North Central Health Care
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OFFICIAL NOTICE AND AMENDED AGENDA

Notice is hereby given that the **North Central Community Services Program Board** will hold a meeting at the following date, time and location shown below.

Thursday, April 29, 2021 at 3:00 pm
North Central Health Care - Wausau Board Room
1100 Lake View Drive, Wausau, WI 54403

The meeting site identified above will be open to the public. However, due to the COVID-19 pandemic and associated public health directives, North Central Health Care encourages Committee members and the public to attend this meeting remotely. To this end, instead of attendance in person, Committee members and the public may attend this meeting by telephone conference. If Committee members or members of the public cannot attend remotely, North Central Health Care requests that appropriate safety measures, including adequate social distancing, be utilized by all in-person attendees.

Persons wishing to attend the meeting by phone may call into the telephone conference beginning five (5) minutes prior to the start time indicated above using the following number:

Meeting number (access code): 1-408-418-9388 Access Code: 123 152 4075

Our Mission

Langlade, Lincoln, and Marathon Counties partnering together to provide compassionate and high-quality care for individuals and families with mental health, recovery, and long-term care needs.

AGENDA

1. CALL TO ORDER

2. CHAIRMAN'S ANNOUNCEMENTS

3. PUBLIC COMMENT FOR MATTERS APPEARING ON THE AGENDA (Limited to 15 Minutes)

4. PATIENT IN THE BOARD ROOM (5 Minutes)

5. CONSENT AGENDA AND MONITORING REPORTS
   - A. Board Minutes and Committee Reports
     - i. ACTION: *Motion to Approve the March 25, 2021 NCCSP Board Minutes*
     - ii. FOR INFORMATION: Minutes of the March 18, 2021 Executive Committee Meeting
     - iii. Policy Governance Monitoring Reports
       1. Recent State, Federal, and Accreditation Reports –
          - a. Mount View Care Center Annual Survey Report
     - iv. Executive Operational Reports

6. BOARD EDUCATION
   A. Community Treatment Programs (20 Minutes) – J. Hintz

7. BOARD DISCUSSION AND ACTION
   A. CEO Report and Board Work Plan – M. Loy

   B. ACTION: *Motion to Accept the Dashboards and Executive Summary* (5 Minutes) – M. Loy

   C. ACTION: *Motion to Accept the March Financials* (5 Minutes) – J. Meschke

   D. ACTION: *Motion to Approve Market Adjustments for Certified Nursing Assistants, Dietary, and Housekeeping Positions* (10 Minutes) – M. Loy

   E. Overview and Discussion on Commitment Order Process and Decision-Making (15 Minutes) – M. Loy & R. Gouthro

   F. ACTION: *Approve Contract with Aegis for Restorative Nursing Program* (5 Minutes) – J. Nickel

   G. ACTION: *Approve Modification to the 2021 Budget to Purchase Contract Management Software* (5 Minutes) – D. Adzic

   H. ACTION: Review and Approval of Board Policy – *Motion to Approve the following Polices:*
      i. Strategic Planning Policy
      ii. Budget Policy

   I. ACTION: *Approve Resolution in Support of 2021 Senate Bill 239 to Amend 51.15(5) of the State Statutes; relating to: excluding time for evaluation and treatment of certain medical conditions from the time limit for emergency detention without a hearing*

8. BOARD CALENDAR AND FUTURE AGENDA ITEMS

9. BOARD EXPERIENCE OPTIMIZER

10. ADJOURN

NOTICE POSTED AT: North Central Health Care
COPY OF NOTICE DISTRIBUTED TO:
Wausau Daily Herald, Antigo Daily Journal, Tomahawk Leader,
Merrill Foto News, Langlade, Lincoln & Marathon County Clerks Offices

Presiding Officer or Designee

DATE: 04/28/2021 TIME: 2:30 PM BY: D. Osowski

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NORTH CENTRAL COMMUNITY SERVICES PROGRAM
BOARD MEETING MINUTES

March 25, 2021 **3:00 p.m.** **Wausau Board Room**

Present via conference phone (due to Covid19) unless otherwise noted by "HCC" which denotes in-person attendance.

X	Eric Anderson	X	Randy Balk	X	Chad Billeb
EXC	Ben Bliven	EXC	John Breske	EXC	Kurt Gibbs
EXC	Deb Hager	X	Lance Leonhard	X	Dave Oberbeck
X(HCC)	Robin Stowe	EXC	Gabe Ticho	X	Pat Voermans
X	Bob Weaver	X	Cate Wylie		

Staff Present: Michael Loy, Jill Meschke, Jaime Bracken, Jarret Nickel, Tom Boutain, Dr. Rob Gouthro, Jennifer Peaslee

Others Present: Jason Hilger, Langlade County Manager
Dejan Adzic, Asst. Marathon County Corp. Counsel

Call to Order

- Meeting was called to order at 3:00 p.m. by E. Anderson.

Chairman Announcements

- Thanks to B. Bliven for his interest and willingness to participate on the North Central Health Foundation Board.
- Jason Hilger, recently hired as Langlade County Manger, was introduced, and welcomed.

Public Comments for Matters Appearing on the Agenda

- None

Patient in the Board Room

- Individual was unavailable this month.

Consent Agenda and Monitoring Reports

- **Motion**/second, Stowe/Leonhard, to approve the February 25, 2021 NCCSP Board Minutes. Motion carried.
- CEO Report Highlights:
    - Covid Update: vaccination rate is around 70% for employees, and over 90% of residents at Mount View Care Center and 70% at Pine Crest, in-person visitation is occurring again in the nursing homes, and we are beginning to operate in a fashion prior to the pandemic.
    - CLA strategic review is underway.

- Just wrapped up a successful annual certification survey at Mount View Care Center, as well as the behavioral health services program recertification visit, reports will be provided next month, waiting for our Joint Commission survey and the annual survey at Pine Crest.

- Review and Approval of Board Policies
  - This is standard annual review of policies; minor updates were made to the policies that were provided in the Board Packet.
  - **Motion**/second, Wylie/Balk, to approve the Cash Management, Fund Balance, Risk Reserve Guidelines, and Write-Off of Accounts Receivable Policies as presented. Motion carried.
- Approve Recommendations of the Medical Executive Committee
  - **Motion**/second, to approve the recommendations for appointments and reappointments from Medical Executive Committee, Voermans/Leonhard, motion carried.

<u>Board Education</u>

- Update on the Campus Renovations and Debt Service Model – M. Loy
  - Loy provided a history of the project that began in 2017, a construction status update, as well as an overview of the evolving situation in planning for the last phases of the project including decisions that Marathon County will need to make for the completion of the project in summer 2022.
  - Project is on time and under budget thus far; however, at this time it is projected to exceed the total authorized project by $2.6 million. Majority of additional costs are related to escalating construction costs as well as several physical plant opportunities that are important to include at this time that were not included in the estimating based on the approved design in 2019.
- Update on Physician Recruitment Plan – M. Loy
  - In 2015 the estimated shortage of full-time psychiatrists in our region was at 14, to date that number has been reduced to about 4 in 2019. This has been due largely in part to North Central Health Care hiring several more psychiatrists on staff and in partnership in the Psychiatry Residency program.
  - We have been successful in hiring from our sister residency program in Green Bay with Dr. Daniel Hoppe and Dr. Waqas Yasin joining us in July. Also Dr. Jessica Dotson will be joining us this year as a child and adolescent psychiatrist.
  - Our strategy is to continue to support the Medical College Residency Program as it is a key piece for us to successfully recruit psychiatrists and provide mental health services to our communities.
- The Role of the Governing Body in Achieving Zero Harm and Leading a Culture of Safety – M. Loy
  - As an organization we want to reduce the risk of harm in the process of delivering healthcare.
  - Monitoring harm is done through: Occurrence Reporting, Safety Zone Occurrence Reporting, Admin On-Call, Daily Occurrence Reporting, Daily Safety Huddle, Investigation, Report Closure Monitoring, and Reporting to the Governing Body on a bi-monthly basis.

- The Board would like the bi-monthly reporting to continue and feels the level of reporting is informative and meaningful.
- The Board has consensus on Loy proceeding with the implementation of foundational strategies and tactics for Board Engagement in Zero Harm.

Board Discussion and Action

- Dashboards and Executive Summary – M. Loy
  - Dashboards and Executive Summary are extensive documents that look at variances in performance measures. The Executive Summary only speaks to exceptions (areas not meeting target). Access to CCS (case management program and outpatient programming) teams are working actively to address actions to meet target and, Turnover is being addressed recognizing that many employees leave within the first year which we feel it is due to the pandemic and wages especially for CNA's and nurses. Many have left the industry altogether, but we need to make sure our front-line staff have a competitive career opportunity to other options in the community. There may be potential decisions the Board will need to consider in April in this regard.
  - **Motion**/second, Stowe/Leonhard, to approve the Dashboards and Executive Summary. Motion carried.
- January and February Financials – J. Meschke
  - January and February financials were reviewed. It was also noted that staff are working through forecasting efforts primarily in the nursing homes to reset revenue and expense targets to be more attainable through the rest of 2021. Also, census reductions in the behavioral health hospital are being reviewed. Audit field work is wrapping up in the next few weeks with a planned presentation to the Board in April.
  - Continue to be watchful on any additional funding available through Cares Act dollars. We are also at a point to seek out of county contracts to help increase census for the youth behavioral health hospital and help offset expenses.
  - **Motion**/second, Leonhard/Stowe, to accept the January and February financials. Motion carried.

Consideration of a Motion to Move into Closed Session

- **Motion**/second, Leonhard, 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
- Roll Call Vote: all Ayes. Motion carried.

Reconvene to Open Session and Report Out on Possible Action in Closed Session Item(s)

- **Motion**/second, Stowe/Leonhard, to reconvene in open session at 4:38 p.m. Motion carried.

