verbal and telephone orders must be authenticated, dated, and timed by the ordering provider, within 24 hours as outlined by state and federal regulations. (See DHS 124.12(5)(b)). Verbal orders should be limited to those situations in which it is impossible or impractical to write the order (i.e. an emergency) and are not to be used for the convenience of the ordering practitioner. The Chief Medical Officer, Clinical Director and/or Medical Director and/or attending/consulting physician may co-sign orders for other physicians. For rehabilitation specific orders the appropriate therapist is authorized to contact the physician and obtain an order to treat for the Plan of Care.

4. The attending physician Practitioner is responsible for obtaining informed consent(s) for psychotropic medication(s) prescribed.

5. Orders for medications, X-rays and laboratory tests must include the concise reason.

6. Orders for Restraint and/or Seclusion may be used for emergency situations only when it is likely that the patient may physically harm himself/herself or others, and other alternative modes of treatment are ineffective.

   (a) The term “restraint” includes:

   i. Any manual or physical or mechanical device (i.e., belts, restraint jackets, cuffs, or ties), material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely; or

   Modication when it is used as a restriction to manage the patient’s freedom of movement and is not standard treatment or dosage for the patient’s condition.

   Restraints do not include orthopedically prescribed methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests. Staff cannot use side rails to prevent a patient from getting out of bed as this constitutes a restraint, or wheel chair belts that a patient cannot remove.

   ii. Chemical restraints are a drug or medication used to manage the patient’s behavior or restrict a patient’s freedom of movement and
which are not a standard treatment for the patient’s medical or psychiatric condition. Standard treatment would include any of the following: medication use that is within the pharmacy-parameters set by the FDA, manufacturers for-specified use or evidence based practice, medication use that follows national practice standards, medication used to treat a specific condition based on the patient’s symptoms, and medication use that would support the patient’s stability, improvement in function, or improvement in quality of life. Standard treatment would enable the patient to be effective or appropriately functioning. PRN medications that are standard treatment for a specific psychiatric illness may be used on a short term basis and include specific documentation. Their use must be accompanied by documentation in the care plan/treatment plan, specifying the rationale and the target behaviors to be addressed, and are not considered chemical restraints.

iii. Seclusion refers to the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others. Seclusion does not include being in a locked unit with others.

iv. All orders for physical restraints and/or seclusion must include reason and period of time/episode of illness/duration during which restraint and/or seclusion may be used. Orders are to be time limited: 4 hours for adults, 2 hours for adolescents (9-17 years of age) and 1 hour for children (under age 9). An order may be renewed to continue physical restraints and/or seclusion beyond the 4/2/1 hour thresholds. Emergency restraint and/or seclusion may not continue for more than 24 hours without an evaluation by the Attending Physician and new written order.

v. The Chief Medical Officer/Clinical/Medical Directors authorize attending and on-call physicians to initiate usage of either physical restraint and/or seclusion. Clinical/Medical Directors authorize specially trained Advance Practice Nurse Practitioners, Charge RNs and Physician Assistants to conduct the one-hour review following initiation of restraint or seclusion.

vi. Emergency Situations:

Physical Restraints/Seclusion: Advanced Practice Practitioners and RNs are authorized by the Chief Medical Officer/Clinical/Medical Directors to initiate physical restraint and/or seclusion in emergency situations. The Advanced Practice Practitioner or RN must then notify the attending psychiatrist or the physician on call to obtain an order. The RN or Advance Practice Nurse Practitioner will see the patient and evaluate the need for restraint and/or seclusion within one hour after
initiation of this intervention. A new order must be obtained to continue physical restraints/seclusion beyond the 4/2 hour thresholds; face to face review must occur if order is to be renewed greater than 24 hours. The attending/on-call physician will be responsible to review the restraint/seclusion episode within 24 hours.

Patients with a recent history of physical aggression may be restrained during transport to or from the facility.

8. Infection Control: TB Triage
10. Medical history and exam must be ordered within thirty (30) days prior to admission or within 24 hours of admission. Neurological exam, including cranial nerves, must be addressed in exam.
11. All medications, including scheduled II drugs, antibiotics, anticoagulants, unless otherwise specified by the physician Practitioner, are valid with a maximum duration of 970 days. Prior to stopping these medications, physician Practitioner consultation is required. In the event of surgery, all medications will be discontinued and an order will be required to resume medications upon return of patient to the facility.

IV. MEDICAL RECORDS

1. The attending physician Practitioner is responsible for a complete legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data, legal status, personal history, family history, social history, history of present illness, physical examination, treatment plan, special reports such as consultation, clinical laboratory, x-ray and others, provisional diagnosis, final diagnosis, condition on discharge, discharge summary, follow-up, complaints, death certificate and autopsy report when available.

Discharge summaries are to be completed and authenticated within 30-seven (7) days of discharge. These shall include the final diagnosis, reason for hospitalization, significant findings, condition of the patient on discharge and any special instructions provided.

Delegation of responsibilities: The Medical Staff has delegated the responsibilities for completion of a Social Assessment Section of the Discharge Summary, to the Social Workers, and Intake Coordinator, and Substance Abuse Counselor.

2. Physician Practitioner documentation shall include review/initialing of all lab/x-ray reports. This may be delegated to the Nurse Practitioner or Physician Assistant.
Psychiatric evaluation is required within 24 hours of admission. For readmission within 30 days, for same or related condition, an updated psychiatric evaluation may be completed. This evaluation addresses the patient's current status and/or any changes in the patient's status, within seven (7) days prior to, or within twenty-four (24) hours after admission.

A psychiatric evaluation is required within 24 hours of admission. For AODA admissions the psychiatric evaluation and physical examination will be the responsibility of the internist who may request consultation from a psychiatrist based psychiatric practitioner on their exam.

A physical exam is required for all admissions patients within 24 hours of admission. For readmissions with 30 days, for same or related condition, an updated medical assessment may be completed.

A daily progress note must be written by the attending physician. A physician order is required from the physician Practitioner for a medical consult.

3. **Filed When Complete:** No medical record shall be filed until it is complete, except on order of the Medical Executive Committee.

4. Records shall not be taken out of the facility except as required or allowed by law (See North Central Health Care Confidentiality Policy for permitted by NCHC policy). Copies may be secured only by written authorization of the patient or defined by law.

5. **In case of readmission of the patient, all previous records shall be available for the use of the attending physician.** This shall apply whether the patient is attended by the same physician or by another.

6. **Any activity documented by a Medical Student, Resident Physician, Nurse Practitioner, Advance Practice Nurse Practitioner, or Physician Assistant that requires co-signing will be co-signed by a physician.**

7. **Entries Dated:** All clinical entries in the patient’s medical record shall be accurately dated, timed, and authenticated with the name and title of the person making the entry. Any activity that requires co-signing will be co-signed by a physician. A signature stamp may not be used.

8. **Abbreviations:** Symbols and abbreviations may be used only when they have been approved by the Medical Executive Committee. Abbreviations that are considered dangerous/unapproved abbreviations shall not be used at any time.

9. **Final Diagnosis:** Final diagnosis shall be recorded in full in each patient record without the use of symbols or abbreviations.

10. **Incomplete Records:** If a medical record is not complete within thirty (30) days of discharge, the record will be permanently recorded as delinquent.
V. TRANSFERS

1. Transfers to a general hospital shall be made when services and treatment not offered at the facilities of NCHC are indicated, e.g., surgery, transfusion, maternity, pathology, autopsy, etc.

2. Transfers shall be made in accordance with the transfer agreement in force with NCHC and the general hospital or as emergency circumstances dictate.

VI. CONSULTATION

1. Except in an emergency, consultation with another qualified physician may be held on cases in which, in the judgment of the attending physician:
   a. The diagnosis is obscure.
   b. There is doubt as to the best therapeutic measures to be utilized.

2. The patient's Attending Physician shall be responsible for the determination that consultations are indicated and request thereof.

3. Satisfactory consultation shall include examination of the patient and the record. A written opinion signed by the consultant shall be included in the medical record. The Attending Physician will subsequently review the consultation and incorporate the recommendation as appropriate in the patient's treatment plan.

VII. MISCELLANEOUS

1. Patients with known or suspected contagious diseases or conditions will be handled in accordance with established medical and administrative procedures, including standard precautions.

2. Nursing staff shall contact the Coroner in all cases of death for determination whether an autopsy is indicated, or upon physician request shall determine that an autopsy should be conducted for medical-legal educational interest, following facility policy/procedure.

3. NCHC respects and follows Statutory Advance Directives prepared by patients. In the event the attending physician determines he/she cannot honor the Statutory Advance Directive, he/she will remove himself/herself from the case and collaborate in transitioning care to another physician.

4. Power of Attorney for Healthcare will be activated upon a collaborative determination by the healthcare team, including the attending physician, unit staff and family/significant others. Documentation of
such action will include the reason for the activation supported by a clinical mental status exam.
PRIVILEGE AND APPOINTMENT RECOMMENDATION

Appointee: Patrick R. Heidenhein, M.D.  Appoint/Reappoint: 04-01-2020 to 03-31-2022

Time Period

Requested Privileges
- Medical
- Psychiatry
- Mid-Level Practitioner
- Medical Director

Medical Staff Status
- Courtesy
- Active

Provider Type
- Employee
- Locum
- Contract

Locum Agency: Vista
Contract Name:

CMO PRIVILEGE RECOMMENDATION
The Credentials file of this staff member contains data and information demonstrating current competence in the clinical privileges requested. After review of this information, I recommend that the clinical privileges be granted as indicated with any exceptions or conditions documented.

Comments:

(Chief Medical Officer or Designee Signature)  (Signature Date)

MEC ACTION

MEC recommends that:
- He/she be appointed/reappointed to the Medical Staff as requested
- Action be deferred on the application
- The application be denied

(MEC Committee or Designee Signature)  (Signature Date)

GOVERNING BOARD ACTION

Reviewed by Governing Board: (Date)

Response: Concur
- Recommend further reconsideration

(Governing Board Signature)  (Signature Date)

(Chief Executive Officer Signature)  (Signature Date)
PRIVILEGE AND APPOINTMENT RECOMMENDATION


Time Period

Requested Privileges
- [X] Medical
- [ ] Mid-Level Practitioner
- [ ] Medical Director
- [ ] Psychiatry

Medical Staff Status
- [X] Active
- [ ] Courtesy

Provider Type
- [X] Contract
- [ ] Locum
- [ ] Employee

Locum Agency: ____________________________
Contract Name: Aspinus

CMO PRIVILEGE RECOMMENDATION
The Credentials file of this staff member contains data and information demonstrating current competence in the clinical privileges requested. After review of this information, I recommend that the clinical privileges be granted as indicated with any exceptions or conditions documented.

Comments: ________________________________________________________________

(Chief Medical Officer or Designee Signature) ____________________________  (Signature Date) ______/____/____

MEC ACTION
MEC recommends that:
- [X] He/she be appointed/reappointed to the Medical Staff as requested
- [ ] Action be deferred on the application
- [ ] The application be denied

(MEC Committee or Designee Signature) ____________________________  (Signature Date) ______/____/____

GOVERNING BOARD ACTION
Reviewed by Governing Board: ____________________________  (Date)

Response:  
- [ ] Concur
- [ ] Recommend further reconsideration

(Governing Board Signature) ____________________________  (Signature Date) ______/____/____

(Chief Executive Officer Signature) ____________________________  (Signature Date) ______/____/____
PRIVILEGE AND APPOINTMENT RECOMMENDATION

Appointee: William C. Nieter, M.D.  
Appoint/Reappoint: 03-01-2020 to 02-28-2022  
Time Period

Requested Privileges: 
- X Medical
- ______ Psychiatry
- ______ Mid-Level Practitioner
- ______ Medical Director
- ______ Active

Medical Staff Status: 
- X Courtesy
- ______ Active

Provider Type: 
- ______ Employee
- ______ Locum
- X Contract

Locum Agency: 
Contract Name: Aspitas

CMO PRIVILEGE RECOMMENDATION
The Credentials file of this staff member contains data and information demonstrating current competence in the clinical privileges requested. After review of this information, I recommend that the clinical privileges be granted as indicated with any exceptions or conditions documented.

Comments:

(Chief Medical Officer or Designee Signature)  
1/14/20  
(Signature Date)

MEC ACTION

MEC recommends that:
- V He/she be appointed/reappointed to the Medical Staff as requested
- ______ Action be deferred on the application
- ______ The application be denied

(MEC Committee or Designee Signature)  
1/17/20  
(Signature Date)

GOVERNING BOARD ACTION

Reviewed by Governing Board: [Date]

Response:
- ______ Concur
- ______ Recommend further reconsideration

(Governing Board Signature)  
(Signature Date)

(Chief Executive Officer Signature)  
(Signature Date)
PRIVILEGE AND APPOINTMENT RECOMMENDATION

Appointee: Senca S. Ural, M.D.  Appoint/Reappoint: 03-01-2020 to 02-28-2022

Time Period

Requested Privileges
- Medical
- psychiatry
- Mid-Level Practitioner
- Medical Director

Medical Staff Status
- Courtesy
- Active

Provider Type
- Employee
- Locum
- Contract

Locum Agency: ____________________________
Contract Name: __________________________

CMO PRIVILEGE RECOMMENDATION

The Credentials file of this staff member contains data and information demonstrating current competence in the clinical privileges requested. After review of this information, I recommend that the clinical privileges be granted as indicated with any exceptions or conditions documented.

Comments:

[Signature]
(Chief Medical Officer or Designee Signature)

1/14/20
(Signature Date)

MEC ACTION

MEC recommends that:
- He/she be appointed/reappointed to the Medical Staff as requested
- Action be deferred on the application
- The application be denied

[Signature]
(MEC Committee or Designee Signature)

1-17-20
(Signature Date)

GOVERNING BOARD ACTION

Reviewed by Governing Board: ____________________________
(Date)

Response:
- Concur
- Recommend further reconsideration

[Signature]
(Governing Board Signature)

[Signature]
(Chief Executive Officer Signature)

(Signature Date)
PRIVILEGE AND APPOINTMENT RECOMMENDATION

Appointee Gabriella A. Hagniandreou, MD  Appoint/Reappoint 02-01-2020 to 01-31-2022
Time Period

Requested Privileges  
- Medical
- X Psychiatry

Mid-Level Practitioner
- Medical Director

Medical Staff Status  
- Courtesy
- X Active

Provider Type  
- Employee
- Locum
- X Contract

Locum Agency: 
Contract Name: medical college of wi

CMO PRIVILEGE RECOMMENDATION
The Credentials file of this staff member contains data and information demonstrating current competence in the clinical privileges requested. After review of this information, I recommend that the clinical privileges be granted as indicated with any exceptions or conditions documented.

Comments:

(Chief Medical Officer or Designee Signature) 1/14/21  (Signature Date)

MEC ACTION
MEC recommends that:
- X He/she be appointed/reappointed to the Medical Staff as requested
- Action be deferred on the application
- The application be denied

(MEC Committee or Designee Signature) 1/17/20  (Signature Date)

GOVERNING BOARD ACTION
Reviewed by Governing Board:   

(Date)

Response:  
- X Concur
- Recommend further reconsideration

(Governing Board Signature)  

(Signature Date)

(Chief Executive Officer Signature)  

(Signature Date)
The following items are general updates and communication to support the Board on key activities and/or updates of financial activity since our last meeting.

1) **Financial Results:** The financials did improve for December with a small gain of $78,851. These are preliminary financials and will likely have some changes during the audit process. The final financials for 2019 will be presented with the audit presentation in April.

2) **Revenue Key Points:**
   - The nursing home census declined in December, with an average of 174 per day. The target is 185 per day. Rehab revenue continues to be low. This is impacted by the Medicare census.
   - The hospital census also declined in December, with an average of 11/day. The target is 14 per day.
   - Most outpatient areas were below target in December. This is normal in December due to holidays and weather. Revenue for the Residential programs did remain on target.

3) **Expense Key Points:**
   - Overall expenses for December are over budget target.
   - Health insurance and diversions were within budget targets for the month. Contract services for physicians continue to run over target as well as legal. Food and drugs are over budget targets due to timing of invoices.
   - Overtime and call time continue to run high due to a number of open positions.
   - The support programs continue to overall remain below budget targets. This continues to help with some of the overages in the direct programs.
   - The settlement of $290,000 the Board approved in December is included in the expenses.
4) **Year End Adjustments:**

- There are adjustments that occur at year end that are related to the audit process. It is a practice for NCHC to work as many of the adjustments as possible into the preliminary financials to reduce the number of audit adjustments. These adjustments and their impact to the financials are noted below.
- Year-end inventory for food and drugs results in decrease in inventory and an increase to expense of $17,844.
- Year-end health insurance liability analysis decreased the liability and decreases health insurance expense by ($177,000).
- A revenue cut-off analysis is completed. The analysis reviews any charges related to 2019 that are billed in 2020. An entry is done to update this at the end of each year. The result of this analysis is a decrease to revenue of ($207,000). While this does impact the revenue, the implications are positive. This is indicating that charges are being billed quicker.
- The year-end WIMCR and CCS settlement for 2018 and adjustment to estimated 2019 settlements for 2019 increase revenue by $430,000.
- Other adjustments will be made as staff complete audit work papers and additional year-end information comes in.

5) **2019 Audit:** The year-end audit work is in process. The audit will be completed by the end of March and the presentation is scheduled for the Board meeting in April.
## NORTH CENTRAL HEALTH CARE
## COMBINING STATEMENT OF NET POSITION
## DECEMBER 2019

<table>
<thead>
<tr>
<th></th>
<th>Human Services</th>
<th>Nursing Home</th>
<th>Total</th>
<th>Prior Year Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>(598,832)</td>
<td>4,990,528</td>
<td>4,391,696</td>
<td>7,480,911</td>
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<tr>
<td>Accounts receivable:</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Patient - Net</td>
<td>2,874,208</td>
<td>1,221,873</td>
<td>4,096,081</td>
<td>4,792,134</td>
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<tr>
<td>Outpatient - WIMCR &amp; CCS</td>
<td>2,640,000</td>
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<td>2,640,000</td>
<td>2,147,000</td>
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<tr>
<td>Nursing home - Supplemental payment program</td>
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<td>0</td>
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<tr>
<td>Marathon County</td>
<td>(1)</td>
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<td>(1)</td>
<td>116,765</td>
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<td>Appropriations receivable</td>
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<td>(0)</td>
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<td>Net state receivable</td>
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<tr>
<td>Other</td>
<td>496,826</td>
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<td>496,826</td>
<td>345,998</td>
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<tr>
<td>Inventory</td>
<td>381,138</td>
<td>28,706</td>
<td>409,844</td>
<td>427,687</td>
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<td>Other</td>
<td>147,288</td>
<td>98,520</td>
<td>245,808</td>
<td>149,826</td>
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<td><strong>Total current assets</strong></td>
<td>7,235,138</td>
<td>6,339,626</td>
<td>13,574,764</td>
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<td><strong>Noncurrent Assets:</strong></td>
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<td></td>
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<tr>
<td>Investments</td>
<td>14,166,000</td>
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<td>14,166,000</td>
<td>13,644,000</td>
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<td>Assets limited as to use</td>
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<td>250,934</td>
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<tr>
<td>Contingency funds</td>
<td>500,000</td>
<td>500,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
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<tr>
<td>Restricted assets - Patient trust funds</td>
<td>15,025</td>
<td>21,005</td>
<td>36,031</td>
<td>34,487</td>
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<tr>
<td>Receivable restricted to pool project</td>
<td>3,213,262</td>
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<td>Net pension asset</td>
<td>3,331,431</td>
<td>2,228,367</td>
<td>5,559,798</td>
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<tr>
<td>Nondepreciable capital assets</td>
<td>2,320,709</td>
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<td>2,320,709</td>
<td>300,238</td>
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<tr>
<td>Depreciable capital assets - Net</td>
<td>6,908,211</td>
<td>3,109,216</td>
<td>10,017,427</td>
<td>10,831,674</td>
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<tr>
<td><strong>Total noncurrent assets</strong></td>
<td>30,607,234</td>
<td>5,858,589</td>
<td>36,465,822</td>
<td>26,061,334</td>
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<tr>
<td>Deferred outflows of resources - Related to pensions</td>
<td>6,154,191</td>
<td>4,116,489</td>
<td>10,270,680</td>
<td>12,070,837</td>
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<tr>
<td><strong>TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES</strong></td>
<td>43,996,563</td>
<td>16,314,703</td>
<td>60,311,267</td>
<td>54,740,773</td>
</tr>
</tbody>
</table>
## Combining Statement of Net Position
### December 2019