Possible Announcements or Action Resulting from Closed Session

- No announcements or actions

Board Calendar and Future Agenda Items

- Audit presented next month
- Targeting May for our Board Retreat and in-person if it can be done safely.

Board Experience Optimizer

- Within 24 hours of the Board meeting a brief survey will be sent via email to each Board member. The Experience Optimizer is a Board governance effectiveness tool. Results are shared with the Board chair which helps in preparing and moving the Board forward.

Adjourn

- **Motion**/second, Leonhard/Wylie, to adjourn the meeting at 4:40 p.m. Motion carried.

Minutes prepared by Debbie Osowski, Executive Assistant to CEO

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NORTH CENTRAL COMMUNITY SERVICES PROGRAM BOARD
EXECUTIVE COMMITTEE

March 18, 2021 **3:00 PM** **NCHC – Wausau Board Room**

Present:	X	Eric Anderson	X	Kurt Gibbs	X	Lance Leonhard
	X	Robin Stowe	X	Cate Wylie		

Others Present: Michael Loy, Jarret Nickel, Dejan Adzic, Toni Kellner

Call to Order

A. Meeting was called to order at 3:01 p.m. by Chairman Gibbs.

Public Comment

A. No public comment

Approval of the February 18, 2021 Executive Committee Meeting Minutes

A. **Motion**/second, Wylie/Anderson, to approve the February 25, 2021 Executive Committee Meeting minutes. Motion carried.

Policy Issues for Discussion and Possible Action

A. Overview of Planned Lincoln Industries Operational changes include:
    - In 2020 North Central Health Care (NCHC) assumed management of Lincoln Industries at the same time as Pine Crest Nursing Home. Lincoln Industries provides adult day services and pre-vocational services out of Tomahawk and Merrill. Lincoln County approached NCHC to take on Lincoln Industries in 2020 where we could consolidate costs and help lessen the burden to Lincoln County. The Tomahawk facility was sold, and the program's hub transitioned to a local church. Members and community were accepting of the changes. The Merrill property is a less than quality facility and not in compliance. The cost to repair is too high to proceed with remodeling.
    - The Covid pandemic in early 2020 caused the program to close which contributed greatly to a significant loss of revenue in 2020 resulting in a $200,000 deficit. At one point in 2020 the membership dropped from 112 to 16. With communities slowly opening now, membership is currently around 69 however, roughly 60% of the membership have not re-engaged in programming. Without making changes it is projected there would be a $360,000 loss for 2021 for Lincoln County.
    - This is not a required program for the county to provide nor is it supported by grants or other funding. Had Covid not impacted the program as it did, we feel it would be operating well today as we managed the declining participation over time.

- NCHC's goal is to move toward community-based employment (Pre-Voc) rather than a sheltered workplace. Members needing sheltered work would be transported to the Wausau location at Northern Valley Industries (about a 20-minute commute) and the Merrill location would be closed.
- The Committee felt a presentation of the status of the program along with options for the future of the program be provided first to the Lincoln County Board for review and a decision. Should Lincoln County want to continue with the program but not finance the negative impact, the NCCSP Board would need to discuss.
- C. Wylie will place this topic on the appropriate agendas in Lincoln County for discussion in April.

B. Creation of Finance Committee-Roles and Responsibilities, and Potential Appointments
- Loy approached Chairman Gibbs with the recommendation to create a Finance Committee due to the significant number of new Board members, the major renovations occurring, and changes to programs. It would be beneficial for a Finance Committee to have a greater depth of knowledge into the financial details of the organization and would provide our Chief Financial Officer an opportunity to engage in more depth with the Committee given the limited time during regular Board meetings.
- With the preliminary report from the administrative review that the Board approved in January unavailable yet, Chairman Gibbs recommended waiting to determine the roles, responsibilities, and appointments of the Finance Committee until the review is complete to consider any potential recommendations.
- Suggestion was made to add financials as a standing item on the Executive Committee until a Finance Committee is re-established. Also, Bylaws may need to be amended with the authorization of ad hoc committees.

<u>Operational Functions Required by Statute, Ordinance, or Resolution</u>

A. None

<u>Educational presentations/Outcome Monitoring Reports</u>

A. CEO Report – M. Loy
- COVID-19: back to normal as much as we can be except masks will continue to be worn throughout the building; in person visitations will begin within the next week or two.
- State survey recently completed at Mount View Care Center. Received only a few low-level citations. Survey team was very complimentary.
- We are anticipating The Joint Commission survey at any time. Also, the annual survey for recertification of our Behavioral Health Services is scheduled for next week.

B. Organizational and Program Dashboards
- After reviewing all program dashboards, several focus areas identified include turnover and access for outpatient and community treatment. We have seen improvement in access rates but continue to work to improve the process for better outcomes. We have also been receiving referrals for community treatment which are not appropriate for that program.

C. Board Work Plan
- All items are in progress

D. December, January, and February Financials
    - December financials and year end audit are in process. The audit is scheduled to be complete and presented to the Board in April.
    - January and February financials will be reviewed with the Board. Initially we were close to $1 million loss. After a review of every line item, we identified several errors which brought the loss to $700,000. February is in the black. March census is soft, but we are adjusting and making progress on improving.
    - We are reforecasting and realigning our expense structure for 2021 also.

Next Meeting Date & Time, Location, Future Agenda Items

A. Review of Draft NCCSP Board Agenda for March 25, 2021
    - The Purchasing Policy will be pulled for this month to allow for additional review.
    - Will remove Lincoln Industries discussion based on today's discussion.
    - To expand sober living in Marathon County with a lease for an 8-bed facility. Executive Committee suggested meeting immediately preceding the Board meeting on March 25 to review the details, and if approved, Board would act on the recommendation at the March 25 Board meeting.
B. Committee members are asked to bring ideas for future discussion and educational presentations to the NCCSP Board
C. Next Meeting: Thursday, April 15, 2021, at 3:00 p.m. in the North Central Health Care Board Room

Announcements

A. C. Wylie noted Lincoln County has an appointment for Corporation Counsel, Carrie Johnson, who will start March 29, 2021.

Adjournment

- **Motion** to adjourn by Anderson, second by Leonhard. Motion carried. Meeting adjourned at 4:06 p.m.

Minutes prepared by Debbie Osowski, Executive Assistant to CEO

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MEMORANDUM

DATE: April 23rd, 2021
TO: North Central Community Services Program Board
FROM: Jarret Nickel, Operations Executive
RE: Mount View Care Center Annual Survey Report

For the past 11 months survey activity for skilled nursing facilities has been paused with only critical or infection prevention surveys occurring. In March normal survey processes returned which resulted in Mount View Care Center (MVCC) undergoing their annual State survey. I am pleased to announce that all survey results were above state and national averages for number of citations. MVCC's annual survey was four days in length and six surveyors were in the facility during this time. During this type of survey all residents are interviewed, and a sample size is pulled which was 32 of the 135 residents in the facility at the time of survey. From this sample size all resident medical charts are pulled and reviewed in detail to see if any standards of care or regulatory codes have been followed incorrectly. Also, during this survey process surveys interview staff, inspect kitchen and dining rooms, and observe medication and treatment process. MVCC received only 2 low level citations compared the state average of 8.1 and national average of 9.5. This validates the high quality of care being provided at MVCC each day. Regulatory compliance has also been achieved providing no interruption in reimbursement or certification.

The documentation for the Annual Recertification is attached as part of this Board's monitoring reports.

Tony Evers
Governor

Karen E. Timberlake
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF QUALITY ASSURANCE
BUREAU OF NURSING HOME RESIDENT CARE
NORTHWESTERN REGIONAL OFFICE
610 GIBSON STREET, SUITE 1
EAU CLAIRE WI 54701-3687

Telephone: 715-836-4752
Fax: 715-836-2535
TTY: 711 or 800-947-3529

March 24, 2021 **EMAIL**

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Kristin Woller, Administrator
North Central Health Care, License # 2931
1100 Lake View Drive
Wausau, WI 54403

Survey Type: Recertification, State Licensure, Life Safety Code
Survey Date: March 11, 2021
SOD Event ID: ZUMD11, ZUMD21

Dear Ms. Woller:

On March 11, 2021, a survey was conducted at your facility by the Division of Quality Assurance to determine if your facility was in compliance with federal requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found the most serious deficiency to be a scope and severity of F, as evidenced by the attached CMS-2567, whereby corrections are required.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations. The federal Statement of Deficiencies (SOD) is enclosed.

COMPLETION DATE

The date by which deficiencies must be corrected to avoid possible imposition of remedies is April 11, 2021.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. The Centers for Medicare & Medicaid Services (CMS) will provide you with a separate, formal notification should they determine that termination or any other remedy is warranted.

REMEDIES

Remedies may be imposed if one or more of the following occur:

- An acceptable plan of correction is not submitted timely or does not contain sufficient information to verify the facility has attained and will maintain substantial compliance
- Your facility fails to achieve substantial compliance by the completion date

In addition, if you do not achieve substantial compliance by June 11, 2021, CMS must deny payment for new admissions.

PLAN OF CORRECTION

The Plan of Correction (POC) must be received in this office within ten calendar days of receipt of this letter (or the first working day if the due date is on a weekend or holiday or within 12 calendar days if the E-SOD was received on a Friday). Return the first page, signed and dated, of the Statement(s) of Deficiencies (SOD), along with the completed POC form for those deficiencies which were noted on the SOD.

To be acceptable, a provider's plan of correction must include the following:

- What corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.
- What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.
- Dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility.
- Documentation to support a LSC waiver request (if appropriate), including financial hardship statement; floor plan; cost estimate and additional safeguards implemented.

SUPPORTING EVIDENCE OF COMPLIANCE

For all deficiencies cited at a scope/severity level D, E, or F non-substandard quality of care, a desk review may be completed per guidance in State Operations Manual, Chapter 7, 7317.2. While the plan of correction serves as the facility's allegation of compliance, substantial compliance cannot be certified and any remedies imposed cannot be lifted until compliance has been verified.

QSO 20-35 states, "SAs must request facilities to submit evidence that supports correction of noncompliance so that a desk review can be performed based on the latest compliance date on the POC. **NOTE: A desk review cannot be completed without supporting evidence from the facility.** This evidence may include documentation containing dates of training, staff in attendance, and evidence that staff were evaluated for skill(s) competency. It may also include monitoring for policy implementation and successful performance by staff."

Therefore, you must submit supporting evidence of compliance for all deficiencies cited at scope/severity level D, E or F non substandard quality of care before a desk review can be completed (including Life Safety Code deficiencies if applicable).

Acceptable evidence may include, but not limited to:

- An invoice or receipt verifying purchase or repairs;
- Attendance records/sign in sheets for in-service training;
- Syllabus or content of in-service provided;
- Contact with resident council;
- Monitoring/Audit plan

Evidence should be kept to a minimum and submitted electronically to:
dhsdqabnhrcesodnwro@dhs.wisconsin.gov

If documentation includes any resident PII or PHI, it must be encrypted.

INFORMAL DISPUTE RESOLUTION

In accordance with s.488.331, you have the opportunity to dispute the survey findings through the Informal Dispute Resolution (IDR) process. To make your request, send the following information:

- Completed Informal Dispute Resolution Request Form DQA F-62514
- One copy of the SOD, without the POC
- One copy of the Resident and Staff Key
- One copy of your supporting documentation for the IDR review

Please send the information to:

- MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534, Office: 585-348-3492; Fax: 1-888-866-6190; WIDQAIDR@maximus.com Attention: State Appeals/IDR Review, **OR**
- Submit electronically through MAXIMUS Federal's Secure File Exchange. Instructions may be requested by sending an email to: StateAppealsEast@maximus.com **NOTE:** Access to the Secure File Exchange requires requesting an account 24 hours before you intend to submit your supporting documentation. A request for an account may be made during regular business hours EST.

This request must be received by MAXIMUS on or before the tenth calendar day following receipt of the SOD (or the first working day if the due date is on a weekend or holiday or within 12 calendar days if the E-SOD was received on a Friday). The day the facility receives the SOD is Day 0.

See DQA Publication P- 01856 – IDR for Nursing Homes and Facilities Serving People with Developmental Disabilities for important information and further direction about IDR. An acceptable

POC must be submitted timely whether or not an IDR is requested, and the effective date of any enforcement action will not be delayed by an incomplete IDR process.

SUPERIOR HEALTH NURSING HOME QUALITY IMPROVEMENT COLLABORATIVE

The Division of Quality Assurance would like to encourage you to participate in the Superior Health Nursing Home Quality Improvement Collaborative, an initiative under the Centers for Medicare & Medicaid Services Quality Improvement Organization Program. Efforts for Wisconsin nursing homes are carried out by MetaStar.

Superior Health is comprised of eight organizations in Wisconsin, Illinois, Michigan, and Minnesota (including MetaStar). The Focus of the collaborative is to improve the quality and healthcare of consumers, residents, clinicians, health care organizations and communities by supporting these areas:

- Improving nursing home quality by focusing on reducing resident harm, reducing unnecessary hospitalizations and increasing participating facility's Five Star Quality Rating
- Increase quality of care transitions
- Increase resident safety by reducing adverse drug events and healthcare related infections
- Improve access to behavioral health services

For more information, please contact Diane Dohm at ddohm@metastar.com or Toni Kettner at tkettner@metastar.com, call (608) 274-1940, or visit https://www.superiorhealthqa.org

CLINICAL RESOURCE CENTER

You may also want to access the Clinical Resource Center (CRC) website at https://crc.chsra.wisc.edu. The website is designed to provide key information about clinical care with each care area module organized using a framework that provides tools, guidelines, related regulations and additional resources for learning.

If you have any questions, please contact me at tammy.modl@dhs.wisconsin.gov or by telephone at 715-836-3030.

Sincerely,

Tammy Modl

Tammy Modl
Regional Field Operations Director
Bureau of Nursing Home Resident Care

cc: Centers for Medicare & Medicaid Services
Disability Rights Wisconsin

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525132	A. BUILDING **03** B. WING _____	**03/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CENTRAL HEALTH CARE	**1100 LAKE VIEW DR** **WAUSAU, WI 54403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A Recertification Survey was conducted by the Wisconsin Division of Quality Assurance on 03/09/2021. North Central Health Care was found to be in substantial compliance with the following applicable regulations for emergency preparedness: 42 CFR Subpart 483.73 - Emergency Preparedness For Long-Term Care (LTC) was MET North Central Healthcare is a two-story structure built in 1972, with Type II(000) construction. Healthcare additions were constructed in 1986 with Type I(322) construction. The entire facility was surveyed as a type II (000) building. The 1986 two-story skilled nursing addition contains a ventilator unit on north wings of the first floor. The building also has a behavioral health clinic and hospital attached to the health care occupancy, but was not surveyed, as it was separated with 2-hour rated construction. All portions of the facility were sprinkled. The facility has two (2) Level-1 emergency generators that provided power to the emergency loads. The facility contained 12 patient care wings and 16 smoke compartments. North Central Healthcare was licensed for 165 beds, with a census of 135 residents at the time of the survey. The facility was surveyed under the 42 CFR Subpart 483.73 for a Long term Care occupancy. No federal deficiencies of the Emergency Preparedness Code were cited.	E 000		
K 000	INITIAL COMMENTS A standard Recertification Survey for Life Safety	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525132	A. BUILDING **03** B. WING _____	**03/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CENTRAL HEALTH CARE	**1100 LAKE VIEW DR** **WAUSAU, WI 54403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Code compliance was conducted by the Wisconsin Division of Quality Assurance on 03/09/2021. North Central Health Care was found to be NOT in substantial compliance with the following applicable regulations for long term care facility participation in Medicare-Medicaid: 42 CFR Subpart 483.90 - Physical Environment was NOT MET 42 CFR Subpart 483.90(a) - Safety from Fire was NOT MET NFPA 101(2012 edition) - Life Safety Code was NOT MET North Central Healthcare is a two-story structure built in 1972, with Type II(000) construction. Healthcare additions were constructed in 1986 with Type I(322) construction. The entire facility was surveyed as a type II (000) building. The 1986 two-story skilled nursing addition contains a ventilator unit on north wings of the first floor. The building also has a behavioral health clinic and hospital attached to the health care occupancy, but was not surveyed, as it was separated with 2-hour rated construction. All portions of the facility were sprinkled. The facility has two (2) Level-1 emergency generators that provided power to the emergency loads. The facility contained 12 patient care wings and 16 smoke compartments. COVID-19 Note: Facility opted to utilize 1135 Blanket Waiver to forgo or delay some Life Safety inspections, testing, and maintenance (ITM) requirements, specifically allowed by the waiver. The waiver was utilized due to COVID-19 in order to limit the potential exposure of residents to outside vendors entering the building.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525132	A. BUILDING **03** B. WING _____	**03/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CENTRAL HEALTH CARE	**1100 LAKE VIEW DR** **WAUSAU, WI 54403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 North Central Healthcare is licensed for 165 beds, with a census of 135 residents at the time of the survey. The facility was surveyed under the 2012 Life Safety Code, Chapter 19 for an existing health care occupancy. Five (5) federal deficiencies of the Life Safety Code were cited.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not ensure that egress corridors are continuously maintained free of materials that obstruct egress as required per NFPA 101 (2012 edition) sections 19.2.1, 7.1.10.2.1, 19.2.3.4(4), & 19.2.3.5. The deficient practice could affect 24 of 135 residents, as well as an undetermined number of staff and visitors. Findings Include: 1. On 03/09/2021 at 9:55 am, observation revealed that access to the exit in the Southern Remembrance corridor was obstructed due to furniture placed in the corridor. There were three (3) recliners set around the Nurses Station, used by residents. A wooden bench, not fixed, had been placed against the corridor wall across from a recliner, decreasing the corridor width to	K 211		

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K 211	Continued From page 3 approximately 4-feet. 2. On 03/09/2021 at 10:05 am, observation revealed that access to the exit in the 2200-Wing corridor was obstructed due to furniture placed in the corridor. A wooden end-table, not fixed, had been placed against the corridor wall and smoke barrier door frame. 3. On 03/09/2021 at 11:52 am, observation in the Upper-D Unit revealed that two (2) non-mobile infection control tables, without wheels or casters, were located in the corridor across from the elevators. The 4'x4' folding tables had paper bags containing staff personal protective equipment (PPE) stored on the table tops. 4. On 03/09/2021 at 12:05 pm, observation revealed that access to the exit in Side-1 of the Upper-D Unit was obstructed due to a chair and end-table stored against the exit stairwell door. 5. On 03/09/2021 at 1:08 pm, observation revealed that access to the exit door at the bottom landing of the Employee Entrance Stairwell was obstructed due to the placement of a Rubbermaid container of sidewalk salt, an alcohol based hand rub stand, a temperature screening stand, and a infection control screening cart at the bottom landing. These deficient conditions were confirmed at the time of discovery by a concurrent interview with Staff A.	K 211		
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure	K 311		