#### Human Services  | Nursing Home  | Total  | Prior Year  | Combined  |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Liabilities:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current portion of capital lease liability</td>
<td>22,460</td>
<td>6,789</td>
<td>29,249</td>
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<tr>
<td>Accounts payable - Trade</td>
<td>1,554,716</td>
<td>1,039,937</td>
<td>2,594,653</td>
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<tr>
<td>Appropriations advances</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Accrued liabilities:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and retirement</td>
<td>1,259,114</td>
<td>842,211</td>
<td>2,101,326</td>
<td>1,993,131</td>
</tr>
<tr>
<td>Compensated absences</td>
<td>1,073,605</td>
<td>718,126</td>
<td>1,791,731</td>
<td>1,702,438</td>
</tr>
<tr>
<td>Health and dental insurance</td>
<td>401,464</td>
<td>268,536</td>
<td>670,000</td>
<td>847,000</td>
</tr>
<tr>
<td>Other Payables</td>
<td>120,338</td>
<td>80,493</td>
<td>200,831</td>
<td>234,000</td>
</tr>
<tr>
<td>Amounts payable to third-party reimbursement programs</td>
<td>216,503</td>
<td>0</td>
<td>216,503</td>
<td>220,000</td>
</tr>
<tr>
<td>Unearned revenue</td>
<td>39,180</td>
<td>0</td>
<td>39,180</td>
<td>76,863</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td>4,687,381</td>
<td>2,956,092</td>
<td>7,643,472</td>
<td>6,526,570</td>
</tr>
<tr>
<td><strong>Noncurrent Liabilities:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net pension liability</td>
<td>565,969</td>
<td>378,572</td>
<td>944,541</td>
<td>1,582,088</td>
</tr>
<tr>
<td>Long-term portion of capital lease liability</td>
<td>56,883</td>
<td>17,193</td>
<td>74,076</td>
<td>0</td>
</tr>
<tr>
<td>Related-party liability - Master Facility Plan</td>
<td>323,558</td>
<td>97,796</td>
<td>421,354</td>
<td>0</td>
</tr>
<tr>
<td>Patient trust funds</td>
<td>15,025</td>
<td>21,005</td>
<td>36,031</td>
<td>34,487</td>
</tr>
<tr>
<td><strong>Total noncurrent liabilities</strong></td>
<td>961,435</td>
<td>514,567</td>
<td>1,476,002</td>
<td>1,616,575</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td>5,648,816</td>
<td>3,470,658</td>
<td>9,119,475</td>
<td>8,143,145</td>
</tr>
<tr>
<td><strong>Deferred inflows of resources - Related to pensions</strong></td>
<td>6,587,067</td>
<td>4,406,036</td>
<td>10,993,103</td>
<td>5,021,704</td>
</tr>
<tr>
<td><strong>Net Position:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net investment in capital assets</td>
<td>8,856,242</td>
<td>3,109,216</td>
<td>11,965,459</td>
<td>11,131,912</td>
</tr>
<tr>
<td>Restricted for capital assets - pool project</td>
<td>3,213,262</td>
<td>0</td>
<td>3,213,262</td>
<td>0</td>
</tr>
<tr>
<td><strong>Unrestricted:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board designated for contingency</td>
<td>500,000</td>
<td>500,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Board designated for capital assets</td>
<td>152,595</td>
<td>0</td>
<td>152,595</td>
<td>250,934</td>
</tr>
<tr>
<td>Undesignated</td>
<td>22,269,374</td>
<td>4,687,734</td>
<td>26,957,108</td>
<td>28,818,618</td>
</tr>
<tr>
<td>Operating Income / (Loss)</td>
<td>(3,230,793)</td>
<td>141,058</td>
<td>(3,089,736)</td>
<td>374,459</td>
</tr>
<tr>
<td><strong>Total net position</strong></td>
<td>31,760,681</td>
<td>8,438,008</td>
<td>40,198,689</td>
<td>41,575,924</td>
</tr>
</tbody>
</table>

**TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION**

| 43,996,563 | 16,314,703 | 60,311,267 | 54,740,773 |
NORTH CENTRAL HEALTH CARE  
COMBINING STATEMENT OF REVENUES AND EXPENSES  
FOR PERIOD ENDING DECEMBER 31, 2019

<table>
<thead>
<tr>
<th>Revenue:</th>
<th>TOTAL</th>
<th>ACTUAL</th>
<th>BUDGET</th>
<th>VARIANCE</th>
<th>TOTAL</th>
<th>ACTUAL</th>
<th>BUDGET</th>
<th>VARIANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Patient Service Revenue</td>
<td>$5,102,026</td>
<td>$4,226,085</td>
<td>$875,941</td>
<td>$54,037,616</td>
<td>$51,821,900</td>
<td>$2,215,716</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Revenue:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Match / Addendum</td>
<td>418,922</td>
<td>418,151</td>
<td>771</td>
<td>5,018,577</td>
<td>5,017,806</td>
<td>771</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grant Revenue</td>
<td>172,063</td>
<td>210,375</td>
<td>(38,312)</td>
<td>6,305,830</td>
<td>6,305,500</td>
<td>330</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Appropriations - Net</td>
<td>525,486</td>
<td>525,486</td>
<td>(0)</td>
<td>6,305,831</td>
<td>6,305,831</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental and Other Revenue</td>
<td>312,042</td>
<td>349,219</td>
<td>(37,176)</td>
<td>4,043,578</td>
<td>4,190,623</td>
<td>(147,045)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Other Revenue</td>
<td>1,428,512</td>
<td>1,503,230</td>
<td>(74,718)</td>
<td>18,034,980</td>
<td>18,038,760</td>
<td>(3,780)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
<td>6,530,538</td>
<td>5,729,315</td>
<td>801,223</td>
<td>72,072,596</td>
<td>69,860,660</td>
<td>2,211,936</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenses:</th>
<th>TOTAL</th>
<th>ACTUAL</th>
<th>BUDGET</th>
<th>VARIANCE</th>
<th>TOTAL</th>
<th>ACTUAL</th>
<th>BUDGET</th>
<th>VARIANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Expenses</td>
<td>4,702,835</td>
<td>4,409,175</td>
<td>293,660</td>
<td>58,534,002</td>
<td>52,159,983</td>
<td>6,374,019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indirect Expenses</td>
<td>1,783,214</td>
<td>1,513,925</td>
<td>269,289</td>
<td>17,186,175</td>
<td>17,950,677</td>
<td>(764,502)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Expenses</td>
<td>6,486,049</td>
<td>5,923,100</td>
<td>562,949</td>
<td>75,720,178</td>
<td>70,110,660</td>
<td>5,609,518</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Operating Income (Loss)       | 44,489 | (193,785) | 238,274    | (3,647,581) | (250,000) | (3,397,581) |

<table>
<thead>
<tr>
<th>Nonoperating Gains (Losses):</th>
<th>TOTAL</th>
<th>ACTUAL</th>
<th>BUDGET</th>
<th>VARIANCE</th>
<th>TOTAL</th>
<th>ACTUAL</th>
<th>BUDGET</th>
<th>VARIANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest Income</td>
<td>31,796</td>
<td>20,833</td>
<td>10,963</td>
<td>369,796</td>
<td>250,000</td>
<td>119,796</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donations and Gifts</td>
<td>3,714</td>
<td>0</td>
<td>3,714</td>
<td>54,508</td>
<td>0</td>
<td>54,508</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gain / (Loss) on Disposal of Assets</td>
<td>(1,148)</td>
<td>0</td>
<td>(1,148)</td>
<td>133,543</td>
<td>0</td>
<td>133,543</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Nonoperating Gains / (Losses)</td>
<td>34,362</td>
<td>20,833</td>
<td>13,529</td>
<td>557,846</td>
<td>250,000</td>
<td>307,846</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Income / (Loss) | $78,851 | ($172,951) | $251,803   | ($3,089,735) | $0 | ($3,089,735) |
## NORTH CENTRAL HEALTH CARE  
### COMBINING STATEMENT OF REVENUES AND EXPENSES  
#### FOR PERIOD ENDING DECEMBER 31, 2019

<table>
<thead>
<tr>
<th></th>
<th>CURRENT MONTH ACTUAL</th>
<th>CURRENT MONTH BUDGET</th>
<th>CURRENT MONTH VARIANCE</th>
<th>YTD ACTUAL</th>
<th>YTD BUDGET</th>
<th>YTD VARIANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>51.42/.437 PROGRAMS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Patient Service Revenue</td>
<td>$3,452,552</td>
<td>$2,544,595</td>
<td>$907,957</td>
<td>$33,491,429</td>
<td>$31,939,900</td>
<td>$1,551,529</td>
</tr>
<tr>
<td>Other Revenue:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Match / Addendum</td>
<td>418,922</td>
<td>418,151</td>
<td>771</td>
<td>5,018,577</td>
<td>5,017,806</td>
<td>771</td>
</tr>
<tr>
<td>Grant Revenue</td>
<td>172,063</td>
<td>210,375</td>
<td>(38,312)</td>
<td>2,666,995</td>
<td>2,524,500</td>
<td>142,495</td>
</tr>
<tr>
<td>County Appropriations - Net</td>
<td>400,486</td>
<td>400,486</td>
<td>(0)</td>
<td>4,805,830</td>
<td>4,805,831</td>
<td>(1)</td>
</tr>
<tr>
<td>Departmental and Other Revenue</td>
<td>196,864</td>
<td>238,277</td>
<td>(41,413)</td>
<td>2,573,354</td>
<td>2,859,324</td>
<td>(285,970)</td>
</tr>
<tr>
<td>Total Other Revenue</td>
<td>1,188,334</td>
<td>1,267,288</td>
<td>(78,954)</td>
<td>15,064,756</td>
<td>15,207,461</td>
<td>(142,705)</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>4,640,886</td>
<td>3,811,883</td>
<td>829,003</td>
<td>48,556,185</td>
<td>47,147,361</td>
<td>1,408,824</td>
</tr>
<tr>
<td>Expenses:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Expenses</td>
<td>3,440,756</td>
<td>3,154,058</td>
<td>286,698</td>
<td>42,537,535</td>
<td>37,410,139</td>
<td>5,127,396</td>
</tr>
<tr>
<td>Indirect Expenses</td>
<td>1,123,292</td>
<td>842,302</td>
<td>280,990</td>
<td>9,791,417</td>
<td>9,987,222</td>
<td>(195,805)</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>4,564,048</td>
<td>3,996,360</td>
<td>567,687</td>
<td>52,328,952</td>
<td>47,397,361</td>
<td>4,931,591</td>
</tr>
<tr>
<td>Operating Income (Loss)</td>
<td>76,838</td>
<td>(184,477)</td>
<td>261,315</td>
<td>(3,772,767)</td>
<td>(250,000)</td>
<td>(3,522,767)</td>
</tr>
<tr>
<td>Nonoperating Gains (Losses):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Income</td>
<td>31,796</td>
<td>20,833</td>
<td>10,963</td>
<td>369,796</td>
<td>250,000</td>
<td>119,796</td>
</tr>
<tr>
<td>Donations and Gifts</td>
<td>1,651</td>
<td>0</td>
<td>1,651</td>
<td>38,635</td>
<td>0</td>
<td>38,635</td>
</tr>
<tr>
<td>Gain / (Loss) on Disposal of Assets</td>
<td>(1,148)</td>
<td>0</td>
<td>(1,148)</td>
<td>133,543</td>
<td>0</td>
<td>133,543</td>
</tr>
<tr>
<td>Total Nonoperating Gains / (Losses)</td>
<td>32,299</td>
<td>20,833</td>
<td>11,466</td>
<td>541,974</td>
<td>250,000</td>
<td>291,974</td>
</tr>
<tr>
<td>Income / (Loss)</td>
<td>$109,137</td>
<td>($163,644)</td>
<td>$272,781</td>
<td>($3,230,793)</td>
<td>($0)</td>
<td>($3,230,793)</td>
</tr>
</tbody>
</table>
# NORTH CENTRAL HEALTH CARE
## COMBINING STATEMENT OF REVENUES AND EXPENSES
### FOR PERIOD ENDING DECEMBER 31, 2019

<table>
<thead>
<tr>
<th></th>
<th>CURRENT MONTH</th>
<th>CURRENT MONTH</th>
<th>CURRENT MONTH</th>
<th>YTD</th>
<th>YTD</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ACTUAL</td>
<td>BUDGET</td>
<td>VARIANCE</td>
<td>ACTUAL</td>
<td>BUDGET</td>
<td>VARIANCE</td>
</tr>
<tr>
<td><strong>NURSING HOME</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Revenue:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Patient Service Revenue</td>
<td>$1,649,475</td>
<td>$1,681,490</td>
<td>($32,016)</td>
<td>$20,546,187</td>
<td>$19,882,000</td>
<td>$664,187</td>
</tr>
<tr>
<td>Other Revenue:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Appropriations - Net</td>
<td>125,000</td>
<td>125,000</td>
<td>0</td>
<td>1,500,000</td>
<td>1,500,000</td>
<td>0</td>
</tr>
<tr>
<td>Departmental and Other Revenue</td>
<td>115,178</td>
<td>110,942</td>
<td>4,236</td>
<td>1,470,224</td>
<td>1,331,299</td>
<td>138,925</td>
</tr>
<tr>
<td><strong>Total Other Revenue</strong></td>
<td>240,178</td>
<td>235,942</td>
<td>4,236</td>
<td>2,970,224</td>
<td>2,831,299</td>
<td>138,925</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>1,889,653</td>
<td>1,917,432</td>
<td>(27,779)</td>
<td>23,516,412</td>
<td>22,713,299</td>
<td>803,112</td>
</tr>
<tr>
<td><strong>Expenses:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Expenses</td>
<td>1,262,079</td>
<td>1,255,117</td>
<td>6,962</td>
<td>15,996,468</td>
<td>14,749,844</td>
<td>1,246,624</td>
</tr>
<tr>
<td>Indirect Expenses</td>
<td>659,922</td>
<td>671,622</td>
<td>(11,700)</td>
<td>7,394,758</td>
<td>7,963,455</td>
<td>(568,697)</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>1,922,001</td>
<td>1,926,739</td>
<td>(4,738)</td>
<td>23,391,226</td>
<td>22,713,299</td>
<td>677,927</td>
</tr>
<tr>
<td><strong>Operating Income (Loss)</strong></td>
<td>(32,349)</td>
<td>(9,307)</td>
<td>(23,041)</td>
<td>125,186</td>
<td>0</td>
<td>125,186</td>
</tr>
<tr>
<td><strong>Nonoperating Gains (Losses):</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Income</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Donations and Gifts</td>
<td>2,063</td>
<td>0</td>
<td>2,063</td>
<td>15,872</td>
<td>0</td>
<td>15,872</td>
</tr>
<tr>
<td>Gain / (Loss) on Disposal of Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Nonoperating Gains / (Losses)</strong></td>
<td>2,063</td>
<td>0</td>
<td>2,063</td>
<td>15,872</td>
<td>0</td>
<td>15,872</td>
</tr>
<tr>
<td><strong>Income / (Loss)</strong></td>
<td>($30,286)</td>
<td>($9,307)</td>
<td>($20,979)</td>
<td>$141,058</td>
<td>$0</td>
<td>$141,058</td>
</tr>
<tr>
<td>BANK</td>
<td>LENGTH</td>
<td>MATURITY DATE</td>
<td>INTEREST RATE</td>
<td>AMOUNT</td>
<td>Insured/ Collateralized</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>---------------</td>
<td>---------------</td>
<td>---------</td>
<td>-------------------------</td>
<td></td>
</tr>
<tr>
<td>PFM Investments</td>
<td>455 Days</td>
<td>2/13/2020</td>
<td>2.73%</td>
<td>$482,000</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>BMO Harris</td>
<td>549 Days</td>
<td>2/26/2020</td>
<td>2.50%</td>
<td>$500,000</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Abby Bank</td>
<td>730 Days</td>
<td>3/15/2020</td>
<td>1.71%</td>
<td>$400,000</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>People's State Bank</td>
<td>365 Days</td>
<td>3/28/2020</td>
<td>2.10%</td>
<td>$250,000</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>PFM Investments</td>
<td>365 Days</td>
<td>4/3/2020</td>
<td>2.58%</td>
<td>$486,000</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>PFM Investments</td>
<td>730 Days</td>
<td>4/29/2020</td>
<td>2.57%</td>
<td>$473,000</td>
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</tr>
<tr>
<td>Abby Bank</td>
<td>730 Days</td>
<td>5/3/2020</td>
<td>2.00%</td>
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<tr>
<td>BMO Harris</td>
<td>365 Days</td>
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<td>2.45%</td>
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<tr>
<td>People's State Bank</td>
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<tr>
<td>People's State Bank</td>
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<td>2.40%</td>
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<tr>
<td>PFM Investments</td>
<td>365 Days</td>
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<td>2.53%</td>
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<tr>
<td>People's State Bank</td>
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<tr>
<td>PFM Investments</td>
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<tr>
<td>PFM Investments</td>
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<td>12/30/2020</td>
<td>1.60%</td>
<td>$490,000</td>
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<tr>
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<tr>
<td>CoVantage Credit Union</td>
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<td>1/29/2021</td>
<td>2.00%</td>
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<tr>
<td>CoVantage Credit Union</td>
<td>455 Days</td>
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<tr>
<td>Abby Bank</td>
<td>730 Days</td>
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<td>2.72%</td>
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<td>7/19/2021</td>
<td>2.45%</td>
<td>$500,000</td>
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**TOTAL FUNDS AVAILABLE** $14,166,000

**WEIGHTED AVERAGE** 495.53 Days 2.174% INTEREST
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<th>ASSETS</th>
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<tr>
<td><strong>Current Assets</strong></td>
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<tr>
<td>Checking/Savings</td>
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<td><strong>CHECKING ACCOUNT</strong></td>
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<tr>
<td>Adult Day Services</td>
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<td>Adventure Camp</td>
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<tr>
<td>Alvin Therapy Dog</td>
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<tr>
<td>Birth to 3 Program</td>
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<tr>
<td>Clubhouse</td>
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<tr>
<td>Community Treatment - Adult</td>
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<tr>
<td>Community Treatment - Youth</td>
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<tr>
<td>Fishing Without Boundries</td>
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<td>General Donated Funds</td>
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<td>Hope House</td>
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<td>Housing - DD Services</td>
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<td>Langlade HCC</td>
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<tr>
<td>Legacies by the Lake</td>
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<td>Music in Memory</td>
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<tr>
<td>Legacies by the Lake - Other</td>
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<td>Total Legacies by the Lake</td>
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<tr>
<td>Marathon Cty Suicide Prev Task</td>
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<tr>
<td>National Suicide Lifeline Stipe</td>
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<td>Northern Valley West</td>
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<tr>
<td>Nursing Home - General Fund</td>
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<tr>
<td>Outpatient Services - Marathon</td>
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<tr>
<td>Pool</td>
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<tr>
<td>Prevent Suicide Langlade Co.</td>
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<tr>
<td>Recovery Coach</td>
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<td>Resident Council</td>
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<td>United Way</td>
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<td>Voyages for Growth</td>
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<tr>
<td><strong>Total CHECKING ACCOUNT</strong></td>
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<tr>
<td><strong>Total Checking/Savings</strong></td>
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<tr>
<td><strong>Total Current Assets</strong></td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIABILITIES &amp; EQUITY</th>
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</thead>
<tbody>
<tr>
<td><strong>Equity</strong></td>
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<tr>
<td>Opening Bal Equity</td>
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<tr>
<td>Retained Earnings</td>
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<tr>
<td>Net Income</td>
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<tr>
<td><strong>Total Equity</strong></td>
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<tr>
<td><strong>TOTAL LIABILITIES &amp; EQUITY</strong></td>
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Month Ending December 31, 2019

<table>
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<tr>
<th>ACCOUNT DESCRIPTION</th>
<th>CURRENT MONTH ACTUAL</th>
<th>CURRENT MONTH BUDGET</th>
<th>YTD ACTUAL</th>
<th>YTD BUDGET</th>
<th>DIFFERENCE</th>
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<tr>
<td><strong>REVENUE:</strong></td>
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<tr>
<td>Total Operating Revenue</td>
<td>6,530,538</td>
<td>5,729,315</td>
<td>72,072,596</td>
<td>69,860,660</td>
<td>2,211,936</td>
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<tr>
<td><strong>EXPENSES:</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Salaries and Wages</td>
<td>2,746,991</td>
<td>2,931,969</td>
<td>32,220,009</td>
<td>34,459,665</td>
<td>(2,239,656)</td>
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<td>Fringe Benefits</td>
<td>703,230</td>
<td>1,089,048</td>
<td>13,288,472</td>
<td>12,800,000</td>
<td>488,472</td>
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<td>Departments Supplies</td>
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<td>666,986</td>
<td>8,472,824</td>
<td>8,003,832</td>
<td>468,992</td>
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<td>Purchased Services</td>
<td>884,282</td>
<td>503,254</td>
<td>10,064,011</td>
<td>6,065,050</td>
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<td>Utilities/Maintenance Agreements</td>
<td>443,933</td>
<td>259,704</td>
<td>4,580,108</td>
<td>3,116,451</td>
<td>1,463,657</td>
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<td>Personal Development/Travel</td>
<td>57,835</td>
<td>44,662</td>
<td>505,255</td>
<td>535,950</td>
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<td>Other Operating Expenses</td>
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<td>176,309</td>
<td>1,677,541</td>
<td>2,115,712</td>
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<td>Insurance</td>
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<td>39,250</td>
<td>458,560</td>
<td>471,000</td>
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<td>Depreciation &amp; Amortization</td>
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<td>145,250</td>
<td>1,981,462</td>
<td>1,743,000</td>
<td>238,462</td>
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<td>Client Purchased Services</td>
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<td>66,667</td>
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<td><strong>TOTAL EXPENSES</strong></td>
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<td>20,833</td>
<td>557,846</td>
<td>250,000</td>
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<td><strong>EXCESS REVENUE (EXPENSE)</strong></td>
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<td>(172,951)</td>
<td>(3,089,735)</td>
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<td>(3,089,735)</td>
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# North Central Health Care
## Write-Off Summary
### December 2019

<table>
<thead>
<tr>
<th>Category</th>
<th>Current Month</th>
<th>Current Year To Date</th>
<th>Prior Year To Date</th>
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<tbody>
<tr>
<td><strong>Inpatient:</strong></td>
<td></td>
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</tr>
<tr>
<td>Administrative Write-Off</td>
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<td>Bad Debt</td>
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<td><strong>Outpatient:</strong></td>
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<tr>
<td>Administrative Write-Off</td>
<td>$38,701</td>
<td>$186,715</td>
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<td>Bad Debt</td>
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<td><strong>Nursing Home:</strong></td>
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<tr>
<td>Daily Services:</td>
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<tr>
<td>Administrative Write-Off</td>
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<td>Ancillary Services:</td>
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<td>$574</td>
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<td><strong>Pharmacy:</strong></td>
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<td>Administrative Write-Off</td>
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<td>$926</td>
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<td>Bad Debt</td>
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<td>$671</td>
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<td><strong>Total - Administrative Write-Off</strong></td>
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<td>Month</td>
<td>Nursing Home</td>
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<td>May</td>
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<td>5,578</td>
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<td>5,547</td>
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<td>5,390</td>
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<td>355</td>
<td>434</td>
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<td>YTD</td>
<td>67,525</td>
<td>5,110</td>
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<tr>
<td></td>
<td>5,110</td>
<td>1,894</td>
<td>5,110</td>
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</tbody>
</table>
## North Central Health Care
### Review of 2019 Services
#### Langlade County

**Outpatient Services**  
- **2019 Actual Rev:** $469,095  
- **2019 Budg Rev:** $677,989  
- **2019 Variance:** ($208,894)  
- **2019 Actual Exp:** $587,353  
- **2019 Budg Exp:** $798,212  
- **2019 Variance:** ($210,859)  
- **2019 Program Variance:** $1,965

**Community Treatment-Adult**  
- **2019 Actual Rev:** $729,595  
- **2019 Budg Rev:** $597,293  
- **2019 Variance:** $132,302  
- **2019 Actual Exp:** $565,653  
- **2019 Budg Exp:** $606,293  
- **2019 Variance:** ($40,640)  
- **2019 Program Variance:** $172,942

**Community Treatment-Youth**  
- **2019 Actual Rev:** $1,522,472  
- **2019 Budg Rev:** $1,277,503  
- **2019 Variance:** $244,969  
- **2019 Actual Exp:** $1,354,564  
- **2019 Budg Exp:** $1,277,503  
- **2019 Variance:** ($77,081)  
- **2019 Program Variance:** $167,888

**Day Services**  
- **2019 Actual Rev:** $303,829  
- **2019 Budg Rev:** $326,000  
- **2019 Variance:** ($22,171)  
- **2019 Actual Exp:** $350,567  
- **2019 Budg Exp:** $326,000  
- **2019 Variance:** ($24,567)  
- **2019 Program Variance:** ($46,738)

**Shared Services:**

### Inpatient
- **2019 Actual Rev:** $477,155  
- **2019 Budg Rev:** $465,253  
- **2019 Variance:** $11,902  
- **2019 Actual Exp:** $577,503  
- **2019 Budg Exp:** $544,545  
- **2019 Variance:** ($32,958)  
- **2019 Program Variance:** ($21,056)

### Hospital Psychiatry
- **2019 Actual Rev:** $138,940  
- **2019 Budg Rev:** $95,468  
- **2019 Variance:** $43,472  
- **2019 Actual Exp:** $100,551  
- **2019 Budg Exp:** $95,468  
- **2019 Variance:** ($5,083)  
- **2019 Program Variance:** $38,389

### Crisis
- **2019 Actual Rev:** $78,168  
- **2019 Budg Rev:** $62,211  
- **2019 Variance:** $15,957  
- **2019 Actual Exp:** $341,046  
- **2019 Budg Exp:** $295,510  
- **2019 Variance:** ($45,536)  
- **2019 Program Variance:** ($29,579)

### MMT (Lakeside Recovery)
- **2019 Actual Rev:** $104,832  
- **2019 Budg Rev:** $138,183  
- **2019 Variance:** ($33,351)  
- **2019 Actual Exp:** $460,553  
- **2019 Budg Exp:** $434,176  
- **2019 Variance:** ($26,377)  
- **2019 Program Variance:** ($59,728)

### Outpatient Psychiatry
- **2019 Actual Rev:** $26,457  
- **2019 Budg Rev:** $25,818  
- **2019 Variance:** $639  
- **2019 Actual Exp:** $78,922  
- **2019 Budg Exp:** $86,128  
- **2019 Variance:** $6,206  
- **2019 Program Variance:** $6,845

### Birth To Three
- **2019 Actual Rev:** $94,068  
- **2019 Budg Rev:** $104,766  
- **2019 Variance:** ($10,698)  
- **2019 Actual Exp:** $166,750  
- **2019 Budg Exp:** $193,063  
- **2019 Variance:** ($26,313)  
- **2019 Program Variance:** $15,615

### Group Homes
- **2019 Actual Rev:** $288,425  
- **2019 Budg Rev:** $194,689  
- **2019 Variance:** $93,736  
- **2019 Actual Exp:** $268,167  
- **2019 Budg Exp:** $194,689  
- **2019 Variance:** ($73,478)  
- **2019 Program Variance:** $20,258

### Supported Apartments
- **2019 Actual Rev:** $0  
- **2019 Budg Rev:** $0  
- **2019 Variance:** $0  
- **2019 Actual Exp:** $0  
- **2019 Budg Exp:** $0  
- **2019 Variance:** $0  
- **2019 Program Variance:** $0

### Contract Services
- **2019 Actual Rev:** $0  
- **2019 Budg Rev:** $0  
- **2019 Variance:** $0  
- **2019 Actual Exp:** $304,049  
- **2019 Budg Exp:** $98,717  
- **2019 Variance:** ($205,332)  
- **2019 Program Variance:** ($205,332)

### Totals
- **2019 Actual Rev:** $1,281,380  
- **2019 Budg Rev:** $1,234,782  
- **2019 Variance:** $46,598  
- **2019 Actual Exp:** $2,671,018  
- **2019 Budg Exp:** $2,218,003  
- **2019 Variance:** ($453,015)  
- **2019 Program Variance:** ($406,417)

### Base County Allocation
- **2019 Actual Rev:** $798,531  
- **2019 Budg Rev:** $798,531  
- **2019 Variance:** $0  
- **2019 Actual Exp:** $0  
- **2019 Budg Exp:** $0  
- **2019 Variance:** $0

### Nonoperating Revenue
- **2019 Actual Rev:** $23,905  
- **2019 Budg Rev:** $15,430  
- **2019 Variance:** $8,475  
- **2019 Actual Exp:** $0  
- **2019 Budg Exp:** $8,475  
- **2019 Variance:** $0

### County Appropriation
- **2019 Actual Rev:** $298,483  
- **2019 Budg Rev:** $298,483  
- **2019 Variance:** $0  
- **2019 Actual Exp:** $0  
- **2019 Budg Exp:** $0  
- **2019 Variance:** $0

**Excess Revenue/(Expense)**  
- **2019 Actual Rev:** $5,427,290  
- **2019 Budg Rev:** $5,226,011  
- **2019 Variance:** $201,279  
- **2019 Actual Exp:** $5,529,175  
- **2019 Budg Exp:** $5,226,011  
- **2019 Variance:** ($303,164)  
- **2019 Program Variance:** ($101,885)
### North Central Health Care

**Review of 2019 Services**

**Lincoln County**

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| Totals                    | $1,346,196              | $1,408,785 ($62,589)   |          | $3,262,729              | $2,741,514 ($521,215) | ($583,804) |

| Base County Allocation    | $829,977                | $829,977 $0            |          | $6,371,924              | $5,763,847 ($608,077) | ($315,959) |
| Nonoperating Revenue      | $33,366                 | $21,910 $11,456       |          | $33,366                 | $21,910 $11,456      | $11,456  |
| County Appropriation      | $712,416                | $712,416 $0            |          | $712,416                | $712,416 $0          | $0       |

| Excess Revenue (Expense)  | $6,067,421              | $5,763,847 $303,574   |          | $6,371,924              | $5,763,847 ($608,077) | ($304,503) |
|-----------------|-------------------------|-------------------------|-----------------------|-------------------------|-------------------------|---------|---------------------|
| Outpatient Services | $1,346,889 | $1,900,861 | ($553,972) | $2,194,039 | $2,249,284 | $55,245 | ($498,727) |
| Community Treatment-Adult | $4,233,485 | $3,911,057 | $322,428 | $4,100,543 | $3,991,057 | ($109,486) | $212,942 |
| Community Treatment-Youth | $4,734,352 | $3,745,694 | $988,658 | $4,389,519 | $3,745,694 | ($643,825) | $344,833 |
| Day Services | $1,503,636 | $1,490,253 | $13,383 | $1,473,810 | $1,490,253 | $16,443 | $29,826 |
| Clubhouse | $251,278 | $504,099 | ($252,821) | $461,657 | $596,099 | $134,442 | ($118,379) |
| Demand Transportation | $424,269 | $438,235 | ($13,966) | $398,672 | $438,235 | $39,563 | $25,597 |
| Aquatic Services | $706,331 | $801,463 | ($95,132) | $1,102,378 | $1,143,808 | $41,430 | ($53,702) |
| Pharmacy | $5,872,843 | $5,127,887 | $744,956 | $5,983,596 | $5,127,887 | ($855,709) | ($110,753) |
| $19,073,083 | $17,919,549 | $1,153,534 | $20,104,214 | $18,782,317 | ($1,321,897) | ($168,363) |

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| Totals | $30,105,921 | $29,010,613 | $1,095,308 | $40,427,852 | $36,407,503 | ($4,020,349) | ($2,925,041) |
| Base County Allocation | $3,390,069 | $3,389,298 | $771 | $312,525 | $212,660 | $99,865 | $99,865 |
| Nonoperating Revenue | $3,794,932 | $3,794,932 | $0 | $37,603,447 | $36,407,503 | ($1,195,944) | ($4,020,349) | ($2,824,405) |
AGREEMENT FOR THE JOINT SPONSORSHIP OF COMMUNITY PROGRAMS

Between

Langlade, Lincoln & Marathon Counties

January 1, 2017—December 31, 2021 TBD May 1, 2020 – April 30, 2025
I. PARTIES
   A. Counties ................................................................. 5
   B. North Central Community Services Program ................. 5

II. PURPOSE........................................................................... 5
   A. Legislative Policy ...................................................... 5
   B. Legislative Purpose .................................................... 5
   C. County Responsibility ................................................. 6
   D. Required County Program – Mental Health .................. 6
   E. Required County Program – Protective Services and Protective Placement ................................. 6
   F. Multicounty Agreement Requirement ............................. 6
   G. Prior Joint County Agreements Superseded .................... 6
   H. Member Counties’ Legislative Purpose ......................... 6

III. BACKGROUND.................................................................... 7
   A. Wisconsin Law Enactment ............................................. 7
   B. County Community Program Establishment .................... 7
   C. Developmental Disabilities Program ......................... 87
   D. Marathon County Nursing Home .................................. 8
   E. Designated Protective Services Agencies ...................... 8
      1. Langlade County ....................................................... 8
      2. Lincoln County ...................................................... 8
      3. Marathon County ................................................... 8
   F. Initial Joint County Agreement ...................................... 89

IV. NORTH CENTRAL COMMUNITY SERVICES PROGRAM DUTIES ...... 9
   A. Agreements for Services .............................................. 9
   B. Agreements for Facilities ............................................ 9
   C. Contract for Legal Services ......................................... 109
   D. Provision of Services ................................................ 10
   E. Prepare Local Plan ..................................................... 10
   F. Program Implementation ............................................. 110
   G. School Board Referrals; Interagency Cooperation ........... 110
   H. Budget ........................................................................ 11
   I. Costs of Services ........................................................ 11
   J. Reports, Surveys, and Approvals .................................. 11
   K. Authorize Care .......................................................... 11

V. RETAINED COUNTY BOARD AUTHORITY COMMITTEE .............. 11
   A. Purpose ................................................................. 11
   B. Committee Composition ............................................. 12
   C. Reporting Relationship .............................................. 12
   D. Duties and Responsibilities ......................................... 12
   E. Other Organizational Relationships ................................. 16
<table>
<thead>
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<th>IX. MISCELLANEOUS</th>
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<td>B. Assignment</td>
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<td>C. Waiver and Modification</td>
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<td>L. Immunity</td>
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JOINT COUNTY AGREEMENT

Langlade, Lincoln and Marathon Counties agree to continue sponsorship of a multicounty department of community programs known as North Central Community Services Program, for the purposes of administering a community mental health, alcoholism and drug abuse program and Protective Services and Protective Placement on the following terms:

I. PARTIES

A. Counties. Langlade, Lincoln and Marathon Counties are political subdivisions of the State of Wisconsin, established pursuant to §§2.01(34), 2.01(35), and 2.01(37), Wis. Stats., respectively, and doing business as quasi-municipal corporations, pursuant to §59.01, Wis. Stats.

B. North Central Community Services Program ("NCCSP") is a multicounty community services program established pursuant to §§ 51.42 and 66.0301, Wis. Stats., and is also designated to provide Protective Services and Protective Placement to residents of Lincoln, Langlade and Marathon Counties, pursuant to §55.02, Wis. Stats. It is intent of the member counties that the multicounty community services program established herein be construed to be a political corporation or governmental subdivision or agency thereof pursuant to Wis. Stat. Chapters 893 and 895, and related statutes. NCCSP is not a party to this Agreement, but rather it is created by virtue of the agreement of Langlade, Lincoln and Marathon Counties.

II. PURPOSE

This Agreement of the Counties is based on the following policies and mandates of the State of Wisconsin as found in the Wisconsin Statutes:

A. Legislative Policy. The Wisconsin Legislature has stated in Wisconsin Statutes that it is the policy of the State to assure the provision of a full range of treatment and rehabilitation services in the state for all mental disorders including for mental illness, alcoholism and other drug abuse.

B. Legislative Purpose. To carry out the policy of the State of Wisconsin the Legislature enacted Section § 51.42 of the Wisconsin Statutes stating its purpose as follows:

The purpose and intent of this section is to enable and to encourage counties to develop a comprehensive range of services offering continuity of care, to utilize and expand existing governmental, voluntary and private community resources for provision of services to prevent or
ameliorate mental disabilities, including but not limited to mental illness, developmental disabilities, mental retardation, alcoholism and drug abuse; to provide for the integration of administration of those services and facilities organized under this section through the establishment of a county department of community programs; unified governing and policy-making board; and to authorize state consultative services, reviews and establishment of standards and grants-in-aid for such programs of services and facilities.

C. **County Responsibility.** The Legislature has decreed that the county boards of supervisors have the primary responsibility for the well-being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens and for providing Protective Services and Protective Placement to persons residing within their respective counties and ensuring that those individuals in need of such emergency services found within their respective counties receive immediate emergency services.

D. **Required County Program -Mental Health.** In § 51.42 of the Statutes, the Legislature has required that the county board of supervisors of every county, or the county boards of supervisors of two or more contiguous counties, shall establish a county department of community programs on a single-county or multicounty basis to administer a community mental health, developmental disabilities, alcoholism and drug abuse program, make appropriations to operate the program and authorize the county department of community programs to apply for grants-in-aid under § 51.423 of the Statutes.

E. **Required County Program -Protective Services and Protective Placement.** In §55.02 of the Statutes, the Legislature has required that every county board of supervisors shall designate a county department to have the responsibility for planning for the provision of protective services and protective placement and for directly providing protective services and protective placement.

F. **Multicounty Agreement Requirement.** Section 51.42(3)(c) of the Statutes provides that no grant-in-aid may be made to a multicounty department of community programs until the counties which established the multicounty department of community programs have drawn up a detailed contractual agreement, approved by the Secretary of the Department of Health Services, setting forth the plans for joint sponsorship, a detailed contractual agreement between the counties which established the multicounty department of community programs is entered into and approved by the secretary of the Wisconsin Department of Health and Social Services. It is the intent of Langlade, Lincoln and Marathon Counties that this agreement satisfy the requirements of § 51.42(3)(c) of the Wisconsin Statutes.

G. **Prior Joint County Agreements Superseded.** The Agreement supersedes all previous agreements between Lincoln, Langlade and Marathon Counties concerning the establishment and ongoing sponsorship of the North Central Community
Services Program, including the Joint County Human Services Agreement entered in July of 1983, the updated Joint County Agreement entered in 1986, and the updated Joint County Agreement entered in 2008, and the updated Joint County Agreement entered in 2017. In 2012, Lincoln and Langlade County passed a Revised Joint County Agreement which Marathon County never ratified. This Agreement supersedes that agreement as well.

H. Member Counties’ Legislative Purpose. The intent of Lincoln, Langlade and Marathon Counties is to establish a multicounty department of community programs that is responsive to the needs and priorities of the member counties, effectively operating as a county department of multiple counties under a government service model, as opposed to an independent not-for-profit entity. This agreement governs the provision of all services provided to the member counties by, or through, NCCSP in accordance with Chapter 51 of the Wisconsin Statutes. Each of the member counties remain free to contract with NCCSP for the administration of any other health care program or institution.

III. BACKGROUND

Although a recitation of the history of this Agreement is not required by law in order to constitute an enforceable Agreement, it has been deemed by the authors to contain relevant context for interpretation as well as future drafters of ongoing revisions. The establishment of the North Central Community Services Program (NCCSP) was based on the following State and County enactments:

A. Wisconsin Law Enactment. Section 51.42 of the Wisconsin Statutes was enacted by the Wisconsin Legislature in Section 361 of Chapter 125 of the Laws of 1971 creating the liability of the counties to provide programs of treatment and rehabilitative services for mental illness, developmental disabilities, alcoholism and other drug abuse.

B. County Community Program Establishment. Langlade, Lincoln and Marathon Counties each passed resolutions to combine with the others to establish the Community Mental Health Program to provide services in mental health, mental retardation, alcoholism and drug abuse pursuant to § 51.42 of the Statutes. The Boards of Supervisors of Langlade and Lincoln Counties passed their resolutions on March 14, 1972 and the Board of Supervisors of Marathon County passed its resolution on March 17, 1972. The resolutions each also provided for the creation of a board of directors to be the governing and policy-making board for what was then called the “Community Mental Health Program.” The County resolutions provided for the election of twelve (12) directors to the board by Marathon County and one (1) director each to the board by Langlade and Lincoln Counties and for other provisions regarding the election and terms of office of board members. In July of 1972 the Counties enacted resolutions providing that the Marathon County Board of Supervisors would elect ten (10) members and the Langlade and Lincoln County
Boards of Supervisors would elect two (2) members each to the Board. In March of 2020, the Counties enacted resolutions providing that each member County’s respective number of members directors would generally be based on each member County’s respective total budget expenditures determined as of the effective date of the new Joint County Agreement, whereas and that no County would have fewer than two (2) members. Based on the 2019 NCCSP annual budget this Agreement provides, effectively providing that the Marathon County Board of Supervisors would elect nine (9) members, the Lincoln County Board of Supervisors would elected three (3) members and the Langlade County Board of Supervisors would elect two (2) members each to the Board.