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K 311	Continued From page 4 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of vertical openings and shafts with self-closing doors in accordance with NFPA 101 (2012 edition) Sections 19.3.1, 8.6, & 8.3.4. This deficient practice could affect 12 of 135 residents, as well as an undetermined number of staff and visitors. Findings include: 1. On 03/09/2021 at 12:06 pm, observation revealed that the second floor stairwell door, on Side-1 of the Upper-D Unit Stairwell, did not display a visible label displaying the listed fire-rating of the assembly. 2. On 03/09/2021 at 12:07 pm, observation revealed that the second floor stairwell door, on Side-1 of the Upper-D Unit Stairwell, did not fully close without assistance. These deficient conditions were confirmed at the time of discovery by a concurrent interview with Staff A.	K 311		
K 355 SS=E	Portable Fire Extinguishers	K 355		

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K 355	Continued From page 5 CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain portable fire extinguishers as required by NFPA 101 (2012 edition) Sections 19.3.5.12 and 9.7.4.1; NFPA 10 (2010 edition) Sections 6.1.3.1, 7.2.2. This deficient practice has the potential to affect an 12 of 135 residents, as well as an undetermined number of staff and visitors. Findings include: On 03/09/2021 at 12:03 pm, observation revealed that access to the portable fire extinguisher on Side-1 of the Upper-D Unit was obstructed by the storage of a chair and a salon-type hair dryer in front of the extinguisher cabinet. This deficient practice was confirmed at the time of discovery by a concurrent interview with Staff A.	K 355		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall	K 372		

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K 372	Continued From page 6 be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not maintain smoke barriers in accordance with the requirements of NFPA 101 (2012 edition), Sections 19.3.7, 19.3.7.1, 19.3.7.3, 8.5, 8.5.2 and 8.5.6. This deficient practice could affect 24 of 135 residents, as well as an undetermined number of staff and visitors. Findings include: 1. On 03/09/2021 at 9:51 am, observation at the smoke barrier leading into Southern Reflections revealed a 2-inch metal sleeve penetration, with data cables running through, that was not properly fire stopped. 2. On 03/09/2021 at 10:07 am, observation at the 2200-Wing smoke barrier revealed a 1-inch metal sleeve penetration, with data cables running through, that was not properly fire stopped. 3. On 03/09/2021 at 10:15 am, observation at the 2100-Wing smoke barrier, at the Sun Room, revealed a 1-inch metal sleeve penetration, with data cables running through, that was not properly fire stopped. 4. On 03/09/2021 at 10:47 am, observation at the	K 372		

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K 372	Continued From page 7 2300-Wing smoke barrier revealed a 2-inch metal sleeve penetration, with data cables running through, that was not properly fire stopped. These deficient conditions were confirmed at the time of discovery by a concurrent interview with Staff A.	K 372		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to properly maintain electrical	K 920		

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K 920	Continued From page 8 devices in accordance with NFPA 101 (2012 edition), Sections 19.5.1.1 and 9.1.2, and NFPA 70 (2011 edition) Sections 400.8, 590.2(B). This deficient practice could affect 12 of 135 residents, as well as an undetermined number of staff and visitors. Findings include: 1. On 03/09/2021 at 10:25 am, observation in the Southern Reflections Nurses Office 2123 revealed a flexible cord multi-outlet strip device powering a fan. 2. On 03/09/2021 at 11:25 am, observation in the Link Office 1728 revealed a flexible cord multi-outlet strip device powering a personal refrigerator. 3. On 03/09/2021 at 1:30 pm, observation in the Charting Room 1319 revealed a flexible cord multi-outlet strip device powering both a personal refrigerator and a fan. These deficient conditions were confirmed at the time of discovery by a concurrent interview with Staff A.	K 920		

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F 000	INITIAL COMMENTS This was a recertification survey conducted at North Central Health Care from 03/08/21 through 03/11/21. Federal citations issued: 2 The most serious citation was F812 cited at a scope/severity level of F (potential for more than minimal harm)/(widespread). Census: 135 Sample size: 32	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to assess, treat and develop a care plan for a non pressure related wound for 1 resident (R)(R42) out of 27 sampled residents. R42 developed a non pressure wound on the top of the right foot on 01/13/21. The facility did not assess this wound to determine the causative factors, conduct weekly assessments, and did not develop a care plan to treat this wound.	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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This is evidenced by:

According to the NPIAP (National Pressure Injury Advisory Panel) all pressure and non pressure wounds should be assessed at least weekly to include measurements of the wound, a description of the wound bed, a description of any exudate, pain associated with the wound and whether the wound is improving, unchanged, or worsening. In addition, the assessment should include causative factors and those factors be included on the treatment plan.

R42 was admitted to the facility for long term care on 09/23/19. R42 had the following, but not all inclusive, diagnoses: arthritis, diabetes, coronary artery disease, chronic kidney disease, and obesity.

R42 contracted Covid19 on 11/10/20 which caused R42 to decline in mobility and strength. R42 recovered from Covid19 and was referred to therapy for strengthening. R42 had returned to independent mobility with the use of a walker.

On 12/24/20, R42 was ambulating in the bathroom when her knees gave out and she fell onto both knees. R42 was diagnosed with bilateral tibia (lower leg bone) fractures at the knee union. R42 was evaluated by a physician and was placed on bedrest and to wear bilateral leg immobilizers. The immobilizers covered both legs from the mid thigh to a few inches above the ankles.

On 12/31/20, R42 was evaluated by an orthopedic physician who diagnosed a right hip fracture along with the bilateral tibia fractures.

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R42 was hospitalized from 12/31/20 and returned to the nursing facility on 01/02/2021 following the right hip surgery.

On 01/13/21, Registered Nurse (RN) J noted R42 developed two fluid filled blisters on the top of the right foot. There was no measurement of the blisters. The orthopedic physician was notified of these blisters on 01/14/21. There was no treatment ordered, there was no care plan developed, and there were no causative factors identified for these blisters.

On 01/19/21, RN I noted the blisters were soft, dry, and flat with a "small red scab like area." RN I did not thoroughly assess the wound as required by NPIAP.

There was no additional description or mention of R42's non pressure related wound on the top of the right ankle throughout the medical record including nurses notes, weekly skin assessments, or care plan. There were eight days when the nurses notes included reference to R42's "slight" edema of the right leg or ankle. The first date R42 was noted to have edema was on 01/03/21 and last date with R42's leg edema was on 02/09/21. The documentation did not describe the degree of edema in the standard descriptive terminology.

Surveyor reviewed R42's medical record, both electronic and physical, and was unable to locate any assessment of R42's top right foot wound. Surveyor was unable to locate any investigation into the cause of this wound, a care plan or treatment for this wound.

On 03/09/21 at 8:25 a.m., Surveyor observed

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R42's non pressure related wound on the top of the right foot with the help of Certified Nursing Assistant (CNA) H. The wound was open to air and was surrounded by dry scaly skin. The wound bed had a thin dark brown eschar layer that covered approximately 60% and the remaining 40% of the wound bed had a fragile pink surface. There was no drainage and there was no pain associated with this wound. The wound was approximately 3 cm (centimeters) by 2.5 cm. R42 had no lower leg edema and both heels were floated off the bed with soft pillows.

On 03/11/21 at 7:49 a.m., Surveyor interviewed RN G who identified self as the Nurse Manger for R42's unit. RN G confirmed R42 developed two blisters on the top of the right foot on 01/13/21. RN G stated the facility team discussed R42's blisters and determined the cause of the blisters were likely extensive lower leg edema and not the rubbing of the immobilizers. According to RN G, the immobilizers did not come in contact with the blisters, thus could not have been the cause. Surveyor stated the medical record did not include any evidence of lower leg edema and RN G confirmed there was little documentation of R42's blisters and edema.

On 03/11/21 at 8:24 a.m., Surveyor interviewed RN I who identified self as a Wound Care Certified nurse since 2012. RN I confirmed R42 developed two blisters on the top of right foot and she had ruled out the immobilizer braces as a causative factor. RN I stated she did not assess these blisters; however, she did assess R42's DTI (deep tissue injury) of the right heel weekly. RN I stated she assesses all vascular, pressure, and diabetic wounds weekly. RN I stated R42's wounds could have started due to edema which

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F 684	Continued From page 4 would classify the wound as vascular in nature. RN I stated she was instructed to assess all types of wounds at least weekly for size, drainage, pain, signs of infection, healing, and appropriate treatment. RN I stated R42's wound on the top of the ankle was still present and was covered by a thin layer of a "brown scab."	F 684		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility did not prepare and store foods in a safe and sanitary manner. This has the potential to affect all (135) residents. Example #1: The facility's practice of storing eggs, used for	F 812		

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F 812	Continued From page 5	F 812		

made to order, fried eggs, does not include dating the unused eggs with an expiration date. This practice has the potential to serve residents eggs that may be expired.

Example #2:
The facility does not cover equipment (i.e.: mixers, food processor, blender and can opener) after cleaning. Un-covered equipment in food preparation areas has the potential to be contaminated from food spillage or splash.

Example #3:
The facility's refrigerators and freezers used for storage of resident snacks on the units are not monitored to ensure safe storage of resident food items.

Example # 4:
Surveyor observed Dietary Aide (DA) F using a thermometer to take food temperatures without proper sanitation of the thermometer. The single-use alcohol pad was re-used for multiple food items. The alcohol was not allowed to air dry on the thermometer prior to inserting into foods. This practice has the potential to cross contaminate foods and introduce chemicals from the alcohol into the foods.

Findings Include:

Example #1:

On 3/08/21 at 10:05 a.m., during the initial tour of the kitchen, Surveyor noted 6 flats of 30 eggs each in refrigerator labeled as #1. The flats of eggs were not dated. Surveyor asked Cook D about the flats of eggs. Cook D explained the flats of eggs are removed from the original carton

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F 812	Continued From page 6	F 812		

and used for fried eggs twice a week. The unused eggs are returned to refrigerator #1 for future use. The flats are not dated or labeled. Surveyor asked how long this practice has been in place. Cook D and Dietary Manager (DM) C explained the facility began frying eggs in the kitchen when communal dining stopped with the pandemic a year ago. Cook D and DM C further explained the living units used to fry eggs on the units and return unused eggs to the original carton. Surveyor asked if the facility has a pulling process or system of labeling the eggs to ensure expired eggs are not used to fry resident eggs. DM C responded the current system does not ensure the cooks are not using expired eggs for resident fried eggs.