C. Developmental Disabilities Program. In 1973, the Legislature passed the Developmental Disabilities Act, which allowed Counties to form separate Developmental Disabilities Services programs or to provide the services through the Community Services Program under § 51.42 of the Statutes. Lincoln County chose to form a separate Developmental Disabilities Services Program, while Langlade and Marathon Counties joined together to provide services for the developmentally disabled.

In 2008, Marathon County joined with Portage and Wood County to create Community Care of Central Wisconsin (CCCW), pursuant to Wis. Stats. Sections §§ 46.2803 thru 46.2895, in order to provide regional care for Developmentally Disabled persons residing in those counties. In 2011, Langlade and Lincoln Counties also joined the CCCW. Since joining, each County now pays a required liability directly to the State of Wisconsin for the operation of CCCW, or its successor organization(s) who were created for the provision of services for the developmentally disabled. NCCSP continues to be a service provider for the developmentally disabled, but the Counties are no longer are required to provide these services.

In 2020, Lincoln County transferred their Development Disabilities Services Program from their Social Services Department to the NCCSP Board, effectively joining with Langlade and Marathon Counties in having the NCCSP provide services for the developmentally disabled on behalf of the counties together.

D. Marathon County Nursing Home. On November 13, 1973, the Marathon County Board of Supervisors passed a resolution providing for the governance of its Nursing Homes by the NCCSP Board.

There has been a separate Nursing Home Management Agreement in existence since 1998. In December 2006, the NCCSP Board appointed a Nursing Home Operations Committee to assist in the oversight of the operations of the Marathon County Nursing Home (Mount View Care Center).
E. Lincoln County Nursing Home. On September 17, 2019, the Lincoln County Board of Supervisors passed a resolution providing for the governance of its Nursing Home (Pine Crest) to by the NCCSP Board.

There was a separate Nursing Home Management Agreement executed following the adoption of the transfer. The NCCSP Board expanded the scope of the Nursing Home Operations Committee to assist in the oversight of the operations of both Pine Crest Nursing Home and Mount View Care Center.

F. Designated Protective Services and Protective Placement Agencies. Pursuant to § 55.02(2), the Chairperson of each County Board of Supervisors is responsible for designating the county department responsible for planning for the provision of protective services and protective placement and for directly providing protective services, protective placement, or both, or entering into a contract for the provision of protective services and protective placements.

E—Since 2009, following the implementation of Family Care, the Chairpersons of the County Boards of Langlade, Lincoln, and Marathon Counties, have designated the NCCSP to serve as the Protective Services Agency responsible for planning for the provision of protective services and protective placement and for directly providing protective services and protective placement. The Chairpersons of the County Boards of Supervisors in each of the Counties has designated agencies under § 55.02 of the Statutes to be responsible for the provision of protective services and protective placements as follows:

1. Langlade County. In Langlade County, the Chairperson of the County Board of Supervisors has designated the Langlade County Department of Social Services as the Protective Services Agency responsible for those residents of Langlade County suffering from physical disabilities and the infirmities of aging and NCCSP as the Protective Services Agency responsible for those residents of Langlade County experiencing mental illness, alcoholism and other drug abuse and developmental disabilities.

2. Lincoln County. In Lincoln County, the Chairperson of the County Board of Supervisors has designated the Lincoln County Department of Social Services as the Protective Services Agency responsible for those residents of Lincoln County suffering from physical disabilities and the infirmities of aging, the Lincoln County 51.437 Board as the Protective Services Agency responsible for those adult residents who are developmentally disabled and NCCSP as the Protective Services Agency responsible for those residents experiencing mental illness and alcoholism and other drug abuse.

Marathon County. In Marathon County, the Chairperson of the County Board of Supervisors originally designated the Marathon County Department of Social Services as the Protective Services Agency responsible for those residents of Marathon County suffering from physical disabilities and the infirmities of aging who became incompetent while residing outside of a nursing home facility operated by NCCSP. NCCSP was
designated the Protective Services Agency responsible for those residents of Marathon County experiencing mental illness, alcoholism and other drug abuse, and developmental disabilities and for those residents suffering from the infirmities of aging if the person became incapacitated due to infirmities of aging while residing in a nursing home facility operated by NCCSP. In 2008, all adult protective services and protective placements within Marathon County were unified under NCCSP.

F.G. Initial Joint County Contract. In July of 1983, the three Counties entered into a “Joint County Human Services Agreement” for the continued sponsorship of what is now known as the Community Services Program under a more detailed agreement than the provisions of the earlier County Board resolutions. The agreements were updated by action of the three counties in 1986, 1995 and 2008. In 2012, the counties initiated a process to again revise the agreement. As a result of the revision process, Lincoln and Langlade County each passed resolutions adopting the revised agreement; however, the revised agreement was not ratified by Marathon County. In January of 2016, Marathon County adopted a resolution directing the examination of whether a different governance structure was more well-suited for the provision of services required under § 51.42. Thereafter, in September of 2016, Marathon County adopted a resolution directing Marathon County Administration to negotiate a new agreement with both Lincoln and Langlade Counties that was time-limited, provided greater county oversight and control of NCCSP, and was committed to (1) financial integrity, (2) program adaptability and consistency, and (3) ongoing quality measurement, reporting and improvement. Representatives from each of the member counties met on multiple occasions during the ensuing months. Thereafter, in December of 2016, all three Counties ratified a resolution for a new Joint County Agreement effective January, 2017. This Agreement is the product of those meetings and negotiations, and, as indicated above, this Agreement supersedes all previous Joint County Contracts/Agreements.

IV. NCCSP PROGRAM DUTIES

The NCCSP shall perform the duties listed below as well as all other duties provided by Wisconsin Statutes.

A. Agreements For Services. NCCSP shall enter into Agreements to render services to or secure services from other agencies or resources, including out of state agencies or resources as permitted under § 51.42 or any other applicable provision of state or federal law and as permitted under this Agreement.

B. Agreements For Facilities. NCCSP shall enter into Agreements for the use of any facility as an approved public treatment facility under § 51.45 for the treatment of alcoholics or persons who are drug dependent if NCCSP deems it to be an effective and economical course to follow. ($51.42(3)(a)(2).
C. **Contract For Legal Services.** NCCSP shall contract for legal services from the Marathon County Corporation Counsel's Office. NCCSP shall pay Marathon County, on behalf of the member Counties, for said pro-rated cost allocation for legal services using an approved allocation methodology set by the NCCSP Board. NCCSP is responsible for developing an appropriate operating budget for legal services. The interest of each of the Counties, as it relates to the NCCSP, shall be represented equally by the Marathon County Corporation Counsel's Office, and the interests of NCCSP shall be represented by the Marathon County Corporation Counsel's Office believes it has a potential conflict of interest in the specific representation. In the event Marathon County Corporation Counsel has such a concern, it will convey that information to NCCSP and authorize NCCSP, through its CEO, to secure outside counsel for a limited-scope representation.

D. **Provision of Services.** NCCSP shall, within the limits of available state and federal funds and of county funds appropriated to match and overmatch state funds, offer the following services and facilities to provide for the program needs of persons suffering from mental disabilities:

1. Collaborative and cooperative services with public health and other groups for programs of prevention.
2. Comprehensive diagnostic and evaluation services, including assessment as specified under §§ 114.09(2)(bm), 343.30(1q) and 343.305(10) and assessments under §§ 48.295(1) and 938.295(1).
3. Inpatient and outpatient care and treatment, residential facilities, partial hospitalization, day treatment, intensive outpatient, emergency care and supportive transitional services.
4. Related research and staff in-service training, except that NCCSP shall consult the county department of developmental disabilities services under § 51.437 in Lincoln County in developing in-service training on emergency detention and emergency protective placement procedures before providing these services to Lincoln County.
5. Continuous planning, development and evaluation of programs and services for all population groups.
6. Ensure that pregnant women are given first priority for services for alcohol and drug abuse if funding is insufficient to meet the needs of all eligible individuals. See § 51.42(3)(at)

D.E. **Prepare Local Plan.** NCCSP shall prepare, as further described below and in § 51.42(3)(at), a local plan, every three (3) years, or as otherwise required by the Department of Health Services (DHS), which includes an inventory of all existing resources, identifies needed new resources and services and contains a plan for meeting the needs of the mentally ill, developmentally disabled, alcoholic, drug abusers and those with other psychiatric disabilities for citizens residing within the jurisdiction of the NCCSP and for persons in need of emergency
services found within the jurisdiction of NCCSP. The plan shall also include the establishment of long-range goals and intermediate-range plans, detailing priorities and estimated costs and providing for coordination of local services and continuity of care. The plan shall state how the needs of homeless persons and adults with serious and persistent mental illness, children with serious emotional disturbances and minorities will be met by NCCSP. The NCCSP shall submit the plan to the Department of Health Services for review in accordance with § 51.42(7)(a)9 and § 51.02(1)(f) in accordance with the deadlines established under § 51.42(7)(a)9. Source: sec. 51.42(3)(ar)5.

F.E. Program Implementation. Under the supervision of its Chief Executive Officer (as defined pursuant to Article VI of this Agreement), and using qualified personnel with training or experience, or both, in mental health or in alcoholism or drug abuse, NCCSP shall be responsible, as further described in this Agreement, for the planning and implementation of programs relating to mental health, developmental disabilities, alcoholism and drug abuse.

F.G. School Board Referrals; Interagency Cooperation. NCCSP shall acknowledge receipt of notifications received under § 115.812 (2) of the Wisconsin Statutes.

G.H. Budget. NCCSP shall submit a proposed budget covering services based on the Local Plan for the succeeding calendar year to the Committee, for provision to the county boards of supervisors of Langlade, Lincoln and Marathon Counties, no later than September 1 for approval by the County boards of supervisors and inclusion as part of the proposed County budgets. NCCSP shall submit a final budget to DHS. See § 51.42(3)(ar)8.

H.I. Costs of Services. NCCSP shall determine the cost of all services it purchases based on standards and requirements prescribed by § 46.036, Wis. Stats. See § 51.42(3)(ar)9.

H.J. Reports, Surveys, and Approvals. NCCSP shall provide all reports, conduct all surveys and obtain all approvals required by law, including but not limited to the following:

1. Annually report to the department of health services ("department") regarding the use of any contract entered into under § 51.87,
2. Except in an emergency, review and approve or disapprove all admissions to nursing homes of mentally ill persons under age 65 who are residents of the county, and
3. Submit to the department in a timely fashion, as specified by the department, any reports necessary to comply with the requirements under 42 USC 300x-52.

H.K. Authorize Care. NCCSP shall authorize all care of any patient in a state, local
V. RETAINED COUNTY BOARD AUTHORITY COMMITTEE

A. Purpose. The Retained County Board Authority Committee ("the Committee") is an entity designated by each of the respective member county Boards of Supervisors to exercise authority retained by the respective County Boards, as provided under sec. 51.42(5) of the Wisconsin Statutes, in the manner described within this agreement.

B. Committee Composition

1. Each individual county's representatives shall be appointed by the Board of Supervisors of the respective member counties in accordance with Chapter 59 of the Wisconsin Statutes. The committee shall be comprised of four (4) members. Individual member counties are represented within the committee as follows:

a. Marathon County — 2 members
b. Lincoln County — 1 member
e. Langlade County — 1 member

2. Term of Office — the term of office for each representative of the respective member counties appointed to the Committee shall coincide with the respective terms of the representative’s County Board.

C. Reporting Relationship. Representatives of the member counties report directly to their respective member County Boards.

D. Duties and Responsibilities:

1. General
   a. Exercise the retained authority of the member counties, as provided for within the Wisconsin Statutes and as specifically described below, relative to the following:

   2. The Chief Executive Officer ("CEO") of the NCCNP — 51.42(5)(a)4
      a. Selection
         i. The Committee shall participate in the selection planning process, including the definition of the position duties and qualifications.
ii. The Committee shall be afforded the ability to access all applicant materials, reports, other materials, and information obtained by NCCSP that is relevant to the selection of the CEO.

iii. The Committee shall be afforded the ability to participate in candidate interviews.

iv. The Committee shall make its own independent recommendation to the respective member County Boards regarding the hiring decision.

b. Appraisal

i. The Committee shall participate with the CEO and the Board in the development of an annual work plan for CEO, which includes performance metrics.

ii. The Committee shall conduct a performance appraisal of the NCCSP CEO on a semi-annual basis. The appraisal should evaluate the CEO in light of the approved work plan and any other criteria deemed appropriate by the Board.

c. Removal

i. The Committee has the authority to, and is charged to, if appropriate circumstances are deemed to exist, make an independent recommendation to the respective county boards for the removal of the CEO.—

3. Salaries of NCCSP Employees—51.42(5)(a)5

a. Non-CEO Employee Compensation—The Committee shall receive a proposed compensation policy from the Board for all NCCSP employees, no later than July 1, 2017.

i. The Committee is authorized to modify the proposed policy and grant final approval on behalf of the respective county boards. Final approval shall be granted no later than August 15, 2017.

ii. Upon final approval, the Committee shall transmit the compensation policy to the NCCSP Board for implementation.

b. CEO Compensation—The Committee shall review the CEO Compensation Plan on an annual basis.

i. The Committee is authorized to modify the proposed CEO compensation plan and grant final approval on behalf of the respective county boards. Final approval shall be granted no later than August 15 of each calendar year.

4. Budget—51.42(5)(a)6

a. The Committee shall receive the proposed budget from the NCCSP Board, review same, and create the final budget for submission to the respective County Boards, no later than October 1 of each calendar year.
b. The Committee shall participate with the Board in the creation and updating of program development plans which establish intermediate and long range goals based upon community needs assessment, which are explicit about tradeoffs and the impact of changes to the member Counties’ system.

i. In advance of the Board preparing its annual operating budget, no later than June 1 of each calendar year, the Committee shall communicate the budget guidelines and priorities of the member counties to the Board.

e. The Committee shall select an independent certified public accounting firm to perform an annual audit of the financial records of NCCSP and forward its selection to the NCCSP Finance, Personnel and Property Committee.

i. The Committee shall review any and all audit reports and shall attend any presentation by the auditing firm of the NCCSP yearly audit.

d. The Committee shall consider any and all requests for financial transfers to or from particular program areas in excess of $20,000.

i. Transfers cannot be artificially divided to eliminate compliance with this section.

5. Assessment of Services—51.42(5)(a)12

a. Development of Performance Standards

i. The Committee shall clarify Program Outcome Expectations in the form of performance standards for each of the services provided by NCCSP, no later than July 1 of each calendar year.

ii. The Committee is not responsible for making care-related decisions with respect to individual patients. All decisions of the Committee shall be deemed to be in the nature of policy-making or governance functions. Each member county is responsible for reviewing this document with their insurer and providing insurance to cover any potential liability for the decisions of its representatives on the Committee.

b. Reporting and Improvement

i. The Committee shall receive regular reports from NCCSP for each of the programs/services it provides that detail the program's effectiveness relative to (1) all federal, state, and other applicable regulatory quality standards, as well as (2) the previously identified
performance standards and, if desired, recommend changes in service delivery models.

4) In the event that a particular program does not meet either quality or performance standards, the Committee has the authority to direct NCCSP to (1) prepare an Improvement Plan, which details specific proposed revisions to the existing program and service delivery model to satisfy applicable quality and performance standards and provides an estimated cost and funding plan to implement the Improvement Plan, and (2) evaluate alternative delivery methods and/or programs to determine whether a provider exists that is capable of providing a similar service or program and the estimated cost of contracting for said service or program and report the findings to the Committee.

e.—Direct Provision or Contracted Services
   i.—After consideration of any Improvement Plan and evaluation of the alternative delivery methods, the Committee shall determine whether any specific shared program is to be provided directly by the NCCSP, the NCCSP should implement all or a portion of any Improvement Plan, or the program should be contracted for with other providers and direct the NCCSP to make such contracts.

d.—Program Creation, Modification, Suspension or Termination
   i.—In this agreement, the term “substantially modify” shall be defined through discussions between the RCA and the NCCSP CEO, regularly reviewed, and updated as necessary to ensure clarity of expectation. This definition, once established, shall be memorialized in writing and communicated to the respective member counties.
   ii.—The Committee is responsible for reviewing applications from NCCSP to substantially modify, suspend or terminate an existing program or create a new program.

e.—State and Federal Inspection Reports and Remediation Plans
   i.—The Committee shall review all state and federal inspection reports and remediation plans of NCCSP.

6.—Extension, Revision, or Termination of Agreement
   a.—Member county representatives on the Committee are responsible for the ongoing assessment of the Tri-County program as a mechanism for meeting the needs of the individual member counties.
b. Beginning in January of the third year of the agreement (2020), the Committee shall begin formulating a formal recommendation as to whether (1) the agreement should be extended, (2) the agreement should be modified and a successor agreement be approved, or (3) the tri-county agreement should be allowed to terminate. The recommendation shall be reported no later than July 1 of that year to each of the member county Boards of Supervisors.

1. The member county representatives on the Committee shall present the recommendation to their respective member county Board of Supervisors.

7. Bylaws
   a. The Committee shall adopt Bylaws and Policies that, among other things, address the issues of quorum and provide for the selection of a Committee Chair, as required to conduct business to govern its operation.
   b. The Committee shall file Bylaws and any amendments with the County Clerk of each of the three Counties within thirty (30) days of adoption.

8. Exchange of Information
   a. The Committee Chair, or his or her designee, is expected to attend meetings of the Board to ensure appropriate levels of information sharing and coordination.

E. Other Organizational Relationships
   1. The Retained County Board Authority Committee will work with NCCSP to develop policies designed to guide NCCSP’s provision of community programs for the residents of each of the member counties. The NCCSP’s focus will be on the generation and implementation of those policies and programs. The Retained County Board Authority Committee’s focus is on ensuring that the NCCSP organization remains responsive to the member counties and works to establish and sustain a strong working relationship between the NCCSP and the member counties, through the exercise of the retained powers of the member counties.

   2. Each member county Board of Supervisors shall designate a County Board Standing Committee to which the Retained County Board Authority Committee will provide periodic reports.

VI.V. NORTH CENTRAL COMMUNITY SERVICES PROGRAM BOARD

A. Purpose. The North Central Community Services Program Board is an entity comprised of representatives from the member counties that is focused on addressing
the needs of the Tri-County Regional Community with respect to mental health and alcohol and drug dependent treatment programs.

B. Appointment of North Central Community Services Program Board. The County Boards of Supervisors of Langlade, Lincoln and Marathon Counties or other appointing authorities authorized by law have appointed and shall continue to appoint a governing and policy-making board to be known as the North Central Community Services Program Board (NCCSP Board).

C. Composition of the Board. In accordance with § 51.42(4)(b)2, the North Central Community Services Program Board (“The Board”) shall be composed of fourteen (“14”) Board members. Four of said board members shall be appointed by virtue of their respective status as follows:

1. The highest ranking appointed Administrative Official of each member County, or his or her staff designee, shall be appointed by virtue of his or her position by his or her respective County Board.

2. The President of the NCCSP Medical Staff shall be appointed by the Marathon County Board of Supervisors by virtue of his or her election to such position by the organized Medical Staff. Said appointment shall be performed by the Marathon County Board of Supervisors by virtue of NCCSP’s primary campus location being within Marathon County.

By agreement of the parties, the composition of the remaining ten (10) board members should be determined based on the approximate share of the NCCSP’s overall budget expenditures on behalf of each respective member county at the time the Agreement was signed. In 2020, applying this methodology provides for the remaining board members to be allocated as follows: seven (7) board members being appointed by Marathon County; one (1) board member being appointed by Langlade County; and two (2) board members being appointed by Lincoln County.

D. Board Representation

1. All persons appointed to the NCCSP Board shall represent the interests of the mentally ill, the interest group of the developmentally disabled, interest group of the alcoholic and the interest group of the drug dependent, within the Tri-County Regional Community as described in §51.42(4)(b)2 of the Wisconsin Statutes.

E. At least one Board member shall be an individual who receives or has received services for mental illness, developmental disability, alcoholism or drug dependency or shall be a family member of such an individual. The North Central Community Services Program Board (“The Board”) shall be composed of fourteen (“14”) Board members appointed as follows: Ten (10) board members shall be residents of Marathon County and appointed by Marathon County; two (2) board members shall be residents of Langlade
County and appointed by Langlade County; and two three (2) board members shall be residents of Lincoln County and appointed by Lincoln County.

D—

E. Board Representation

1. All persons appointed to the NCCSP Board shall represent the interests of the mentally ill, the interest group of the developmentally disabled, interest group of the alcoholic and the interest group of the drug dependent, within the Tri-County Regional Community. Source: sec. as described in §51.42(4)(b)2 of the Wisconsin Statutes.

— At least one Board member shall be an individual who receives or has received services for mental illness, developmental disability, alcoholism or drug dependency or shall be a family member of such an individual.

— The President of the NCCSP Medical Staff shall be appointed as one of Marathon County's designated Board members by virtue of being elected to such position by the organized Medical Staff. The President of the NCCSP Medical Staff does not need to be a resident of Marathon County.

2.

F-2. The highest appointed Administrative Official of each County, or his/her designee, shall be appointed as one of the County's appointments to the Board by virtue of being appointed to their position by each County Board.

G-F. Appointment of County Supervisors. No more than seven (7) members of the NCCSP Board may be County Supervisors. At least one (1), but not more than two three (23), of the appointees from any one County shall be a member of the County's Board of Supervisors and shall be designated as such at the time of the appointment. In making appointments to the Board, member County Boards of Supervisors are encouraged to the greatest extent possible to appoint members that fulfill the competencies expressed by the NCCSP Executive Committee ("the Committee"). County Supervisor appointments of more than one (1) from each County shall be made only when the appointment fills a specific NCCSP Board competency as desired by the NCCSP Executive Committee ("the Committee"). At any time that a County's Board of Supervisors designated member or members are no longer County Board Supervisors, the appointing County Board of Supervisors shall immediately appoint a successor Supervisor or Supervisors to the NCCSP Board.

H-F. Term of Office. Each NCCSP Board member shall hold office for a term of three (3) years. Board members shall serve staggered terms with one-third (1/3) of the members appointed each year. Board members fulfilling designated appointments by virtue of the position they hold, shall be replaced immediately by the appointment of their successor. At any time that a County's Board of Supervisors designated member or members are no longer County Board Supervisors, the
appointing County Board of Supervisors shall immediately appoint a successor Supervisor or Supervisors to the NCCSP Board.

4-G. Removal for Cause. Any NCCSP Board member may be removed from office for cause on recommendation of the NCCSP Board to the appointing county and a two-thirds (2/3) vote of the appointing county Board of Supervisors. The Board member must receive due notice in writing and a hearing on the charges against the Board member. Four (4) or more absences during a twelve (12) month period from regularly scheduled Board meetings may be considered cause for recommendation of removal to the appointing authority.

4-H. Removal of a County Board Supervisor Board or Designated members. In the event that any NCCSP Board member was a member of a member county Board of Supervisors when appointed and the member is not reelected to that office, the member shall be considered removed upon due notice in writing from the NCCSP Board Chairperson. See § 51.42(4)(a)1.

4-I. Vacancies. Any vacancy on the NCCSP Board shall be filled for the remainder of the term in the manner that the original appointment was made.

L. Other Appointing Authority. In any instance in this section where appointment or removal is indicated to be made by the Chair of the County Board of Supervisors or by the County Board of Supervisors it is intended that appointment may be made by other appointing or removing authorities as authorized by law.

K. Executive Committee of the NCCSP Board

1. General – There shall be an Executive Committee of the NCCSP Board (“the Committee”), which who shall serve as the designated entity within the NCCSP Board to exercise authority retained by the respective County Boards, as provided permitted under 51.42(5) of the Wisconsin Statutes and as provided in this Agreement. The Committee should focus on ensuring that the NCCSP organization remains responsive to the member counties and works to establish and sustain a strong working relationship between the NCCSP and the member counties, through the exercise of the retained powers of the member counties specified in this Agreement.

   — Committee Composition – The Committee shall be comprised of the following fivefour (54) members of the NCCSP Board as follows:

   2. The highest appointed Administrative Official from each County, or his/her designee, and the Chair of the NCCSP Board. (See section V.L.10(b))
   
   —The Chair-Elect of the Board is expected to attend Committee meetings as an ex officio non-voting member.
3. Reporting Relationships – The highest appointed Administrative Official, or his/her staff designee, shall be designated by their appointment as the “Retained County Official” for purposes of exercising and communicating authority retained by and on behalf of each County Board. Each member county Board of Supervisors shall designate a County Board Standing Committee to which each Retained County Official will provide periodic reports or recommendations to.

4. Duties and Responsibilities:
   a. Selection of the Chief Executive Officer (“CEO”)
      i. The Committee shall develop a selection plan, including the definition of the position duties and qualifications, in consultation with the Board, for the hiring of the CEO.
      ii. The Committee is responsible for the execution of the selection plan; however, in doing so it shall and must afford the Board (1) the ability to access all applicant materials, reports, and other materials or information obtained by the Committee that is relevant to the selection of the CEO; and (2) the ability to participate in candidate interviews.
      iii. The Committee shall make a hiring recommendation to the Board, which the Board shall consider whether to accept or reject the recommendation, and forward a recommendation for appointment of the CEO to each County Board.
      iv. In the event the Board accepts the Committee’s recommendation, the recommendation shall be forwarded to the respective member County Boards of Supervisors for consideration. In the event the Board rejects the Committee’s recommendation, the Committee shall resume recruitment for the CEO position. At the same time, each Retained County Official shall make its own independent recommendation to their respective County Board regarding the hiring decision by the NCCSP Board.

b. Appraisal of the CEO
   i. The Committee shall participate with the CEO and the Board in the development of an annual work plan for the CEO, which includes performance metrics.
   ii. The Committee shall conduct a performance appraisal of the NCCSP CEO on a semi-annual basis. The appraisal should evaluate the CEO in light of the approved work plan and any other criteria deemed appropriate by the NCCSP Board.
c. Compensation of the CEO
   i. The Committee shall review the CEO Compensation Plan on an
      annual basis and grant final approval on behalf of the Board and
      each of their respective County Boards.

d. Removal of the CEO
   i. The Committee has the authority to, and is charged to, if
      appropriate circumstances are deemed to exist, make a
      recommendation to the Board who shall consider and forward a
      recommendation for removal of the CEO to each County Board.
   ii. At the same time, each Retained County Official shall make its own
       independent recommendation to their respective County Board
       regarding the recommendation to remove the CEO independent of
       the NCCSP Board's recommendation.

e. Budget
   i. In advance of the Board preparing its annual operating budget, no
      later June 1 of each calendar year, the Committee shall communicate
      the budget guidelines and priorities of the member counties to the
      Board.
   ii. The Committee shall coordinate the efforts of the Board in the
       creation and updating of program development plans as part of the
       annual budget development which establish intermediate and long
       range goals based upon community needs assessment which are
       explicit about tradeoffs and the impact of changes to the member
       Counties’ system.
   iii. The Committee shall review and recommend a proposed budget to
       the NCCSP Board, who shall then review and recommend the
       proposed budget to each respective County Boards, no later than
       October/September 1 of each calendar year.
   iv. The Committee shall be responsible for the selection of an
       independent certified public accounting firm to perform the annual
       audit of the financial records of NCCSP.

f. Assessment of Services - § 51.42(5)(a)12
   i. Development of Performance Standards
      1) With input from the Board, the Committee shall clarify
         Program Outcome Expectations in the form of performance
         standards for each of the services provided by NCCSP, no later
         than July of each calendar year.
   ii. Reporting and Improvement
      1) In the event that a particular program does not meet either
         quality or performance standards, on behalf of the Board, the
         Committee has the independent authority to direct the CEO to
         (i) prepare an Improvement Plan, which details specific
proposed revisions to the existing program and service delivery model to satisfy applicable quality and performance standards and provides and estimated cost and funding plan to implement the Improvement Plan, and (2) evaluate alternative delivery methods and/or programs to determine whether a provider exists that is capable of providing a similar service or program and the estimated cost of contracting for said service or program and report the findings to the Committee.

iii. Consideration of Improvement Plans

1) The Committee is responsible for reviewing all Improvement Plans and After consideration of any Improvement Plan and evaluation of the alternative delivery methods, the Committee shall determine whether any specific shared program is to be provided directly by NCCSP. NCCSP should implement all or a portion of any Improvement Plan, or the program should be contracted for with other provider and direct NCCSP to make such contracts. The Committee shall make a formal recommendation will be communicated to the Board for implementation consideration.

iv. Program Creation, Modification, Suspension, or Termination

1) The Committee is responsible for reviewing applications from the CEO to substantially modify, suspend, or terminate an existing program or create a new program. Any application that is approved by the Committee shall be forwarded to the Board for consideration.

g. Extension, Revision, or Termination of Agreement

i. Retained County Officials on the Committee are responsible for the ongoing assessment of the Tri-County program as a mechanism for meeting the needs of the individual member counties.

ii. Beginning in January of the third year of the Agreement (TBD) the Committee shall begin formulating a formal recommendation as to whether (1) the Agreement should be extended, (2) the Agreement should be modified and a successor Agreement be approved, or (3) the Agreement should be allowed to terminate. The recommendation shall be reported no later than July 1 of that year to each of the member county Boards of Supervisors.

iii. The Retained County Officials on the Committee shall present the recommendation to their respective county Board of Supervisors.

I. Powers of the NCCSP Board

1. General – s. 51.42(3)(ar)-(bm)
a. The NCCSP Board shall assume all of the powers and duties of North Central Community Services Program not expressly or impliedly reserved by the member counties or delegated by the member counties to the Retained County Board Authority Committee ("the Committee") as provided by this agreement, subject to the rules promulgated under Wisconsin Administrative Code and Wisconsin Statute, as follows:

2. The Chief Executive Officer ("CEO") of the NCCSP

a. Selection
   i. Develop a selection plan, in consultation with the Committee, for the hiring of the CEO.
   ii. The Board is responsible for the execution of the selection plan and must afford the Committee (1) the ability to access all applicant materials, reports, and other materials or information obtained by NCCSP that is relevant to the selection of the CEO, and (2) the ability to participate in candidate interviews.
   iii. The Board shall make a recommendation for the selection of the CEO to the Committee for consideration.

b. Appraisal
   i. The Committee shall inform the NCCSP Board of its assessment of the CEO's performance in writing on no less than two (2) occasions per year.
   ii. The assessment shall reference the CEO's performance in light of the work plan generated by the Committee and any other criteria deemed appropriate by the Board.

c. Removal
   i. The Board is authorized to recommend to the Committee that the County Boards of the member counties remove the CEO.

3.2. Budget and Planning

a. The Board shall propose an annual budget to the respective member County Boards - Retained County Board Authority Committee, no later than September October 1 of each calendar year, for approval and submission to the respective member County Boards.

b. The Board shall facilitate the creation, and frequent updating, of intermediate and long-range goals and program development plans that are based on community needs assessment of the Tri-County Regional Community, which detail priorities, estimate costs, and are explicit about tradeoffs and the impact of changes to the member counties. § 51.42(5)(a)1.

4.3. Program Service Delivery Measurement, Reporting, and Improvement - § 51.42(5)(a)11.

a. Delivery
i. The Board shall develop program delivery models that comply with all federal, state, and other applicable regulatory quality standards.

ii. The Board shall seek to implement programs in such a manner that satisfies the performance standards created by the Committee.

b. Measurement

i. The Board shall— with the assistance of community partners such as the Medical College of Wisconsin, Aspirus Wausau Hospital, Marshfield Clinic, and other medical or treatment service providers—create and implement mechanisms capable of capturing data related to (1) all federal, state, and other applicable regulatory quality standards, and (2) each of the performance standards identified by the Committee for each of the programs operated by NCCSP.

c. Reporting

i. The Board shall receive regular reports for each of the programs/services it provides that detail the program’s effectiveness relative to (1) all federal, state, and other applicable regulatory quality standards, as well as (2) the previously identified performance standards and, if desired, recommend changes in service delivery models.

ii. The Board shall receive and review all state and federal inspection reports and remediation plans related to NCCSP programs and services.

i. The Board and the CEO shall provide a formal report to the Committee on a semi-annual basis for each of the programs operated by NCCSP. The report shall address (1) all federal, state, and other applicable regulatory quality standards, and (2) each of the performance standards identified by the Committee.

d. Improvement

i. In the event that a particular program does not meet either quality or performance standards, the Board shall submit a recommendation to the CEO to develop and present to the Board an Improvement Plan, which (1) details specific proposed revisions to the existing program and service delivery model to satisfy quality or performance standards and (2) provides an estimated cost and funding plan to implement the Improvement Plan.

ii. The Board is responsible for reviewing and approving recommendations from the Committee relative to Improvement Plans. When reviewing a recommendation of the Committee, the Board may recommend within the Improvement Plan that the Committee modify the existing performance standards.
e. **Program Creation, Modification, Suspension or Termination**

   — The Board is responsible for reviewing applications to substantially modify, suspend, or terminate an existing program or create a new program that have been approved by the Committee. New program creation or substantially modifying, suspending or terminating an existing shared program or shared program delivery model without formal application to, and approval by, the Board is prohibited.

   **DEFINITION OF SUBSTANTIALLY MODIFICATION NECESSARY:**

   i. In this agreement, the term “substantially modify” shall be defined through discussions between the RCA and the NCCSP CEO, regularly reviewed, and updated as necessary to ensure clarity of expectation. This definition, once established, shall be memorialized in writing and communicated to the respective member counties.

   ii. The Board is prohibited from creating a new program or substantially modifying, suspending or terminating an existing shared program or shared program delivery model without formal application to, and approval by, the Committee.

   iii. Any application to create a new program or substantially modify, suspend or terminate an existing shared program or shared program delivery model shall be made in writing and should include (1) an explanation of the program at issue; (2) a projected cost or cost savings of the proposed action, and (3) a summary of the other NCCSP program services that may be impacted by the proposal, and (4) a summary of the anticipated impact on individual Member County Departments as a result of the proposed action.

   iv.i. Without approval as set forth above, the CEO may make interim program modifications or suspensions until such time as the Committee Board meets to make a final determination.

f. **Personnel Policies and Salaries**

   i. **Personnel Policies**

      1) The Board shall establish personnel policies for all NCCSP employees that are generally consistent with the personnel policies of the member counties.

   ii. **Salaries**

      1) **Non-CEO Employee Compensation** - The Board shall prepare and annually review a compensation policy and plan covering all of its employees with the exception of the CEO and provide said plan to the Committee, no later than July 1, 2017, for consideration and approval.
a. Salary/Compensation ranges for each of the employee classifications.

b. References to salary/compensation ranges from similar positions with comparable Departments of Community Programs within the State of Wisconsin or the country or other comparable markets.

c. Hiring policies that provide guidance on the circumstances under which an employee may be hired at various points within the position’s pay range.

d. Policies detailing the process for the creation of new positions, the classification of new positions within the existing salary/compensation range system, and the reclassification of existing positions within the existing salary/compensation range system.

b. Upon receipt of the final compensation policy approved by the Committee, the Board shall implement the compensation policy.

2) CEO Compensation—The Board shall, by July 1 of each calendar year, provide the Committee with an annual compensation plan specific to the CEO.

a. Upon receipt of the annual CEO compensation plan approved by the Committee, the Board shall implement the plan.

5-4 Provision of Care

a. Within the limits of available State and County appropriations and maximum available funding from other sources, NCCSP may offer the following services and facilities to provide for the program needs of persons experiencing mental disabilities:

i. Pre-care, aftercare and rehabilitation and habilitation services.

ii. Professional consultation

iii. Public informational and educational services

iv. Provide treatment services specified in a conditional release plan approved by a court to a county resident conditionally released under § 971.17 of the statutes and subject to the State's obligation to reimburse NCCSP for the treatment and services provided.

6-5 Service Allocation

a. NCCSP may allocate services among recipients based on the availability of its limited resources.

6. Facility Use Agreements
a. NCCSP shall develop Facilities Use Agreements with member counties to govern control and maintenance of facilities owned by the said counties and occupied by NCCSP.

7. Real Property
   a. NCCSP may own, lease or manage real property for the purposes of operating a treatment facility, as authorized by § 51.42(3)(aw). NCCSP must arrange for the maintenance of any property owned or leased directly by NCCSP and not owned by a member county.

8. Other County Health Care
   a. NCCSP may administer other County health care programs or institutions that any of the three County boards of supervisors may designate, but the budget for such designated program or institution shall be separated from the general budget of NCCSP and the designating county shall fund such program or institution operations by separate appropriation.

9. Conflict of Interests
   a. NCCSP shall adopt and enforce a policy to avoid conflicts of interest.

10. Bylaws
    a. NCCSP shall adopt Bylaws and Board Policies that, among other things, address the formation of appropriate committees and sub-committees, the issue of quorum, and provide for the selection of a Board Chair and Chair-Elect, as required to conduct business to govern its operation, including the business and operation of its committees and sub-committees.
    
    b. Selection of NCCSP Board Chair and Chair-Elect: the NCCSP Board Chair and Chair-Elect shall be appointees of the Marathon County Board of Supervisors elected at large by the members of the NCCSP Board.
    
    a. The Chief Administrative Officer of Marathon County, or his or her staff designee, and the President of the NCCSP Medical Staff are ineligible for selection as NCCSP Board Chair and Chair-Elect.
    
    b. NCCSP shall file Bylaws and any amendments with the County Clerk of each of the three Counties within thirty (30) days of adoption.

11. Exchange of Information
    a. The Board Chair, or his or her designee, is expected to attend meetings of the Committee to ensure appropriate levels of information sharing and coordination.

12. Legal Services
    NCCSP shall contract with Marathon County for private professional legal services to represent its interests and to provide for its legal services needs. NCCSP shall be provided a full-time attorney as well as reasonable support for the office. The attorney shall report to the CEO and will be located at the NCCSP corporate office but shall be an employee of Marathon County. Each member county will share a proportional expense related to the adequate funding of these services. This provision satisfies the requirement of section 51.42(3)(am)1. of the Wisconsin Statutes that the Corporation Counsel of each of the Counties notify NCCSP that he or she is unable to provide in a timely manner the
professional legal services needed by NCCSP to carry out its duties. This provision seeks
to avoid potential conflicts by acknowledging that legal counsel contracted by NCCSP
shall represent the interests of NCCSP as they relate to all three Counties and shall not
represent the interests of any of the three Counties separately. The interests of the
individual Counties shall be represented by each County’s Corporation Counsel.

M. Additional Powers and Duties

1. The NCCSP Board shall do all of the following, unless expressly or impliedly
   prohibited by terms set forth in this agreement:
   a. Develop coordination of local services and continuity of care where
      indicated.
   b. Utilize available resources and develop new resources to carry out the
      legislative mandate and the mission of the organization.
   c. Comply with State and Federal requirements.
   d. Assist in arranging cooperative working agreements with service
      providers.
   e. Continually evaluate the needs of the member counties’ communities and
      the quality of the service delivery of programs provided by NCCSP in
      accordance with the expressed provisions and intent of this
      agreement.
   f. Post meeting agendas, minutes and support materials (packets) in
      accordance with Wisconsin Open Meetings Law.
   g. Comply—to extent permitted by state and federal law, administrative
      code or other legal rule—with Wisconsin Public Record Law.
   h. Appoint members of the Medical Staff.

N. Additional Discretionary Powers. In addition to the forgoing, the Board shall have
the power to:

1. Enter into contracts with individual, or multiple, member counties or non-
   profit organizations for the administration of any other health care programs
   or institutions that are within the Mission of NCCSP, including organizations
   existing or operating outside the member counties but not the State of
   Wisconsin with the following stipulations.

   a. Management Agreement Required. Any contracts entered into by the
      NCCSP Board under this provision shall be legally permissible for a
      government agency to enter into and shall have a time limited and well-
      defined Management Agreement between the parties which legally and
      financially separates the organization from the NCCSP Programs and
      Services performed for or on behalf of the member counties.
b. Separate Governance Required. Individual, or multiple, member counties entering into such contracts with NCCSP may shall designate an entity wholly independent of NCCSP for the purpose of governance of said health care program or institution. At no time, shall any contract change the composition or representation on the NCCSP Board.

c. Accounting. The budget for any program or institution under this provision shall be separated from the general budget of NCCSP and shall at no time be funded or subsidized by the member counties or the operations of NCCSP.

d. Contribution to Operations. Any such agreement under this provision should return a sufficient contribution of income to the operations of NCCSP of greater than 10% of net operations on an annual basis over an average of any three (3) year period.

b. Marathon County Nursing Home Facilities. Marathon County shall meaningfully review its delegation of governance of the Mount View Care Center to NCCSP and report to the remaining member counties, through their respective representatives on the Committee, Marathon County’s intent with regard to the designation of its governance authority with regard to its nursing home facility within one (1) calendar year from the effective date of this agreement.

e. Marathon County Aquatic Therapy Pool. Marathon County shall meaningfully review its delegation of governance and operation of the Aquatic Therapy Pool to NCCSP and report to the remaining member counties, through their respective representatives on the Committee, Marathon County’s intent with regard to the designation of governance and operational authority of the Aquatic Therapy Pool within one (1) calendar year from the effective date of this agreement.