Surveyor requested the facility policy for storage of food items. Surveyor received the policy titled "Safe Food Handling and Sanitation" with a date issued of 8/05/2020, which notes the following: ~Preparation and storage of food items: label and date all foods.

On 3/08/21 at 2:18 p.m., Surveyor spoke with R104 on her satisfaction with her food at the facility. R104 is cognitively intact. R104 expressed she has been served rotten/spoiled eggs three times. On one occasion the eggs were hard boiled and on two occasions the eggs were hard fried. The eggs were discolored greenish-black and smelled like rotten eggs. R104 further expressed she has been on a farm all her life and knows rotten egg smell and taste. R104 indicated she could not eat the eggs and spit them out. R104 further indicated she did not get sick because she did not eat the eggs.

Example #2:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525132	A. BUILDING _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CENTRAL HEALTH CARE	1100 LAKE VIEW DR WAUSAU, WI 54403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 7	F 812		

On 3/08/2021 at 9:55 a.m., during the initial tour, Surveyor noted 3 large industrial sized mixers, a commercial sized food processor, a blender and a can opener. One of the large mixers was in use. The other equipment was not in use and was not covered. Surveyor spoke with Cook E who was preparing foods in the area of the large mixers. Surveyor asked Cook E if the mixers are covered when not in use. Cook E expressed she has worked at the facility 32 years. The mixers have never been covered while not in use. Surveyor spoke with DM C about covering large equipment when they are not being used. DM C indicated the equipment is not covered after washing. Equipment should be covered when not in use. This is to prevent anything from getting in them and to prevent cross contamination.

Surveyor noted the facility's policy for safe food handling and sanitation, as noted above states:
~Cross-contamination: means the transfer of harmful substances or disease-causing microorganisms to foods by hands, food contact surfaces, sponges, cloth towels, or utensils which are not cleaned ...
~Food Contamination: means the unintended presence of harmful substances, including, but not limited to microorganisms, chemicals, or physical objects in foods.

Example #3:
On 3/10/2021 at 10:45 a.m., Surveyor and DM C conducted a tour of the facility's unit refrigerators and freezers, where snack foods are stored for resident consumption. Surveyor and DM C viewed all 6 units' refrigerators/freezers. The freezers on all 6 units did not contain a thermometer for monitoring of temperatures to ensure the freezers maintained a safe storage

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F 812	Continued From page 8	F 812		

temperature. The freezers contained water bottles on the door, which were in a frozen state. Surveyor noted the freezer contained frozen items, such as individual sized ice creams intended for resident consumption. The refrigerators had thermometers present. The thermometers were checked and were noted to be in a temperature range that was acceptable for safe storage. The refrigerators contained various foods intended for resident consumption. Surveyor asked DM C about monitoring of the refrigerators and freezers. DM C explained the unit staff are to monitor the water bottles daily to ensure the bottles remain in a frozen state. Unit staff are to check the refrigerator temperatures and record the temperature on the log each day. Surveyor asked for the logs for the last month (February 2021) and current month to date (March 2021). DM C further expressed stockers check the refrigerators and freezers twice a week to discard foods items that are expired. Stating the current system of monitoring does not ensure proper temperatures are maintained to stay out of the danger zone to prevent bacterial growth.

On 3/10/2021, the Director of Nursing (DON) informed Surveyor the facility unit refrigerators and freezers had previously been on a system that would alert staff if the temperatures were out of range for safe storage of foods. The alarm system was discontinued approximately a year ago. When the system was discontinued the thermometers were placed in the refrigerators and the water bottles were placed in the freezers. Staff are to check both each day.

Surveyor reviewed the logs of the unit refrigerators and freezers and noted the following: February 2021: 4 of the 6 unit

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F 812	Continued From page 9	F 812		

refrigerators/freezers had no log. 2 of the units had logs in place but were not checked on 9 of 28 and 10 of 28 days.
The logs direct staff as follows: Temperatures will be recorded for refrigerators and freezers every day. There is no directive to instruct staff to check the water bottle to ensure the water is in a frozen state.

The facility policy for safe food handling and sanitation noted above states:
~Danger Zone: Means temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow the rapid growth of pathogenic microorganisms that can cause foodborne illnesses.
~Storage temperatures:
Freezer: +10 to -10 degrees Fahrenheit, frozen state
Refrigerator: 41 degrees Fahrenheit maintained at or below

Example: #4:

On 3/10/2021 at 11:24 a.m., Surveyor observed dietary staff readying items for lunch. Dietary Aide (DA) F was observed taking food temperatures of foods on the steam table. DA F wiped the thermometer with an alcohol pad and immediately inserted the thermometer into the sliced turkey. DA F wiped the thermometer with same alcohol pad and inserted into the rice. The thermometer was not allowed to air dry. DA F wiped the thermometer with a new wipe after she recorded temperatures. The thermometer was inserted into cranberry cream sauce. Again the thermometer was not allowed to air dry. The thermometer was wiped with the same alcohol pad and inserted in the gravy. DA F continued taking temperatures of

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F 812	Continued From page 10	F 812		

the foods. DA F did not allow the thermometer to air day after being wiped with the alcohol pad. DA F reused the alcohol pads multiple times. Surveyor asked DA F about the observation. DA F expressed she was trained to use the alcohol wipe up to three times before discarding. DA F also expressed she was not aware of wait time for alcohol to air dry before inserting the thermometer into foods.

On 3/10/2021 at 11:40 a.m., Surveyor asked DM C about the observation. DM C indicated the alcohol pads are single use. The pads should not be reused or used multiple times due to cross contamination of foods. Thermometers need to be air dried for 10 seconds after wiping with alcohol pads to prevent contamination of chemicals into foods.

Surveyor referenced the facility policy for safe food handling and sanitation as noted above. The policy states:
~Each pan of food produced is to have temperatures checked prior to serving. Thermometer is to be sanitized between each pan using an alcohol swab. The thermometer should be air dried before probe is inserted into foods.

DEPARTMENT OF HEALTH SERVICES
STATE OF WISCONSIN
Division of Quality Assurance
F-00344 (07/17)

PLAN OF CORRECTION

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License/Certification/ID Number (X1):	**525132**
Survey Date (X3):	**03/11/2021**
Survey Event ID Number:	**ZUMD11**

ID Prefix Tag (X4)	Provider's Plan of Correction (Each corrective action must be cross-referenced to the appropriate deficiency.)	Completion Date (X5)
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K211	**Means of Egress**	
	The following areas listed in the SOD (Southern Reflections corridor, 2200 wing corridor, Upper D unit across from elevator, Upper D side 1 exit and employee entrance stairwell) were all reviewed and are all free of materials that obstruct egress to full use.	**3/30/2021**
	All staff have been educated that the means of egress is continuously maintained free of all obstructions in case of emergency. (Attachment A)	**4/10/2021**
K311	**Vertical Openings - Enclosure**	
	A work order was placed on 3/9/2021 within the work order system to initiate corrective action to make sure the stairwell door on side 1 of Upper D closes without assistance. Work order completed with door closure tested. (Attachment B)	**3/30/2021**
	New door for side 1 of Upper D stairwell has been ordered. A scheduled remodel on Upper D is anticipated to begin on June 1, 2021. This remodel will include replacement of Upper D stairwell door with a door that meets fire rating code and will display a visible label with the fire-rating.	**4/01/2021**
	There are two stairwell doors, one on each side of the unit, that go from the second floor(unit) directly to the outside that are not fire rated. There are no other openings/doors in this stairwell. The doors at top and bottom of the stairs are locked and alarmed. The work that needs to be completed to comply is door and frame removal. The frame is concrete	

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	filled. Completing this work at this time would be very disruptive to the residents on the dementia unit. The residents of this unit will be relocating late August 2021 to the newly built nursing home tower. The current unit will be remodeled in September and we are requesting that we can complete this door and frame replacement at that time when the unit is not occupied. Staff have been made aware of the deficiency and the locations of all fire extinguishers and training on use of them.	
F355	**Portable Fire Extinguishers**	
	The fire extinguisher on Side 1 of Upper D is free of obstruction. The chair and salon type hair dryer has been moved.	**3/30/2021**
	All staff have been educated on keeping fire extinguishers free of storage and to maintain them as required by NFPA 101. (Attachment A)	**4/10/2021**
K372	**Subdivision of Building Spaces – Smoke Barrier Construction**	
	The following areas listed in the SOD (smoke barrier leading into Southern Reflections, 2200 wing smoke barrier, 2100 wing smoke barrier, 2300 wing smoke barrier) were fire caulked to close the metal sleeve penetration and to maintain smoke barriers according to life sections 19.3.7, 19.3.7.1, 19.3.7.3, 8.5, 8.5.2, 8.5.6. (Attachment C)	**3/31/2021**
	The Life Safety Management Plan Policy was reviewed, revised, and updated. See highlighted text for revisions. (Attachment D)	**4/21/2021**
	Facilities Management will complete annual audit on fire door preventative maintenance. (Attachment E)	
K920	**Electrical Equipment – Power Cords and Extension Cords**	
	Fans and personal refrigerators have been moved to a dedicated outlet and	**03/30/2021**

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	removed from the multi outlet strips listed in the SOD (Southern Reflections nurse office, link office 1728 and charting room 1319).	
	All staff have been educated on what can be plugged into a power strip and that extension cords are not used as a substitute for fixed wiring of a structure. (Attachment A)	**04/10/2021**