2. Enter into Facilities Use Agreements with member counties to govern control of facilities owned by the said counties and occupied by NCCSP.

VIII.VI. COMMUNITY PROGRAMS DIRECTOR

A. General Powers

1. The Chief Executive Officer of the North Central Community Services Program shall have all of the administrative and executive powers and duties of managing, operating, maintaining and improving the programs of NCCSP, subject to such delegation of authority as is not inconsistent with powers and duties granted to NCCSP or its Board, powers and duties expressly or impliedly retained by the respective member county Boards of Supervisors or delegated by the member county Boards of Supervisors to the Committee, Wisconsin Statutes and Administrative Code, and rules promulgated by the department.
2. The Chief Executive Officer shall fill the role of the “county community programs director” under section § 51.42 of the Wisconsin Statutes.

B. **Specific Powers and Duties.** In consultation and agreement with the NCCSP Board and the Committee, the Chief Executive Officer shall:

1. Prepare an annual comprehensive plan and budget of all funds necessary for the programs and services of NCCSP. This plan shall establish priorities and objectives for the year as well as any modifications of long range objectives.

2. Prepare intermediate range plans.

3. Prepare an annual report of the operation of NCCSP and other reports required by:
   a. The State of Wisconsin, the federal government, or an agency of subunit of the state or federal government.
   b. A Board of Supervisors of a member county.
   c. The Committee.

4. Make recommendations to the NCCSP Board and the Committee as required by this agreement, including the following:
   a. Personnel and salaries of employees.
   b. **Creation, Modification, Suspension or Termination of Programs/Changes in Program Services.**
      i. In this agreement, the term “substantially modify” is defined as “any act to change the form, quality, or scope of programs or services.” This definition shall be regularly reviewed, and updated as necessary to ensure clarity of expectation through ongoing discussions between the CEO and the Committee.
      ii. The CEO is prohibited from creating a new program or substantially modifying, suspending or terminating an existing shared program or shared program delivery model without formal application to, and approval by, the Committee and the Board.
      iii. Any application to create a new program or substantially modify, suspend or terminate an existing shared program or shared program delivery model shall be made in writing and should include (1) an explanation of the program at issue, (2) a projected cost or cost savings of the proposed action, and (3) a summary of the other NCCSP program services that may be impacted by the proposal, and (4) a summary of the anticipated impact on individual Member County Departments as a result of the proposed action. The application shall be made first to the Committee and then to the Board.
iv. Without approval as set forth above, the CEO may make interim program modifications or suspensions until such time as the Committee and Board can make their respective determinations.

c. Other Changes in Program Services, including:

   b.i. The preparation of an Improvement Plan, which (1) details specific proposed revisions to an existing program and service delivery model to satisfy applicable quality and performance standards and provides and estimated cost and funding plan to implement the Improvement Plan, and (2) evaluates alternative delivery methods and/or programs to determine whether a provider exists that is capable of providing a similar service or program and the estimated cost of contracting for said service or program. Improvement Plans must first be approved by the Committee before being considered by the Board.

5. After consultation with the Board and the Committee, administer the duties of the NCCSP.

6. Comply with state and federal requirements and the terms of this Agreement.

7. Employ and manage staff as he or she deems appropriate to administer the duties of the NCCSP.


   a. The parties recognize that some level of intergroup conflict is inherent in this partnership because of the scarcity of resources, the ambiguity of roles and the law as applied to specific cases, and the differences in organizational values and culture. To address these differences at the lowest possible level, preferably through direct communication between colleagues or peers, the CEO shall work with the chief administrative person from each of the member counties to develop and periodically update protocols for addressing situational intergroup conflict.

9. Convene meetings of member county Finance Directors.

   a. The Finance Director for each County and the Chief Financial Officer for NCCSP will meet on no less than two (2) occasions to evaluate and discuss the status of each County and the financial stability of NCCSP.

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VIII.VII. GENERAL FINANCIAL PROVISIONS

The following general provisions shall apply to the financial affairs of NCCSP:

A. Accounting Period. NCCSP shall use the calendar year as its accounting period.
B. **Accounting Practices.** NCCSP shall follow generally accepted accounting principles.

C. **Annual Audit.** NCCSP through the Finance, Personnel and Property Committee shall retain an independent certified public accounting firm, selected by the Retained County Board Authority Committee, to annually audit the financial records of NCCSP. The audit shall be conducted in accordance with generally accepted auditing standards, government auditing standards and requirements of the American Institute of Certified Public Accountants, and shall include the following supplemental statements: (1) a Balance Sheet, Cash Flow and Income statement for each the Mount View Care Center and Pine Crest Nursing Homes and (2) a Balance Sheet, Income-and Cash Flow statements for North Central Health Care, and (3) a Balance Sheet detailing each respective member counties' fund balance. On or before April 30 of each year, NCCSP shall provide each County, through its respective Administrative official, and the Retained County Board Authority Committee Retained County Official with a copy of the annual audit report and applicable supplemental statements. Unless a member county or the Committee specifically directs otherwise, the Annual Financial Statement shall be deemed accepted by the County ninety (90) days after receipt by the County.

D. **County Appropriations.** County appropriations for operations, reserves and capital purchases shall be determined through a budget development process which follows the procedures detailed in this section.

1. **Community Services Program -** The Community Services Program is the program of services for disability groups experiencing mental illness, alcoholism and other drug abuse. Operations and capital budgets for the Community Services Program shall be prepared and approved by the North Central Community Services Program Board and the Committee, as required by this Agreement, and provided to each of the three Counties as requests for funding approval. A determination of operating reserve needs shall also be made each year by the NCCSP Board, consistent with its Reserve Policy, and communicated to the Board, the Committee, and the three member counties.
   a. **Operations Budget**
      i. An operations budget shall be prepared for the multicounty Community Services Program which projects all revenues and expenses for the next calendar year. Appropriations required from funding Counties for operations for the Community Services Program shall be determined through a process which allocates the revenue and expense items of the budget according to the following provisions and arrives at net appropriations needed from each County for the ensuing calendar year.
ii. The Committee shall provide budget guidelines and priorities to the Board no later than June 1.

iii. The Committee shall review and recommend the proposed budget to the NCCSP Board, who shall then review and recommend a proposed budget to each respective County Boards, no later than September/October 1 of each calendar year.

iv. The Board shall propose an annual budget to the Retained County Board Authority Committee for approval and submission to the respective member County Boards, no later than September 1 of each calendar year.

v. The Committee shall receive the proposed budget from the NCCSP Board, review same, and create the final budget for submission to the respective County Boards, no later than October 1 of each calendar year.

vi. Individual member county Boards of Supervisors shall receive and consider, and approve the proposed budgets. The final allocation to NCCSP shall be determined by the member counties in the context of their complete annual budget.

b. Program Revenue

i. Addendums. Addendums are defined as program funding received from the State of Wisconsin and which are received with designations that the funding will be used for specifically identified groups or individuals.

ii. Addendums related to service programs shall be allocated among the three Counties based on the best available data with regard to the population of the member counties published by the Wisconsin Department of Administration, or another state agency required by law to publish said information. (Such allocation method shall be hereinafter referred to as the “Appropriate Allocation Methodology”)

iii. Third Party Collections. Third party collections for all disability groups shall be first allocated to the respective Counties based on third party collections specifically identified with services separately provided in individual Counties. Third party collections provided in any of the Counties as a part of the common services available to all of the Counties, such as inpatient services, shall be allocated based on the Appropriate Allocation Methodology.

iv. State Base County Allocation. The State Base County Allocation (BCA) shall be divided among the three (3) counties based on the Appropriate Allocation Methodology.

v. Other Revenue. Other revenue which is generated from provision of services not directly related to disability group programs shall be allocated to each program, county, or organization based on where the revenue was generated.
vi. **NCCSP Nursing Home Revenues.** Notwithstanding any other provision contained in this Agreement, revenues derived from the NCCSP’s operation of a member county nursing facility or skilled nursing facility on behalf of the member county shall be allocated exclusively to said member county. With regard to Mount View Care Center, Marathon County and neither Langlade nor Lincoln County shall receive allocation of any such revenues. Mount View revenues shall include revenues attributable to all programs provided by said facility, including but not limited to, post-acute care and rehabilitation services and programs, ventilator program and services, dementia care program and related services, long-term care programs and services, respite care program and services, short-term or long-term residential programs, care and services, and any other programs or services provided in connection with Mount View Care Center.

c. Program Expenses
   i. Expenses of operating the programs shall be allocated to each of the three Counties in a manner that is consistent with the allocation of program revenues.
   ii. Other expenses shall also be allocated in a manner that is consistent with the allocation of Other Revenue, whereas the appropriate expense is matched with the revenue.

2. Reserves Determination
   a. The amount of reserves will be determined by the Reserves Policy. This reserve policy is established in consultation with the Finance Directors of each county and recommended by the Finance, Personnel & Property Committee for approval by the NCCSP Board. Expenditure or distribution of each county’s reserves retained by NCCSP in an amount that exceeds the minimum described in the NCCSP policy, either as an individual transaction or as aggregated annually, is not permitted without approval by the Retained County Authority Committee.

3. Capital Budget
   a. A capital budget shall be prepared to provide for the capital needs of the NCCSP for continued operation. The capital needs amount shall be allocated to the three Counties based on the county in which the capital asset will be located. The capital appropriation request to each County shall individually identify capital assets with a purchase price of $30,000, or more, and shall be sent to the appropriate county for review and approval regardless of funding source consistent with any Facilities and/or Capital Use Agreements between NCCSP and the Counties. Other capital assets of lesser cost shall be grouped together in the capital appropriation request.

4. Ownership and Depreciation
a. Capital assets purchased by NCCSP with capital appropriations shall be owned by the County providing the appropriation but shall be carried on the books of NCCSP and depreciation amounts for capital assets shall be included in program operating expenses. Each County’s fund balance account shall be increased for the amount of the capital appropriation provided for the purchase of capital assets by NCCSP.

5. Insurance Coverage
a. Counties shall be responsible for site (real property) insurance for their respective facilities. Counties shall be entitled to charge back NCCSP for premiums paid. NCCSP shall be responsible for all other necessary and appropriate insurance coverage, including any coverage required by virtue of NCCSP’s use or occupancy of any facility or property.

6. Reconciliation
a. On or before April 30 of each year NCCSP shall determine the operating results for the preceding calendar year. The net excess revenue or expense shall be allocated to each County’s fund balance.

7. Appropriation Payment
a. Each county shall pay to NCCSP one fourth (1/4) of the county’s annual approved appropriation per quarter.

8. Collections from Service Recipients
a. The collection procedures utilized by NCCSP to collect charges from service recipients shall be consistent with established policies and procedures and State laws and administrative regulations applicable to collections.

9. Other Programs
a. Budgets shall be prepared which separately account for revenue and expenses for other County health care programs and institutions administered by NCCSP under the authority of Wis. Stat. 51.42(3)(b) and paragraph IV. NM. above. Operational and capital contributions by a County for which NCCSP is administering another County health care program or institution shall be determined under the provisions of the separate agreement between NCCSP and the authorizing County.

IX. VIII. TERMINATION OF THE AGREEMENT

A. Term of the Agreement. This agreement Agreement is effective as of the Effective Date (May 1, 2020 or January 1, 2017) and for a period of five (5) years thereafter. In the event that this agreement Agreement is not extended by an affirmative vote of each of the respective member county Boards of Supervisors, or a successor agreement is not entered into by affirmative vote of each of the respective member county Boards of Supervisors, prior to December 31, 2020 April 30, 2024, said failure is deemed to constitute notice of intent to withdraw from this agreement Agreement as contemplated under subsection VIII. IX. C. of this agreement Agreement. The failure of one county to affirmatively extend this agreement Agreement, or enter into a successor agreement, does not terminate joint sponsorship of the NCCSP, provided
that the remaining two member counties affirmatively vote to extend this agreement, or enter into a successor agreement. Instead, if only two member counties vote to extend this agreement, or enter into a successor agreement, the Continuation of Sponsorship provision of section IX.D. would be triggered.

B. Annual Review
1. The terms and conditions of this agreement shall be reviewed annually by the Committee and the Board to identify proposed amendments or modifications to address areas of concern.
2. Proposed amendments or modifications to the Agreement shall be reported to the member county Boards of Supervisors for further action.

C.B. Termination of the Agreement. This agreement may be terminated by any member County for any reason (or for no reason) by providing written notice of the intent to withdraw to the other member Counties at least one (1) full calendar year in advance of the effective termination date along with a copy of the resolution adopted by the respective member County approving withdrawal. The effective termination date will be January 1 of the next calendar year following the required full calendar year notice, unless all member Counties agree to an earlier effective termination date. The NCCSP would remain responsible for providing services in the same manner as previously agreed upon until the effective termination date.

D.C. Continuation of Sponsorship
1. The joint sponsorship arrangement under this agreement shall survive the withdrawal of any County if the remaining Counties choose to continue the joint sponsorship by affirmative vote of each of the member county Board of Supervisors and the execution of a successor joint sponsorship agreement no later than six (6) months prior to the effective termination date of this agreement as that date would be calculated in accordance with the provisions above.
2. In the event of continuance, the termination date of the withdrawing County's participation in the Program shall be determined as indicated above, and within six (6) months following the termination date, the equity fund balance of the withdrawing County shall be determined. Payment to the withdrawing County shall then be made during the twelve (12) months following the termination date. Payment shall be made first in property owned by that County but carried on the books of NCCSP at its depreciated value, and the remainder, if any, shall be paid from cash or other assets. If the withdrawing County's equity fund balance account is less than the depreciated value of the property owned by that County but carried on the books of NCCSP, then that County shall appropriate an additional amount to NCCSP to cover this deficit.
3. Any and all facilities use agreements regarding real property owned by the withdrawing county that is occupied by NCCSP shall terminate as of the effective date of the withdrawal, regardless of any continued sponsorship.

F-D. Liquidation of NCCSP

1. Upon the receipt of the notice of intent to withdraw from any member County, or upon the failure of all member Counties to renew this agreement or enter into a successor agreement, NCCSP shall initiate planning relative to winding-up its affairs with the member Counties, while continuing to share costs and provide services in the same manner as existing immediately prior to the notice. On any withdrawal not subject to continuation of sponsorship as provided above, the operations shall be terminated as soon as reasonably possible as determined by NCCSP and agreed to by the Committee. The net equity fund balance of each County shall be determined as of the date operations terminate. NCCSP shall then proceed to liquidate all assets except property and equipment and satisfy all liabilities. When liquidation has been completed the remaining net assets shall be distributed based upon the proportion of each County’s equity fund balance as of the date of termination of operations. The net assets distributed shall first be the property and equipment attributable to each County, and the remainder, if any, shall be paid from cash or other assets. If a County’s equity fund account is less than the depreciated value of the property and equipment owned by that County but carried on the books of NCCSP then that County shall appropriate an additional amount to NCCSP to cover this deficit by January 30 of the year following the next regular budget cycle.

2. NCCSP shall be entitled to withhold any unpaid contract charges from funds to be paid pursuant to this section.

X.IX. MISCELLANEOUS

A. Other Arrangements. No funding County shall enter into any agreement with NCCSP which financially benefits such County at the expense of any of the other funding Counties.

B. Assignment. NCCSP shall not assign this Agreement without the express written consent of Lincoln, Langlade and Marathon Counties.

C. Waiver and Modification. This Agreement, and its terms may only be waived, altered, amended, modified, cancelled or discharged by the parties upon specific written agreement approved by each of the member counties, or as otherwise specifically provided in this Agreement. In the event that the Board identifies
provisions it deems necessary to alter, amend, modify, cancel or discharge, it shall recommend same to each of the member counties for consideration.

D. **Automatic Modification.** If any law enacted by the State of Wisconsin or by the United States of America changes the parties' duties and obligations, NCCSP shall notify Lincoln, Langlade Marathon Counties of the needed changes and this Agreement shall be modified in a manner mutually agreeable to the parties.

E. **Captions.** Captions are used throughout this Agreement for convenience or reference only and shall not be considered in any manner in the construction or interpretation of this Agreement.

F. **Severability.** If any of the terms of this Agreement are declared to be invalid or unenforceable by a court of competent jurisdiction, the remaining provisions, or the application of such to persons or circumstances other than those to which it is declared invalid and unenforceable, shall not be affected, and shall remain effective, valid and enforceable to the fullest extent permitted by law.

G. **Construction.** This Agreement shall be construed according to the laws of the State of Wisconsin. This Agreement shall be interpreted and construed in a fair and impartial manner without regard to such factors as which party prepared the instrument or the parties' relative bargaining powers.

H. **Other Documents.** Each of the parties agrees to sign any other documents as may be appropriate to carry out the intentions expressed in this Agreement.

I. **Entire Agreement.** This Agreement, and any other instruments or agreements it refers to, constitute the entire agreement between the parties with respect to the subject matter, and there are no other representations, warranties, or agreements except as provided in this Agreement.

J. **Counterparts.** This Agreement may be executed in one or more counterparts, each of which shall be deemed an original.

K. **Parties Bound.** Each provision of this Agreement shall extend to and shall, as the case might require, bind and inure to the benefit of the Lincoln Langlade and Marathon Counties and NCCSP and their respective legal representatives, successors and assignees.

L. **Immunity.** Nothing contained in this Agreement is intended to be a waiver or estoppel of the rights of Lincoln, Langlade and Marathon Counties and/or NCCSP and their insurers to assert their rights to all affirmative defenses, limitations of liability and immunities as specifically set forth in Wisconsin Statutes, including sections 893.80, 895.52 and 345.05, and related statutes.
Effective January 1, 2017 or May 1, 2020, or date of last County Approval, whichever is later.

**LANGLADE COUNTY**

BY: __________________________
David J. Solin
County Board of Supervisors Chair
Date: ________________________

BY: __________________________
Judy Nagel
County Clerk
Date: ________________________

BY: __________________________
Robin Stowe
County Manager
Date: ________________________

**LINCOLN COUNTY**

BY: __________________________
Robert Lee
County Board of Supervisors Chair
Date: ________________________

BY: __________________________
Christopher J. Marlowe
County Clerk
Date: ________________________

BY: __________________________
Jason Hake
County Administrative Coordinator
Date: ________________________

**MARATHON COUNTY**

BY: __________________________
Kurt Gibbs
County Board of Supervisors Chair
Date: ________________________

BY: __________________________
Kim Trueblood
County Clerk
Date: ________________________

BY: __________________________
Lance Leonhard
Interim County Administrator
Date: ________________________
Memo

To: Retained County Authority Committee Members
From: Lance Leonhard, RCA Chair, & Scott Corbett, Marathon County Corporation Counsel
Date: December 23, 2019
Re: North Central Health Care provision of legal services

Question Presented: Based on North Central Health Care’s legal service needs, is it viable for a member county to create an Assistant Corporation Counsel dedicated to deliver legal services to North Central Health Care?

Determination: The Tri-County Agreement should be amended to provide that NCHC contract with Marathon County Corporation Counsel for provision of legal services.

Marathon County should create a 1.0 FTE Assistant Corporation Counsel to provide in-house general counsel services and representation to NCHC.

Legal Background:

The delivery of legal services for county departments of community programs is governed by Wisconsin Statutes, specifically Wis. Stats., §51.42(3)(ar)1, which currently reads, in part:

Notwithstanding ss. 59.42 (1) and (2) (b) and 978.05, any multicounty department of community programs may contract for professional legal services that are necessary to carry out the duties of the multicounty department of community programs if the corporation counsel of each county of the multicounty department of community programs has notified the multicounty department of community programs that he or she is unable to provide those services in a timely manner.

This provision was put in place as an amendment to the original statute setting forth duties of a multicounty department of community programs, circa 1983. Prior to that time the Wisconsin Attorney General had opined that the Board created under Wis. Stats., 51.42, did not have authority to contract for private legal services. See 63 Op. Atty Gen. 468 (1974).

Following the amendment of the statute in 1983, Marathon County Corporation Counsel, William A. J. Drengler, requested clarification from the Attorney General regarding some of the practical and legal effects of the amendment. In that opinion, the Attorney General expressly indicated that the 51.42 Board was limited to the employing counsel only to the extent that those duties were declined by Corporations Counsel (and District Attorneys, in counties without Corporation Counsel):
In my opinion the change in the statute grants a multicounty board power to contract for professional legal services with private counsel on an independent contractor basis if sufficient funds are available only ‘if the corporation counsel of each county [or district attorney of each county not having a corporation counsel] of the multicounty board has notified the board that he or she is unable to provide such services in a timely manner.’ The amendment evidently was passed in recognition of the opinion referred to and of the restrictive interpretation of then applicable statutes contained therein. *The Legislature could have granted broader power to the board to retain private counsel, but chose to place a strict rein upon its use.*


Effectively, the Attorney General opinion makes clear that the multicounty board is subordinate to the counties in the sense that it may only hire legal counsel to the extent that area is vacated by the counties. Without independent authority to hire legal counsel, a multicounty community programs board only has the power to hire counsel which is directly ceded to them by the counties.

The Attorney General suggests that counties and their respective 51.42 Boards are in a position to negotiate through the budget process for the specific counsel needed, providing that:

> County boards can also influence the decision of a 51.42/51.437 board with respect to any desire to contract for private counsel by providing adequate competent staff in the offices of corporation counsel and district attorney including county employment of an adequate number of assistants.

*Id.*

Finally, the Attorney General urges that counties and multicounty boards establish clear parameters for representation as follows:

> A multicounty 51.42/51.437 board should seek and rely on advice of the district attorney (district attorneys), corporation counsel (corporation counsels) of the county or counties involved. There may be provisions in the multicounty plan or contract approved under section 51.42(3)(b) and (c) which establish lines of primary responsibility or first reference with respect to rendering legal services to the 51.42/51.437 board.

*Id.* [Emphasis added].

Since receiving the previously referenced Attorney General Opinion, Corporations Counsel from the three participating counties have declined to provide general counsel services and representation to NCHC. That declination continues to be codified within the Tri-County Agreement. We are unaware of an agreement—either inside or outside of the Tri-County Agreement—that established “lines of responsibility or first reference” as suggested by the Attorney General.
Absent direct general counsel and representation through one of the member counties, general counsel services and representation have been provided to NCHC by a number of private attorneys, including the law firms of Hess, Dexter and Reinhardtson as well as Ruder Ware. Currently, attorneys from Ruder Ware provide legal services to NCHC on a contract basis.

While the member counties have not delivered general counsel services or representation to NCHC, each of the member county Corporations Counsel have maintained familiarity with many of NCHC’s core programs and services. Corporations Counsel have historically prosecuted Wisconsin Statutes Chapter 51 involuntary commitment cases as well as, Wis. Stats., Chapter 54/55 adult guardianship and protective placements on behalf of their respective counties. Currently, Marathon County Corporation Counsel prosecutes Chapter 51 actions on behalf of both Marathon and Lincoln Counties and Chapter 54/55 matters on behalf of Marathon, Lincoln and Langlade Counties.

While member Corporation Counsel have not provided general counsel services to NCHC—which began as a multi-county department of community programs—corporation counsels are called upon to deliver general counsel and representation services to several other joint ventures. Marathon County Corporation Counsel provides general counsel services to the Central Wisconsin Airport, City-County Information Technology Commission (CCITC), and Aging & Disability Resource Center of Central Wisconsin (ADRC-CW), as well as the Marathon County Public Library, by contract.

**Nature of Legal Services provided:**

To assess the nature and quantity of legal services needed by NCHC, Marathon County undertook a review of redacted billing information provided by NCHC’s current service provider, Ruder Ware, 17-page memorandum provided by Ruder Ware, and both a summary memorandum from NCHC CEO, Michael Loy, dated January 19, 2017, regarding legal services expenditures from 2013 – 2017 and email correspondence from Michael Loy, dated July 24, 2018, regarding legal services expenditures in 2018. Both the nature and quantity of legal services historically provided to NCHC are examined in further detail below.

The 17-page memorandum provided by Ruder Ware identifies thirty (30) different areas of practice that it provides to NCHC, across which legal professionals completed approximately 340 separate tasks. Some of the tasks listed are redundant across practice areas. The task list later in this memorandum is provided in rank order based on time actually billed. With respect to areas of practice, it is helpful to group the thirty (30) distinct practices areas identified by Ruder Ware as follows:

1) **Federal/State Regulation Compliance**: including both proactive efforts and corrective action, as well as defense of regulatory violations.

2) **Employment/Labor Law**: Hiring and Firing; Personnel Policies; Workers Compensation; Staff Qualifications/Licensure and defense of claims.
3) Confidentiality/HIPAA/Patient Rights/Privacy and defense of liability claims

4) Contract: Services; Leases

5) Collections

6) Medicare/Medicaid reimbursement

Based on the redacted billing statements, which detail services provided from 2016 through December 20, 2018, and the email correspondence from CEO Loy providing an overview of the 2017 legal services expenditures, the following general observations can be made regarding the attorney work performed:

- **Policy work** - The majority of attorney time is devoted to the creation, communication and subsequent modification of policies which are internal to NCHC. These policies are driven primarily, but not exclusively, by external regulations. They also take shape as a result of proactive efforts by NCHC to create procedures to anticipate and avoid issues or problems. A non-exhaustive list includes: medical staff, verbal orders, civil rights, HIPAA security matrix, oversight, investigation process, evidence spoliation, organ procurement, physical security, denial of access, release of records to parent accused of abuse, Substance Abuse Mental Health Services Administration (SAMHSA) regulations, release of records to law enforcement, release of records to POAs, videotaping of crisis interventions, consent by minors when parents refuse, Section 1557 (non-discrimination provision under the Affordable Care Act). In accordance with policies that have been created there is also substantial attorney time spent managing compliance with policies, the creation of an oversight committee, proactive education, integrating with employee performance evaluations, risk assessments and corrective action.

Applying this categorization to the 2017 legal services overview provided by CEO Loy (i.e., collectively considering Program Compliance, HIPAA Compliance, and Medical Staff within this category) we would expect “Policy work” to account for approximately 42.5% of the legal services required by NCHC (738.2 of the total 1,734.75 hours of service rendered in 2017).

**General Counsel** – A significant portion of legal work appears to consist of contract review (e.g., lease agreements, service agreements, Facilities Maintenance Plan, Joint County Contract, etc.); preparing for, attending, and drafting/reviewing agendas and minutes for NCHC Board, Executive Committee, and other subordinate committee meetings; conducting miscellaneous legal research on areas not clearly within the other services categories discussed in this memorandum (i.e., authority of constituent counties to retain authority to approve the hiring of the CEO, research regarding county budgeting and compensation of executives and research regarding external regulatory impact as a result of retained authority); and other miscellaneous
support activities (i.e., review of yearly work plan; project organization, prioritization and oversight; and work with the NCHC Foundation and possible Branch Office development). ¹

Applying this categorization to the 2017 legal services overview provided by CEO Loy (i.e., collectively considering General Counsel and Joint County Contract within this category) we would expect “General Counsel” to account for approximately 30% of the legal services required by NCHC (522.6 of the total 1,734.75 hours of service rendered in 2017).

- **General Labor Law** – The third largest body of legal tasks performed on behalf of NCHC are best characterized as labor and human resources in nature. Examples within the redacted billings provided would include work relating to the terms of the CEO agreement; issues relating to Executive employment, Physician employment, Midlevel employment, the Residency Program, credentialing, background checks, PTO policy, bonus payments, and the Medical director agreement; and legal research regarding Relative Value Units (measure of Medicare reimbursement for physician services), retention loan benefit and fair market compensation.

Applying this categorization to the 2017 legal services overview provided by CEO Loy (i.e., collectively considering General Labor and HR within this category) we would expect “General Labor Law” to account for approximately 18% of the legal services required by NCHC (305.2 of the total 1,734.75 hours of service rendered in 2017).

- **Active Participation in Ongoing Legal Proceedings and Potential Claim Management** – this category is best understood to consist of tasks designed to resolve pending legal actions and mitigate risk of potential, unfiled claims. Examples of such work from the redacted billings provided would include participation in Federal litigation regarding Civil Demand Investigation (100.20 hours), Civil Administrative Demand, Former Nurse Identity Theft issue, HIPPA violation litigation, Discrimination Claims, Termination of Lease litigation, workers compensation claim, complaint letter, internal investigations conducted by attorneys, response to records requests, patient grievance and Medicaid overpayment issue. Potential claim management would include the preparation and amendment of audit letters.

Applying this categorization to the 2017 legal services overview provided by CEO Loy (i.e., collectively considering CMS Appeal and Civil Administration Demand within this category) we would expect “Active Participation in Ongoing Legal Proceedings and Potential Claim

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¹ There are a substantial number of entries in the redacted billings providing “Resident time at NCHC,” which appear to denote that the contract attorney was present at the NCHC for a period of time greater than that which was ultimately billed. E.g., notation from 7/11/17 and 7/13/17 on page 62 of 251 of redacted billing packet. Other references are summary in nature, such as “Resident time. Work regarding general counsel legal services.”
Management” to account for no less than 7% of the legal services required by NCHC (121.15 of the total 1,734.75 hours of service rendered in 2017).²

- Collections – this is the final task category with meaningful legal service time associated. Based on the redacted billing information, most legal service time associated with this task appears to occur in the context of probate proceedings. Our assumption is that these attempts to intervene are likely related to the collection of nursing home related debt.

Based on the 2017 legal services overview provided by CEO Loy, “Collections” accounts for approximately 3% of the legal services required by NCHC (47.6 of the total 1,734.75 hours of service rendered in 2017).

Based on the information provided, our assessment is that the significant majority of NCHC’s legal services needs are consistent with the nature of work performed by County Corporation Counsels across the State of Wisconsin. Marathon County Corporation Counsel is currently responsible for providing legal advice and representation for each of its county departments, as well as multiple joint ventures, having built the specialized knowledge to do so over time. It is our assessment that Marathon County Corporation Counsel has the similar capacity to build the specialized knowledge relative to legal service needs of NCHC.

Quantity and Cost of Legal Services:

An evaluation of the redacted billings and other documents submitted for my review demonstrates that NCHC has been expending considerable financial resources to secure legal services. When these costs are evaluated from an hourly expenditure and annual expenditure perspective, the current costs through the current contractual provider far exceed similar legal service measures within the Marathon County Corporation Counsel’s Office. It is our professional judgement that Marathon County Corporation Counsel can provide said services at significantly lower cost, to the benefit of NCHC and each of the three member counties.

According to the redacted billings, rates for contractually provided legal services—excluding services characterized as “General Counsel Legal Services,” which appear relatively recently to have adopted a flat-fee service agreement of $10,000 per month—range as set forth below:

- Paralegal billing rate - $150-195 per hour
- Attorney billing rate - $210-375 per hour

² The approximate workload suggested by the 2017 Legal Expense Overview is likely a significant underestimate of the work in this category that was reflected in the redacted billings; however, the limited nature of the information within the billings does not allow for the assessment of the potential for considerable savings through increased utilization of insurance counsel in those situations where NCHC is insured against potential damages. Similarly, insurance providers can be extremely helpful in the creation, revision and implementation of policy.
Annually, between 2013 and 2017, NCHC reported total legal services expenditures as follows:

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenses</td>
<td>$141,583</td>
<td>$225,756</td>
<td>$65,074</td>
<td>$272,185</td>
<td>$406,096</td>
</tr>
</tbody>
</table>

The average annual legal service cost during that same five (5) year period was $222,139.

Examining the legal services provided through the lens of “hours of service,” is best accomplished through review of the 2017 Legal Expense Overview email from CEO Loy, which provides that during 2017, a total of 1,734.75 hours of legal services were provided to NCHC. If we assume that a full-time equivalent position equates to a total of 2080 hours available for service in any given year, we understand that in 2017, the year that NCHC obtained the greatest amount of legal service in the five-year period measured, NCHC needed slightly less than one full-time equivalent of collective legal services. Given that the average legal service need during the five-year period from 2013-2017, was approximately one-half of the need in 2017, one could estimate that a 0.5 FTE legal services employee would be sufficient to meet NCHC’s needs. However, based on the narrative comments from CEO Loy in his email correspondence dated July 24, 2018, noting that his assessment is that NCHC remains “vastly under resourced” as it relates to legal services, the remainder of our analysis assumes that the needs of NCHC are more adequately represented by the 2017 workload than the services delivered in the preceding years within the period or the average using during the entire period.

To assess the potential financial benefit of transitioning NCHC’s legal service provision to a County Corporation Counsel’s Office, it is necessary to examine the total compensation costs associated with a Paralegal and Assistant Corporation Counsel, see below:

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</thead>
<tbody>
<tr>
<td>Paralegal</td>
<td>$77,931</td>
<td>$37.47</td>
<td>$87,636</td>
<td>$42.13</td>
<td>$97,343</td>
<td>$46.80</td>
</tr>
<tr>
<td>Asst. Corp. Counsel</td>
<td>$84,639</td>
<td>$40.70</td>
<td>$97,074</td>
<td>$46.67</td>
<td>$109,510</td>
<td>$52.65</td>
</tr>
</tbody>
</table>

Based on the cost differential between the delivery of legal services between the current contractual provider and the Marathon County Corporation Counsel’s Office, both with respect to the hourly rate and the annual expense, it is apparent that the utilization of the Marathon County Corporation Counsel’s Office for NCHC legal services has the potential to result in a considerable reduction in overall legal service cost. There is no doubt that issues will arise that require specialized representation on a case-by-case basis. However, the identification of such issues and oversight of such representation are a hallmark of general counsel responsibilities. The provision of general counsel services by Corporation Counsel will result in greater attorney-time availability at less cost.

Conclusions/Comments:

In light of the nature and quantity of NCHC’s current legal service needs, the cost of NCHC meeting those needs through its current private contractual provider, and given the capabilities and costs
associated with Marathon County Corporation Counsel’s Office delivery of a comparable quantity of legal services, it is our professional recommendation that the Tri-County Agreement be amended to provide that NCHC contract with Marathon County Corporation Counsel for the provision of legal services to NCHC.

Should the Tri-County Agreement be so amended, we would further recommend that Marathon County create a full-time Assistant Corporation Counsel position to be the primary mechanism by which legal services would be rendered. Further review of whether additional legal support staff would be necessary could occur at a later date.
DUE DILIGENCE REPORT

POTENTIAL ACQUISITION OF NORTH CENTRAL HEALTH CARE’S TRI-COUNTY ADULT PROTECTIVE SERVICES
SERVING LANGLEDE, LINCOLN, AND MARATHON COUNTIES

Updated November 20, 2019 – Highlighted and Bolded areas denotes updates/corrections.

RESEARCHED AND PREPARED BY:

Jonette N. Arms, Executive Director
Mike Rhea, Director, Resource Center
Steve Prell, Fiscal Director
Angela Hansen, Communication/Administrative Services Manager
INTRODUCTION

The purpose of this report is to inform the ADRC-CW Board of Directors on the findings related to the potential acquisition of central Wisconsin’s tri-county Adult Protective Services (APS) system. On June 26, 2018, the ADRC-CW was approached by North Central Health Care (NCHC) about the possibility of taking possession of APS for Langlade, Lincoln, and Marathon counties. The reason for this discussion and the specific request was that NCHC does not believe the program and its services align with their organizational mission. After careful thought and consideration, the NCHC Board of Directors and Chief Executive Officer, Michael Loy believe APS would be better supported and aligned with the ADRC-CW’s mission.

After having several follow up conversations between July and September 2018 with the ADRC-CW Leadership Team, Michael Loy and Brenda Christian, Adult Protective Services Manager, the proposition was shared with the ADRC-CW Board at its October 11, 2018 meeting. A summary of the discussion is outlined in the meeting minutes and the Executive Director’s Report. During the October 2018 meeting, the Board granted the executive director and members of leadership permission to continue researching the potential opportunity with the goal of bringing more information back to the Board.

The overall goal would be for the ADRC-CW would take over operations of Adult Protective Services, which would include adopting a staff of seven existing employees –stable and well experienced supervisor, five APS workers, and one specialized administrative support person dedicated solely to APS.

- Current APS employees would transition from NCHC to Marathon County as directed by an amended ADRC-CW’s Intergovernmental agreement.
- APS would be housed within the Wausau regional office building, 2600 Stewart Avenue on the first floor.
- As per the organization chart on page 13 of this report, APS would be a department or additional unit of the ADRC-CW and the APS supervisor would be a direct report to executive director.
- All funds that currently support APS, as noted on the budget page 10 of this report, would follow APS. The funds would be transferred to Marathon County as per contract.
- Langlade, Lincoln, and Marathon counties currently designate $539,177 in tax levy to APS. These funds would remain the same amount regardless of where APS is housed.
- Under contracts and WI statutes, we are prohibited from commingling state allocations. In no case will the ADRC-CW supplant State funds to support APS services. Funds for each area will be used solely as designated by State contract and statutes.

Over the past year, as a part of our investigation, we carefully assessed the viability of procuring Adult Protective Services. Areas of focus included funding, emergency placements, operations, staffing, tri-county agreements, guardianships, technology needs, data storage and maintenance, and after hours crisis response. Our investigation included numerous meetings with Brenda Christian to learn about staffing, finance, and budgeting and overall implementation of operations across the three counties.

However, first and foremost, we considered our mission, which is to promote choice and independence through personalized education, advocacy, and access to services that prevent, delay, and lessen the impacts of aging and disabilities in the lives of adults. We are living and working in rapidly changing times intertwined with the daily challenges of an increasing older adult population and an underserved
population of adults who are disabled. Our responsibility to look at and consider opportunities that would help the ADRC-CW provide higher quality programs and services to our current and future customers and clients.

MISSION ALIGNMENT

The mission of ADRCs highly supports the mission of Adult Protective Services which is to protect risk adults who are (or are at risk of) experiencing abuse, neglect or exploitation and provide a means for long-term care and custody to persons who are incompetent and in need of guardianship and protective placements and or services. Adult Protective Services agencies respond to reports of abusive or neglectful situations involving adults at risk (adults 18 years plus). Adult Protective Services’ responsibility is to investigate the occurrences and then, based on discussions with partners such as ADRC staff and local managed care organizations, make recommendations for services to meet the needs of adults at risk.

While APS and ADRCs are distinct from each other, many of each agencies’ responsibilities align and overlap. Such as, APS has the responsibility to protect the care and safety of adults at risk by:

- Training and updating of ADRC staff regarding the recognition of neglect, self-neglect, financial exploitation or abuse; legal requirements, and reporting protocols.
- Providing contact information for an APS liaison with the ADRC to respond to inquiries from the resource center staff regarding Adult Protective Services.
- Establishing a process for APS staff to refer clients to the ADRC for functional and financial eligibility screens and options counseling.
- Assisting ADRC staff in gathering information needed to determine functional and financial eligibility.
- Understanding ADRC services and when to refer a client to the ADRC for assistance which includes but are not limited to:
  - Options counseling consultation and advice from the ADRC about the options available to meet an individual’s long-term care needs;
  - Working with the ADRC to help clients obtain information and assistance about services, resources, and programs in areas such as: disability and long-term care related services and living arrangements, health and behavioral health, Adult Protective Services, public benefits, employment and training for people with disabilities, home maintenance, nutrition, assistive technology and other topics;
  - Access to publicly-funded long term care including the administration of the long term care functional screen, and enrollment in publicly funded managed care options (e.g., Family Care, Partnership Program);
  - Benefits counseling to help individuals navigate the complex system of public and private benefits by providing accurate and current information, and assisting individuals to apply for, and address problems with Medicare, Social Security, and other state and federally administered benefits.
- Referring to or asking for assistance from the ADRC in situations in which ADRC staff may provide information about services or programs to assist the adult at risk. This may include services such as transportation, congregate or home-delivered meals, caregiver assistance, support groups, benefits counseling, friendly visitors, or chore services.
- Following-up with the ADRC detailing the response provided to any case referred from the ADRC.
• Providing contact information for an APS liaison with the ADRC.