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ID Prefix Tag (X4)	Provider's Plan of Correction (Each corrective action must be cross-referenced to the appropriate deficiency.)	Completion Date (X5)
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F684	**Resident #42 was affected by Quality of Care. Resident developed a non-pressure wound on the top of the right foot on 1/13/21. The facility did not assess this wound to determine the causative factors, conduct weekly assessments, and did not develop a care plan to treat this wound.**	
	All residents have the potential to be affected.	
	The Skin Care Management Policy and Procedure was reviewed, revised, and updated. See highlighted text for revisions. (Attachment A)	**3/15/2021**
	Care plan for resident #42 has been updated to include non-pressure wound and will be reviewed and updated as needed. (Attachment B)	**3/12/2021**
	Nursing home leadership conducted chart reviews for 100% of the residents which indicated there were no new unidentified non pressure related injuries. (Attachment C)	**3/15/2021**
	All nursing staff will be required to complete a mandatory education regarding our Skin Management Policy and Procedure. (Attachment D)	**4/10/2021**
	Nurse leadership will validate understanding of Skin Management Policy and Procedure with a post education review. (Attachment E)	**4/10/2021**
	DON or designee will complete chart review to review any existing or new non pressure related skin issues and to ensure that notification of physician, weekly assessment with documentation of measurement and care plan has been completed, updated, and revised as needed. This audit	**5/19/2021**

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	will be completed 2x/week for the next 30 days beginning on 4/12/21. (Attachment F)	
	Results of audits will be evaluated by the facilities QAPI Committee. Ongoing frequency of audits shall be determined based on the result of the audits.	**5/24/2021**
F812	**Based on observations, interviews and record review, the facility did not prepare and store foods in a safe and sanitary manner. There are four examples of this.**	
	All residents have the potential to be affected.	
	Example #1: The facilities practice of storing eggs does not include dating the unused eggs with an expiration date.	
	• **Safe Food Handling and Sanitation Policy was reviewed, revised, and updated. See highlighted text for updates. (Attachment G)**	**3/08/2021**
	• **The Nutrition Services Manager completed education to all cooks on the correct practice of storing and dating eggs. (Attachment H)**	**3/08/2021**
	• **The Nutrition Services Manager completed education to all nutrition services staff on storing and dating eggs. (Attachment I)**	**3/16/2021**
	• **The Nutrition Services Manager or designee will audit this practice 2x/week for 30 days beginning on 4/12/21. (Attachment J)**	**5/19/2021**
	• **Results of audits will be evaluated by the facilities QAPI Committee. Ongoing frequency of audits shall be determined based on the result of the audits.**	**5/24/2021**
	Example #2: The facility does not cover equipment after cleaning.	
	• **Safe Food Handling and Sanitation Policy was reviewed, revised, and updated. See highlighted text for updates. (Attachment G)**	**3/08/2021**
	• **The Nutrition Services Manager completed education to all cooks on**	**3/08/2021**

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	the correct practice of covering equipment. (Attachment H)	
	• **The Nutrition Services Manager completed education to all nutrition services staff on covering equipment. (Attachment I)**	**3/16/2021**
	• **Covering of equipment was added to the end of the day checklist that the cooks complete daily.**	**3/16/2021**
	• **The Nutrition Services Manager or designee will audit this practice 2x/week for 30 days beginning on 4/12/21. (Attachment K)**	**5/19/2021**
	• **Results of audits will be evaluated by the facilities QAPI Committee. Ongoing frequency of audits shall be determined based on the result of the audits.**	**5/24/2021**
	Example #3: The facilities refrigerators and freezers used for storage of resident snacks are not monitored to ensure safe storage of food.	
	• **Temperatures of Food for Nursing Homes Procedure was reviewed, revised, and updated. (Attachment L)**	**3/10/2021**
	• **Water bottles were removed from all resident freezers and replaced with analog thermometers.**	**3/10/2021**
	• **New temperature logs were place on all refrigerators that store resident food with updated temperature range for the freezer.**	**3/10/2021**
	• **Nurses were educated to read and record refrigerator and freezer temperatures once daily. (Attachment D)**	**3/18/2021**
	• **Nursing home staff will ensure timely completion of resident storage temperature logs which will be scanned into the North Central Health Care Shared O:drive at the end of each month and kept for 5 years.**	**Ongoing**
	• **A member of the Interdisciplinary team will audit temperature logs 2x/week for 30 days beginning on 4/12/2021. (Attachment M)**	**5/19/2021**
	• **Results of audits will be evaluated by the facilities QAPI Committee. Ongoing frequency of audits shall be determined based on the result of the audits.**	**5/24/2021**
	Example #4: Employee (DA) F was observed using a thermometer to take food temperatures without proper sanitation of the thermometer and the single use alcohol pad was re-used for multiple food items.	

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	• **Taking Food and Liquid Temperatures Procedure was created. (Attachment N)**	**3/10/2021**
	• **Nutrition Services Manager completed mandatory education with 100% of nutrition services employees to validate understanding on how to properly take food temperatures and cleaning thermometers. (Attachment O)**	**3/23/2021**
	• **Nutrition Services Manager or designee will audit this practice 2x/week for 30 days beginning on 4/12/21. (Attachment P)**	**5/19/2021**
	• **Results of audits will be evaluated by the facilities QAPI committee. Ongoing frequency of audits shall be determined based on the result of the audits.**	**5/24/2021**
	New dietary employees will be educated on Safe Food Handling and Sanitation Policy and Taking Food and Liquid Temperature Procedure at new hire orientation.	**Ongoing**

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MEMORANDUM

DATE: April 2021
TO: North Central Community Services Program Board
FROM: Dr. Robert Gouthro, Chief Medical Officer
RE: CMO Report

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

1) **Residency & Education**:

- The Central Wisconsin Psychiatry Program Residency Graduation will occur on June 21st at the Leigh Yawkey Woodson Art Museum. COVID rules will limit our invite list, but if you have interest in attending this event, please let us know.

- The C.W. Psychiatry Program has been approved for continuing ACGME accreditation with the removal of all prior citations (areas for improvement often seen in new programs). This is the first time since the program's inception no citations have been present.

2) **Patient Care and Provider Quality (Behavioral Health)**:

- Outpatient group development continues with Cognitive Behavioral Therapy (CBT) for Depression selected as our next foundational group to become available. This is expected to be a popular choice for our community treatment/ chronically mentally ill population. As previously stated, increasing group options will allow for improved patient access and increased focused treatment interventions.

- The No-Show Policy implemented approximately 6 months ago has led to a decrease in the no-show rate of clients enrolled in our programs. More work is needed, and a new policy/procedure has been drafted to address initial intake no-shows of those not currently enrolled. It will include an educational activity and pre-enrollment requirements.

- The outpatient clinic has created a new APNP position to specifically improve the time it takes from inpatient discharge to first contact with an outpatient provider. In addition to improving patient care, we expect a secondary positive impact on dashboard metrics.

- NCHC has begun to work with law enforcement to improve our response to the commitment noncompliance, jail consultation, and filling the gaps which exist between the mental health and legal systems. First on the agenda is to improve interagency communication and improving the commitment and follow up process of our shared clients.

- Dr. Hoppe, a Green Bay resident that will be transitioning to an employed attending on the IP unit in July, is rotating with our Utilization Review Department in an effort to increase the communication between to the two areas, align the understanding of medical necessity, improve care, and insure admission insurance coverage. This Practice will continue with all new hired inpatient providers moving forward.

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MEMORANDUM

DATE: April 22, 2021
TO: North Central Community Services Program Board
FROM: Jaime Bracken, Chief Nursing Officer
RE: Monthly Nursing Services Report

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

Program Updates:

1. **Infection Prevention and Control**
   - The infection control team continues to provide support and education for all our care areas. They have done a great job with monitoring our PPE compliance as well as providing dedicated hands-on training across the organization. We have seen a dramatic increase in our infection control compliance as a result. In this stage of the pandemic, many staff are at risk of becoming complacent, so it is imperative that we continue to reinforce our safety measures.

2. **Education Program/ Learning and Development**
   - We have officially submitted our application to have our own Nursing Assistant Program. This process was a greater undertaking than anticipated however, we are hopeful that we will hear from DHS quickly and anticipate that we can start the classes within 90 days. Mount View Care Center has not been able to hire a CNA since September of 2020 so as you can imagine, this program will be vital for our future success. We have several staff hired this month as hospitality aids who will transition into the program which is exciting news for us!
   - Nurse Practice and the Learning Councils are full steam ahead with several initiatives that will positively impact our employee experience, engagement, and patient safety such as standardizing our clinical competencies, medication administration focused workgroups, and emergency response procedures.
   - The nursing education team continues to offer support to our clinical units as we maintain a state of readiness for state survey and Joint Commission visits across our programs. The team continues to conduct mock medical and behavioral emergency drills.

3. **Behavioral Health Services**
    - Cerner is the focus for the BHS team as we approach our go-live date. The team is working hard to ensure all nursing or direct care workflows are addressed and training documents are created to support the transition. Our leadership teams and super users are engaged in the work and feel we will be ready!
    - Joint Commission continues to be our major focus for our BHS areas as we are now past our survey window. We continue with our mock tracers and audits to focus on ahigh-risk areas such as use of restraints, seclusion, and ligature risks. The team has several action plans in place, and we will continue this process well beyond our survey to ensure long-term compliance.

4. **Long- Term Care**
    - Both nursing homes had unannounced complaint surveys this month and were unsubstantiated. This is great news for the teams especially when the demands of covid are still prevalent within our facilities. Teams are back to weekly testing based on the community positivity rate.
    - The Pine Crest facility is also in their survey window and are conducting tracers and audits as part of their preparation. We anticipate another good survey with them as well.

5. **Pharmacy**
    - The pharmacy team is focusing on the Cerner implementation to ensure our medication administration workflows will translate into the new electronic medical record. Medication administration is a very high-risk area, so it is important that we get this right. We will also implement bar code scanning which will aid in reducing medication administration errors as well.