As well, because ADRCs are a central source of specialized information, assistance, and access to community resources for older people and adults with disabilities as well as their families. ADRCs are also responsible for working with clients as it relates to protecting the care and safety of adults at risk, which includes:

• Training and updating of APS staff regarding ADRC resources, services, and client options.
• Establishing a process for ADRC staff to refer to Adult Protective Services.
• Reporting, in a timely manner, to county APS agencies suspected instances of neglect, self-neglect, financial exploitation, or abuse of ADRC clients.
• Cooperating with APS response, evaluation, reporting, and service plan activities to help ensure that the county has the information needed to investigate a report, develop necessary court documentation, and protect adults at risk.
• Providing the entry point for eligibility determination of publicly funded long-term care services as well as access to other programs needed to protect the health and safety of an adult at risk. Upon referral from the APS agency, the ADRC must gather the information needed to determine functional and financial eligibility and provide options counseling.
• Understanding APS programs, including a general understanding of Wisconsin Statutes and Chapters 51, 54, and 55, as well as when to report abuse, neglect, or financial exploitation.
• Providing contact information for an ADRC liaison with APS agency.

Additionally, both agencies have shared responsibilities which includes ADRC and APS staff consulting and participating with MCO care coordination teams to ensure that a plan of services is in place to address long-term protection needs and comply with court orders or, if needed, to coordinate an urgent services agreement and both Adult Protective Services and ADRC staff may provide short term care coordination when needed.

The above list of individual and shared responsibilities are a few examples. Overall, the accountabilities of both agencies (separate and shared) encompass a more extensive list. However, the objective was to demonstrate within this report how each agency supports the other and how their roles and responsibilities interconnect to support clients and their families.

The above information was referenced from the Wisconsin Department of Health Services, Division of Long Term Care Bureau of Aging and Disability Resources Office on Aging, Adult Protective Services, and Aging and Disability Resource Center Guidelines.

CONSULTATION

ADRCs
There are currently 24 ADRCs throughout the state that operate Adult Protective Services (APS) for their respective counties. ADRC-CW staff consulted with five ADRCs on May 9, 2019, that have APS as a part of their operations. These ADRC’s included, Rock County, Colombia County, Waukesha County, Pierce County, and Manitowoc County. The intent of this meeting was to determine the strengths and challenges that each ADRC had with respect to APS and their perspective regarding the fit APS had with the mission of ADRCs. The consensus of all these counties was that having APS as a part of the ADRC was beneficial.
Strengths identified:

- The work of APS and the ADRC overlap very well (see mission alignment section above)
- Having APS and ADRC combined allows for increased collaboration.
  - Staff will work more seamlessly with mutual customers.
  - Partnership opportunities and community connections will be more strategic and benefit each team.
  - Opportunity to leverage existing collaborations by each entity to better serve our customers.
- Increased efficiencies with workflow and opportunities to get the customer to the appropriate source for support faster.
  - Development of one point of contact to triage calls.
  - Simultaneous work on cases to improve the timeliness of action.
- Connection led to decreased confusion by customers (they no longer had to guess which agency to call to meet their needs).
- Seamless service to customers.

Challenges:

- ADRCs were county-based, and they had to budget for placement costs, which created struggles.
- Legal Fees. Assuring that contracts were developed for legal fees for guardianship proceedings.
- No singular documentation system/systems. Data and documentation systems ranged from using Microsoft Word to handwritten notes.
- Having a multi-county APS program and working with different corporation counsels and county governments is challenging.

Refer to page 11 for a list of challenges/threats and strategies to assist with diverting risks.

The overall assessment by the five ADRC directors consulted indicate that having APS under the auspices of the ADRC is operationally beneficial to the staff working on these teams, the community referring to each entity, and ultimately the customers being served.

Adult protective services operating under ADRCs is not a new concept. There are currently 24 ADRCs that operate APS with 4 of them functioning as regional ADRCs:

- Aging and Disability Resource Center of Adams, Green Lake and Waushara Counties*
- Aging and Disability Resource Center of Chippewa County
- Aging and Disability Resource Center of Columbia County
- Aging and Disability Resource Center of Dunn County
- Aging and Disability Resource Center of Green County
- Aging and Disability Resource Center of Fond du Lac County
- Aging and Disability Resource Center of Jackson County
- Aging and Disability Resource Center of Jefferson County
- Kenosha County Aging and Disability Resource Center
- Aging and Disability Resource Center of La Crosse County
- Aging and Disability Resource Center of the Lakeshore*
- Aging and Disability Resource Center of Marinette County
- Aging and Disability Resource Center of Marquette County
- Aging and Disability Resource Centers of Milwaukee County
- ADRC of the North (Serving Ashland, Bayfield, Iron, Price and Sawyer Counties)*
• Aging and Disability Resource Center of Pierce County
• Aging and Disability Resource Center of Racine County
• Aging and Disability Resource Center of Rock County
• Aging and Disability Resource Center of Sheboygan County
• Aging and Disability Resource Center of Trempealeau County
• Walworth County Aging and Disability Resource Center
• Aging and Disability Resource Center of Barron, Rusk and Washburn Counties*
• Aging and Disability Resource Center of Waukesha County
• Aging and Disability Resource Center of Winnebago County

*Multi-county regional ADRCs

GWAAR
ADRC-CW staff consulted with Jayne Mullins, Older Americans Act Consultant and Elder Abuse Program Specialist at the Greater Wisconsin Agency on Aging Resources, Inc. (GWAAR) Elder Law and Advocacy Center to discuss the opportunity presented. Jayne oversees funding and technical support for all state elder abuse (60 years plus) programs operated through Adult Protective Services units throughout the state. This funding is channeled from the state to GWAAR specifically for Older American Act programs. Jayne Mullins was clear in informing us that the funding annually allocated for all three counties has been standing at $73,203 (Langlade-$13,051; Lincoln-$14,344; Marathon-$45,808) which is minimal to cover elder abuse direct care for the three counties.

Wisconsin Department of Health Services, Department of Public Health, Bureau of Aging and Disability Resources
Jeff Becker, Legal and Protective Services Unit Supervisor at the Office on Aging and his staff provided the following considerations to take into account regarding the ADRC-CW’s possible acquisition of Adult Protective Services:

• Must have experienced staff. It will be very important to hire experienced APS staff. There will be a learning curve associated with operating under the new arrangement, and experienced staff will help with that. In addition to the “normal” workload, the central Wisconsin area has experienced abrupt nursing home and assisted living closures that require urgent action to ensure safety for large numbers of residents. These situations can be extra-intense and stressful, and inexperienced staff may struggle. Experienced APS workers will help smooth the transition and deal with these urgent issues that are likely to occur again.

• Response: If the acquisition moves forward, the ADRC-CW will acquire APS’ existing staff of seven employees, which includes five full-time APS workers, one part-time administrative specialist, and a manager with over 30 years of experience working in this area.

• Scope of work. You will want to have sufficient staff to cover the anticipated caseload over a three-county region. For 2018, the WITS reports (APS incident reports) were as follows: Lincoln—85; Langlade—68; and Marathon—354. It would be good to have solid numbers on the number of emergency protective placements, protective placements, and guardianships for each county; we (BADR) don’t track that information.

• Response: As noted above, the ADRC-CW would maintain all of APS’ personnel. The Managing supervisor already has a prepared workload plan and schedule for APS workers to ensure all
counties are sufficiently covered. That plan, which works well for APS’ caseload, would stay in place.

- **Funding.** The elder abuse allocation for the three counties is $73,203 annually, and the APS allocation is $152,242 annually. You’ll want to ensure adequate staffing within the available state funding plus whatever the counties are able to provide.

  **Response:** With the transfer of APS to the ADRC-CW, as noted above, $73,203 would be our state elder abuse contracted allocation from the combined three counties, $152,242 would be our state APS contracted allocation and $539,177 would be the tax levy allocation from the three counties in addition to $800 for direct services received by APS. These amounts total $765,180 and appear to be adequate to cover personnel and operational costs.

  These costs are outlined in the budget on page 10 of this report and are the same allocations that support the personnel and operational needs of APS as it currently exists under NCHC.

- **Protective placements, guardianships, and Watts reviews.** It will be important to consider how the three counties intend to handle these things, including:
  - Designating facilities for emergency protective placements;
  - Standards (income and assets) to be used by all the counties to determine if the county will file for guardianship and/or protective placements;
  - Determining how the counties will handle paying for corporate guardian fees; and
  - Determining how the counties will pay for the annual protective placement reviews (Watts reviews), including any associated travel costs.

  **Response:** Adult Protective Services currently has an existing agreement with Mount View Care Center within North Central Health Care for emergency protective placements; this agreement has been sufficient to cover emergency protective placement needs. During this exploration study, it was discussed with Brenda Christian, APS manager that in the event the ADRC-CW acquires APS, securing additional contracts with facilities throughout the region will be a priority in order to have additional options and assurances that a bed will be available when needed. Corporate guardian fees and fees for Watts reviews are included as a part of budgeted costs within the line item legal fees, as referenced in the APS budget listed below. Any additional fees for ongoing protective placement costs, or legal fees outside of the budget will be the responsibility of the respective county in which the individual resides. The fees and payment for these services will be added to the tri-county agreement for APS services between the ADRC-CW and the counties represented.

- **MOUs.** There will need to be several MOUs in place between each county and various entities. These would include the law enforcement agencies within each county, the managed care organizations operating within each county, the IRIS consultant, and fiscal employer agencies operating within each county, financial institutions within each county, etc. There can be quite a lot of these types of agreements to put together.

  **Response:** Adult Protective Services currently has MOUs with all of the noted agencies as recommended by the BADR. If an acquisition is approved by the ADRC-CW Board, we would move forward with using the current MOU templates and work with corporation counsel to
develop similar MOUs and would use added language to strengthen partnership roles and responsibilities.

- Interdisciplinary Teams (I-Teams). I-Teams are required in order to receive elder abuse funding (will you have one for all three counties or three separate teams?).

**Response:** APS currently coordinates I-Team meetings for the three-county region; this would not change with the acquisition of APS by the ADRC-CW.

**WHAT’S DRIVING THIS POTENTIAL MERGER?**

Adult Protective Services needs a place and location to be housed and call home. Allowing the ADRC-CW to acquire APS would provide a make sense solution to their displacement and allow for the continuance of APS services at a convenient location. Both the ADRC-CW and APS work together closely to ensure the care and safety of adults at risk who have been or are at risk of abuse, neglect, or financial exploitation. North Central Health Care’s mission focuses on providing care for mental health, recovery and skilled nursing needs. Additionally, NCHC gets paid to provide protective placements for APS clients, in which operating APS could be viewed as a conflict of interest.

The ADRC-CW’s mission fits well with the mission of APS, and many of our clientele are the same, which would work to support the needs of both entities. The ADRC-CW could provide APS with a work environment that is well-established and proficient in serving adults who are aging and disabled. It is our belief that the APS would continue to thrive under the auspices of a supportive cooperative organization, such as the ADRC-CW.

In addition to the strengths listed on pages 4 and 5 of this report, the ADRC-CW is also taking into account that the potential acquisition of APS would create:

- Heightened programmatic impact by integrating complimentary services.
- Stronger strategic positioning with clients, private funders, competitors (other ADRCs), and policymakers.
- Reduced total administrative costs.

To protect against any conflict of interest, APS would function as a separate unit of the ADRC-CW under the leadership of the executive director. Please refer to the attached organization chart, page 13.

**LOGISTICS**

The ADRC-CW has looked into a location and space needs for APS employees. Office space directly above our current Wausau regional office is available and provides appropriate space for APS employees. The office space also allows the ADRC-CW to have a meeting space for clients who have mobility issues where utilizing the first floor would be more beneficial.

Our current landlord, Ghidorzi, would provide the new office space at the same per square foot rate that we currently receive and would incorporate the new costs into our current rental agreement. Ghidorzi has agreed to provide modifications at no cost to the ADRC-CW (paint, new carpeting, remove walls/drywall, add a reception space, etc.).
Adult Protective Services would bring all of their current office furniture, computers, printer, and fax to support their work and customer service needs.

All costs related to transitioning services, moving and integrating APS into the ADRC-CW regional office would be fully the financial responsibility of North Central Health Care. The ADRC-CW will not incur any costs to acquire APS.

BUDGET

The budget for APS services is on the following page 10.

To be clear, this proposed budget is looking at annual, ongoing expenses. Any possible one-time costs, such as moving or new data systems, are not included.

The revenue in this program comes from two grants and levy appropriations from Marathon, Lincoln, and Langlade counties. As was mentioned earlier, the funding levels from these sources have been consistent over the past several years, and we anticipate this will continue in the future.

Within the anticipated expenses, as with our current programs, personnel costs are by far the greatest expense. Per a costing analysis conducted by Marathon County’s Human Resources Department, the current staff in the APS program will receive comparable wages and benefits as they currently receive.

No costs have been budgeted for on-call or afterhours response for APS staff. Just as APS currently functions under NCHC, after-hours calls will continue to go to the Crisis Response Hotline number at no added cost to the ADRC-CW. The current process does not require APS staff to work after hours, weekends or holidays.

The administrative expenses included in the proposed budget are based on staffing in all of our programs including, APS and our current administrative costs. We do not anticipate needing to add to our current administration structure, so what this means is the funds from APS would pay for some of the costs that are currently paid for by our existing resources.

Operating cost estimates are from a variety of sources. Those highlighted in yellow are from the current APS budget as it exists now, just converted to our system. Other expenses in the budget are what we anticipate based on our current experience and history.

The net amount in the proposed budget shows approximately $27,239 of funds beyond our expenses. This is the amount we have for contingencies.
Revenue

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Direct Service Revenue</td>
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</tr>
<tr>
<td>APS State Funding Grant</td>
<td>152000</td>
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<tr>
<td>APS EAN Grant Funding</td>
<td>73203</td>
</tr>
<tr>
<td>Appropriations</td>
<td>539177</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
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</table>

Personnel

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<tr>
<th>Position</th>
<th>Sal</th>
<th>Fringe</th>
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<tbody>
<tr>
<td>Manager (1.0)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>APS1 (1.0)</td>
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<tr>
<td>APS2 (1.0)</td>
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<tr>
<td>APS3 (1.0)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>APS4 (1.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APS5 (1.0)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>APS Admin Asst (.8)</td>
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<td></td>
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<tr>
<td><strong>Total Personel Expenses</strong></td>
<td>387902</td>
<td>127433</td>
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Admin

<table>
<thead>
<tr>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>12% of cost of existing Admin/Fiscal/Clerical Support</td>
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<tr>
<td><strong>Total Admin Expenses</strong></td>
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</table>

Operating Expenses

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<tr>
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</thead>
<tbody>
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<td>Acct/Audit fees</td>
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<td>Housekeeping Services</td>
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<td>Other Prof Serv</td>
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<tr>
<td>Electric</td>
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<td>Gas</td>
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<tr>
<td>Phone</td>
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<tr>
<td>Long Distance</td>
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<td>Computer Maint</td>
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<td>Sub-Contr Serv</td>
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<td><strong>Total Supplies &amp; Expense</strong></td>
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<table>
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<td>Print</td>
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<tr>
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<td>Mlieage</td>
<td>14000</td>
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<tr>
<td>Veh Lease</td>
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<tr>
<td>Other Op Supplies</td>
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<td><strong>Total Fixed Charges</strong></td>
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<td>Gen Liab Insurance</td>
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<td>Office Rent</td>
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<tr>
<td>Fees/Permits</td>
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<td><strong>Total Grants/Contributions</strong></td>
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<table>
<thead>
<tr>
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<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Other Direct Relief</td>
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<tr>
<td><strong>Total Operating Expenses</strong></td>
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<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Expenses</strong></td>
<td>737941</td>
</tr>
</tbody>
</table>

Net -                                  | 27239  |
## Challenges and Threats

| Establishing Protective Placements at no cost to the ADRC-CW. | 1. Go before Langlade, Lincoln, and Marathon county boards to share and impose the importance of their responsibility to cover the costs of protective placements.  
2. In collaboration with the ADRC-CW Board and County Board’s and Corporation Counsel, develop a tri-county agreement specifying the roles and responsibilities of each party and county involved.  
3. The ADRC-CW held a meeting on **October 31, 2019** with corporation counsels from Langlade, Lincoln, and Marathon counties to clarify under state statute that each county is required to cover temporary emergency placements costs. These costs as needed, are outside of current budgeted allocations provided by the State and GWAAR for APS and elder abuse.  
4. Collaborate with other long term care facilities within and possibly outside of the region to provide training for the special needs of clientele and negotiate commitments to allocate more beds for placements. |
|---|---|
| The cost required to cover overall transition and move of APS to ADRC-CW  
1. Updates/modifications to office space.  
2. Physical move of equipment and furniture.  
3. Acquisition of new database and documentation system and all IT needs. | 1. Develop a budget for costs.  
2. Establish written pre-agreement with North Central Health Care to cover all transitional and move costs.  
3. Establish written pre-agreement with North Central Health Care to assist with identifying and covering the cost of the new database and documentation system. |
| Identifying after-hour crisis response for APS calls. | **A meeting was held on November 8, 2019 with North Central Health Care to discuss and confirm that NCHC will continue to provide after-hours response through their crisis hotline.** |
| Legal Fees. Assuring that contracts were developed for legal fees for guardianship proceedings. | Beginning in 2019, NCHC APS contracted with Marathon County Corporation Counsel to provide all legal services. This partnership is working well and would continue after acquisition. |
| Multi-county APS program having to work with different county corporation counsels and county governments. | 1. Establish a written contractual agreement with Marathon County to continue using corporation counsel for all APS legal services.  
2. The ADRC-CW currently works very well with our counties and would continue to work well during and after the acquisition of APS. Strategies that will support this effort are:  
- As mentioned in this report, the ADRC-CW, in collaboration with our three counties, will put MOUs clarifying each parties’ roles and responsibilities.  
- Make sure to have a continuous conversation with counties as needed.  
- Utilize ADRC-CW Board members to ensure they are kept up to date and taking information back to their county boards for discussion. |

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**Next Steps**
If the ADRC-CW Board approves the ADRC-CW to move forward with acquiring APS, staff will develop a plan that will include further conversations with North Central Health Care about covering the full amount of transition costs, gathering estimates for cost of moving, IT, database/documentation system, and any modifications for new rental space not covered by Ghidorzi. We will work with APS, corporation counsel, county finance directors, law enforcement, placement facilities, and others from each county to develop MOUs. We will go before each board to seek approval and get a commitment for the continuation of current levy allotments. Marathon City/County IT and Lincoln County IT will be consulted and utilized to ensure a smooth transition of data, documentation, and all employee computer and telephone needs. The ADRC-CW will also work with GWAAR and the State of Wisconsin to complete the appropriate applications and contracts to have funding transitioned to the ADRC-CW.

A realistic timeline will be created to inform the ADRC-CW Board of each point of action needed to be conducted to establish a final acquisition date. With Board approval, the final step will be to develop a brand identity and communication plan to inform all shareholders throughout the region of the ADRC-CW’s acquisition of APS.

The ADRC-CW executive director requests that the Board:

1. Read and thoroughly review this report and consider (beyond why) how the acquisition can happen.
2. Take into consideration the information outlined in this report.
3. Assess “how” the cultures of the ADRC-CW and APS might work well together.
4. Consider the possibility of long-term viability and success for the ADRC-CW.
5. **Consider fiduciary responsibility with supporting the ADRC-CW budgetary needs.**
6. Think mission and vision for the overall ADRC-CW.
7. Inform staff of approved next steps.
8. Request additional information if needed to ensure you are able to make an informed decision.

In compiling this report, the ADRC-CW Due Diligence Team worked hard to carefully obtain factual information to help board members make clear and informed decisions. The information used and statements of fact made in this report were obtained from sources we consider reliable, but we neither guarantee nor represent the completeness or accuracy.
Thursday February 27, 2020 – 3:00 PM – 5:00 PM

**Educational Presentation:** Campus Renovation Status Update; Overview of Behavioral Health Electronic Medical Record Replacement Project Plan

**Board Action:** Report of recent investigations related to corporate compliance activities and significant events.

**Board Policy to Review:** Capital Assets Management Policy, Cash Management Policy

**Board Policy Discussion Generative Topic:** Diversity and Cultural Competency – Implications for the Board, Management and our Workforce

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NO MEETING IN MARCH

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**Next Regularly Scheduled Meeting is on Thursday, April 16, 2020 (3rd Thursday) – 3:00 PM – 5:00 PM**

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Thursday April 16, 2020 (3rd Thursday) – 3:00 PM – 5:00 PM

**Educational Presentation:** Audit Presentation

**Annual Report & Program Review:** Presentation of the Annual Report from prior year. Review and discuss the organization’s major programs and how the organization’s programmatic performance informs the plans for the current year and beyond.

**Board Action:** Bi-monthly report of investigations related to corporate compliance activities and significant events. Accept Annual Financial Audit and Fund Balance Statement.

**Board Policy to Review:** Fund Balance Policy, Write-off Policy, Risk Reserve Policy

**Board Policy Discussion Generative Topic:** TBD