6. **Clinical Excellence and Quality**
    - We are currently conducting a PDSA regarding our staff scheduling process. The goal is to standardize our process, create efficiencies, improve communication, and reduce unnecessary overtime.
    - We are in the roll out stage for our Falls Prevention Program in the 2nd quarter. A great deal of work has been put into this and the team has done a great job.
    - The leadership team continues to focus on other areas to continue to address adverse events such as medication errors, wounds, and facility acquired infections.
    - I am currently in the process of revamping our quality committees for the nursing homes. This will provide standardization and collaboration across both facilities and the ability to better track the work that is being done within the programs.

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MEMORANDUM

DATE: April 20, 2021
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. Cerner Millennium Behavioral Health Electronic Medical Record (EMR) Implementation Update:

Through its foundational EMR, Cerner's work with NCHC will help facilitate integrated care across its behavioral health services including psychiatric, emergency, rehabilitation, community treatment, and more.

The high-level timeline was drafted to assist leaders and staff with planning/preparation for the targeted Cerner Millennium Go Live in January 2021. Based on checkpoint evaluations between Cerner and NCHC at numerous key project stages, and as the COVID-19 pandemic landscape evolves, orders/guidelines at various local and national levels influenced the proposed timeline. Current Go Live date is scheduled for Q2 2021.

- **System Build and Validation**
  Data collection gathering has wrapped up for core areas and our Cerner consultants have begun to transition our conversations to system build and validation. NCHC and Cerner teams will collaborate to complete system configuration and testing/validation post training environment refresh.
    - ***Cerner Consultants (e.g., Clinical, Core, Patient Accounting/Finance, and Registration/ Scheduling) are building out our training environment and regularly seek clarification/ feedback from our IMS team to confirm understanding during this iterative process.***
    - ***Consultants added for Transaction Services, Health Information Management, and Pharmacy (PharmNet).***
    - ***A Project "Issue" Tracking process implemented for Cerner and NCHC to monitor progress towards resolving break/fix scenarios, identifying solutions for workflows, and/or answering feature/functionality questions recorded during the Future State Workflow event and follow-up testing.***
    - ***An internal Super User "Kick Off" meeting held, in advance of the Future State Workflow Review event, to review the importance of the Super User role in the implementation and set the stage for expectations/involvement moving forward.***

- **Super User Training**
  IMS, Super Users, and department leaders will walk through all registration, scheduling, patient accounting, pharmacy, and other workflows in the system. Super Users receive training on the solution's best practice workflows, as seen in the Future State Workflow Review event, to prepare them to lead End User training.
    - ***Super Users and their respective Directors completed Super User Participation Agreements to highlight the knowledge, skills, abilities, and traits needed to be a successful Super User.***
    - ***We successfully continue to leverage the temporary location, within Lake View Heights, for Cerner Millennium training delivery, testing, and other project-related events.***
    - ***A Cerner Consultant was onsite March 23 through March 24 to deliver Pharmacy Workflows Super User Training sessions.***
    - ***Dialog continues with Directors/Leaders to help make the transition from understanding how to perform workflow tasks, to identifying the who, what, where, when, and why gaps within workflows.***

- **Integration Testing & Data Migration**
  Teams will test and confirm data flows between integrated system as expected and successfully migrate applicable data from legacy system (TIER) to Cerner Millennium.
    - ***Migration of Payor (insurance) information, from the legacy system into Cerner, has been added as a new deliverable and the team worked through those details.***
    - ***Allergy and Medication information, in the legacy system, has been cleaned-up in preparation for the final data migration.***
    - ***Demographic, Encounter, Allergy, Payor, and Medication data migrated into the Cerner Training Domain, for a much larger group of patients from the legacy system, has been completed and the IMS team continues to validate.***
    - ***Expansion of data migration to include the entire file, with all data elements, is on the horizon – file build/import timings and spot checking of random patient/client migrated data to be conducted as we move forward.***
    - ***Cerner Consultants lead IMS team through first round of Test Scripts on March 25 and March 26 to test/validate end-to-end workflows.***
    - ***Gaps identified during the first round of Test Script testing required scheduling of a second round of end-to-end workflow validation April 5 through April 9.***
    - ***Cerner Consultant for Core System and CICBH (Billing) are scheduled to be onsite April 20 through April 22 to work towards resolving unresolved issues identified during first and second rounds of Test Script testing/validation.***
    - ***Cerner Pharmacy Consultants scheduled to be onsite for "Scan Fest" April 27 and April 28 in prepare for transition to Cerner's PharmNet solution.***

- **End User Training**
  Cerner collaborates with NCHC on the development of End User training plans. Super Users deliver End User training to staff to prepare them for using Cerner Millennium. End Users are required to receive training prior to using the system.
    - ***Initial planning has begun to design/develop a brief Cerner End User training course.***
    - ***Work is underway to identify critical tip sheets for End Users to leverage on day one of go live.***

- **Conversion Prep & User Training**
  Information Management Systems (IMS) receives User Management training to support and manage user accounts. Cerner will provide the IMS team the knowledge/tools to perform system maintenance tasks and prepare the production environment, staff, and devices for Go Live. Overall readiness assessment for Go Live event conducted.
    - ***User Management Training, for IMS Team members, is targeted to occur the week of May 3.***

- **Go Live**
  Teams will begin using Cerner Millennium to register and schedule patients who need to receive care on or after the Go Live date and ensure all needed information is available in the new system. Once fully prepared for Go Live, all staff will begin registering, scheduling, charting, and completing all day-to-day tasks in Millennium.

- **Post Launch Health Checks**
  At 30, 60, and 90 days post Go Live, Cerner and the NCHC team will evaluate/document End User and organizational satisfaction, gather opportunities for improvement based on feedback/usage metrics, and as needed, establish short and long-term action plans.

2. Information Management System (IMS) Update:

The team continues to be focused on the Cerner project. The team is working diligently with Cerner and our internal super users to complete the remaining items for a Q2 go live date. The team also celebrated a retirement this week as the IMS team lead retired after 34 years of service at NCHC.

3. Health Information Management (HIM) Update:

This week is Health Information Professionals week. We are recognizing our HIM team for all the hard work they have been doing. The team has also been busy transitioning responsibilities due to our HIM Team Lead resignation with her relocating with her family to Minnesota.

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MEMORANDUM

DATE: April 22nd, 2021
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 NCHC Operations since our last meeting:

1. **Campus Renovations & Improvements:** Warmer weather is upon us and with it brings progress on our construction projects. The nursing tower remains on target for a late Summer completion which will provide 96 skilled nursing beds to our campus. Our behavioral health services remodel moved into the final phase of planning with final designs set to be approved in April. Once these plans are approved construction is anticipated to begin in mid-June. This renovation includes our inpatient hospital, crisis services, and medically monitored treatment unit. Simultaneous planning is also occurring with our current Mount View Care Center facility which will incorporate multiple direct care and support programs. Planning will continue throughout Summer with construction anticipated for Fall 2021.

2. **Skilled Nursing Operations:** Demand for nursing home care is anticipated to continue to recover from the Covid-19 pandemic throughout 2021 with March making some progress. We anticipate our annual survey for Pine Crest to occur in early Summer. Our largest challenge is staffing with a competitive environment and low supply of qualified candidates it has made growing census extremely difficult.

3. **Youth Hospital:** Census improved for March with multiple days above target. Operations continue to improve as more time is spent learning workflows and experience is gained working with youths in our community. A space was identified for our Youth Crisis Stabilization Facility which we anticipate opening in May. This facility will have 8 beds for stabilization and will be staffed around the clock to ensure a safe environment.

4. **Community Living:** Census recovery occurred in March with warmer weather bringing no closure days and vaccinations encouraging membership to return. We believe this trend will continue throughout April and May pending no further increases to Covid-19 cases in our communities. All our live-in programs remain full, and demand is still high for these programs as we see the community benefit from them each day. Our ADS & prevocational services are seeing membership return and community work resume in all three counties.

5. **Covid-19 Screening & Support:** Covid-19 cases were low in March but have increased post spring break with a few days experiencing 10 or more staff out. Community positivity levels fell below 5% in March which allowed for visitation to open but quickly rose back up in April pausing this. We continue to be vigilant in education and PPE offerings while also providing opportunities for vaccinations for our staff and those we serve.

6. **Workforce Status Update:** 2021 continues to be a challenging year with recruitment being about half of 2020. This can be directly correlated to Covid-19 pandemic with a shift of workforce out of healthcare as well as increased unemployment benefits allowing people to stay home longer. The second factor is wages as the market has shifted drastically over the last year as the demand for healthcare services rose nationwide putting a premium on all licensed staff. Staff traveled throughout the nation to provide services with hospitals paying as much as $200 per hour for a respiratory therapist compared to a rate of $30 per hour prior to the pandemic. While it is anticipated this inflation will slow down a higher cost of wages will remain.

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MEMORANDUM

DATE: April 23, 2021
TO: North Central Community Services Program Board
FROM: Michael Loy, Chief Executive Officer
RE: CEO Report – April 2021

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

COVID-19 Response

We have been experiencing a small uptick in COVID activity in the last couple of weeks. As of April 22nd, we have 8 staff out with symptoms or exposures related to COVID-19. There are currently 2 positive cases, 3 tests pending, and the other 2 are exposure cases. The other case was someone who received a negative test for symptoms and is returning. We currently have no employees out with vaccine reactions. We are following CDC guidelines where individuals do not have to quarantine in situations where they have been vaccinated and subsequently exposed to an individual with a known COVID case. There are employees out on leave who did not vaccinate who are still required to quarantine.

Unfortunately, with two positive employee cases occurring in Mount View Care Center we now have Northern Reflections (long-term care), South Shore (post-acute care), and the Vent Unit on enhanced precautions. There is one long-term care resident who has tested positive. With positivity rates increasing and the cases above, we have had to restrict visitation and return to weekly testing. The earliest these units can come off enhanced precautions is April 30th.

We have also been dealing with a recent outbreak in our Community Living programs in our Supported Apartment settings where a few clients and staff have contracted COVID. These units are on enhanced precautions as well, with clients being quarantined in their apartments. Outbreaks have been small in scale and the symptoms mild, especially in individuals who have been vaccinated. This outbreak will have expense implications and some tangential revenue impacts into our Day and Prevocational programs.

Annual Audit

The presentation of the annual audit will be delayed another month to the May Board meeting. With the turnover of the entire Accounting Department within the last year, it has been tremendously time consuming to sort through the work papers from previous years. This is a decision made in conjunction with our CFO and WIPFLI, our audit partner. I have been receiving regular updates and there are no major concerns, it is only taking time to replicate previous audit work to ensure consistent presentation of the financials. The other mitigating factor that will delay the actual final audit completion until later in the year is the information needed from

the federal government relative to COVID payments is needed and the reporting portals remain closed at this time.

Campus Renovations

The Campus Renovations continue to move forward on schedule. The bid package for the "D" wing renovations, the location of the remodel for the adult psychiatric inpatient hospital, detox, crisis and emergency services, and residential treatment programs is set to go out in early May. Work on this phase (Phase 3), is set to commence in June. In June, once we have direction from the Marathon County Board on the final size of Mount View Care Center, we will update and finalize design plans for Phase 4. When design work has been completed on this phase, estimators will provide updated projections on construction costs prior to bidding. We continue to believe that we will need to gain the County Board's support for additional bonding authority prior to letting the bids necessary to complete the project. Initial presentations on these needs and the factors driving the situation were recently presented to the Marathon County Health & Human Services and Human Resources, Finance & Property Committees. Chairs of both Committees also recently toured the campus renovations complete thus far.

Temporary Program Modifications

We are considering the feasibility of splitting our new 16-bed Crisis Stabilization Facility into an adult and youth unit to provide a better temporary solution for Emergency and Crisis Services during Phase 3 of the renovations. This could end up being a longer-term option that would alleviate a need for an additional phase in our campus renovations for the Youth Crisis Stabilization Facility. An update on the final plans will be provide at the Board meeting.

Sober Living Project

The new facility is open and has its first tenants. We are presenting an Update to the Langlade County Board at their April meeting and planning a grand opening celebration event in May.

Lincoln Industries

An update on the changes that are needed for the Lincoln Industries operations is being presented to the Lincoln County Board on Tuesday April 20, 2021. An update will be provided at the Board meeting.

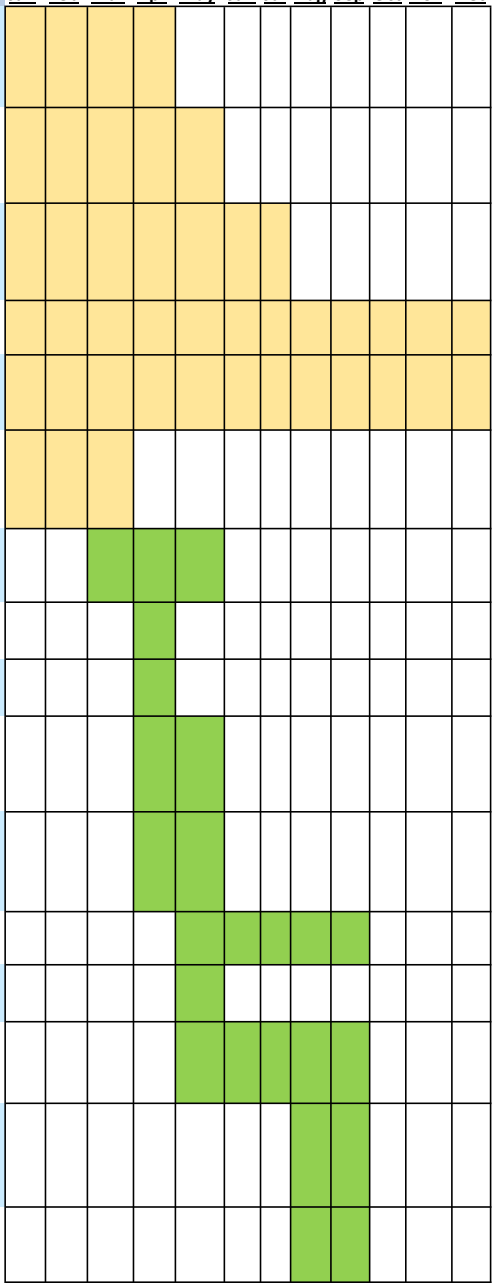
Portage County Health Care Center (PCHCC)

The assessment has been completed. Based on the current operating situation at PCHCC, deteriorating market conditions, facility conditions and needs, and margin risks, NCHC has sent Portage County notification that we will not be pursuing any partnership arrangement at this time.

Adult Protective Services Manager Retiring

Brenda Christian has announced that she will be retiring on May 21, 2021. Brenda has been an employee of North Central Health Care for over 34 years. Brenda has led the Adult Protective Services Department for many years and her contributions to Elder Abuse Awareness have been significant. We will be commencing a search for a new APS Manager immediately and have plans to appoint an interim manager for the program.

Objective	Accountability	Start Date	Measure(s) of Success	Interim Updates	Status
Establish Facility Use Agreements	Board	Jan-20	Signed Facility Use and/or Lease Agreements with each of the three counties	Legacy agreements remain in place. A final draft of the Lease Agreement is being reviewed and will be completed prior to the May NCCSP Board meeting.	Open
Prepare Local Plan	Board	Jan-20	Adopt a 3 Year Local Plan at the Annual Board Retreat	The Human Services Research Institute is completing a draft of the final report to present to the Board in May but will not proceed with the implementation and community engagement portion of the engagement.	Open
Facilitated Discussion on Diversity and Inclusion	Board	Jul-20	Adopted Diversity, Equity, and Inclusion Plan	An internal employee directed committee is being formed to develop recommendations and a plan to the Board in 2021. We continue to focus on improving the quality of the Dashboard data capture for the DEI monitoring outcomes.	Open
Annual Review of Board Policies	Board	Jan-21	Board reviews and approves all Board Policies by December 31	Ongoing, policies are distributed across the 2021 calendar.	Open
Approve Training Plan for Counties	Board	Jan-21	Conduct quarterly stakeholder meetings with each of the three county partners	Pending.	Open
CEO Appraisal	Executive Committee	Jan-21	Executive Committee reviews appraisal with CEO	The 2020 CEO evaluation process has not been initiated.	Open
Annual Report	Board	Mar-21	Annual Report released and presentations made to County Boards	Initial report production has begun.	
Accept the Annual Audit	Board	Apr-21	Acceptance of the annual audit by the NCCSP Board in April	The audit process continues but the presentation is now delayed until the May Board meeting.	Open
County Fund Balance Reconciliation	Board	Apr-21	Fund balance presentation and Adoption by NCCSP Board	Delayed due to the status of the audit above.	Open
Determine Budget Guidelines and Priorities	Executive Committee	Apr-21	Budget guidelines and priorities of the member Counties are communicated to the Board by June 1st		
Nomination and Election of Board Officers	Board	Apr-21	The Governance Committee will send a slate of Officers to the Board to be elected at the Annual Meeting in May		
Recommend Annual Budget to Counties	Board	May-21	Budget recommendation to the Counties by October 1st		
Annual Review of Board End Statements	Board	May-21	Adoption of End Statements with any modifications by June 1st		
Selection of Independent Certified Public Accounting Firm	Executive Committee	May-21	Engagement Letter approved by Executive Committee by October 1st		
Evaluate NCCSP Board Effectiveness	Board	Aug-21	Conduct annual review of the effectiveness of Board's Policy Governance Model and provide recommendations to the Board		
Review and Approve Policy Governance Manual	Board	Aug-21	Approve Policy Governance manual at the September Board meeting		



Objective	Accountability	Start Date	Measure(s) of Success	Interim Updates	Status	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Review and Approve Board Development and Recruitment Plan	Governance Committee	Aug-21	Board Development and Recruitment Plan reviewed and approved by the NCCSP Board														
Review and Approve Performance Standards	Executive Committee	Sep-21	Adopt Annual Performance Standards														
Approve Annual Quality and Safety Plan	Board	Oct-21	Approve plan in December														
Review CEO Succession Plan	Board	Oct-21	Review and update CEO succession plan														
Review and Approve CEO Compensation Plan	Executive Committee	Nov-21	Approve CEO Compensation Plan for the upcoming year by December														
Approve Utilization Review Plan	Board	Nov-21	Approve plan in December														
Board Development Plan and Calendar	Governance Committee	Nov-21	Approve Board Development Plan and Calendar for the upcoming year at the December meeting														

DEPARTMENT: NORTH CENTRAL HEALTH CARE								FISCAL YEAR: 2021									
PRIMARY OUTCOME GOAL	↕	TARGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	2021 YTD	2020
PEOPLE																	
Vacancy Rate	↘	7-9%	6.1%	6.1%	8.6%										6.9%	7.8%
Turnover Rate	↘	20-23% (1.7%-1.95%)	2.8%	2.4%	3.3%										34.4%	N/A
Organization Diversity Composite Index	↗	Monitoring	0.69	0.66	0.67										0.67	N/A
SERVICE																	
Patient Experience (Net Promoter Score)	↗	55-61	52.2	73.8	65.6										66.4	61.0
QUALITY																	
Hospital Readmission Rate	↘	10-12%	10.8%	14.3%	14.4%										13.2%	11.8%
Nursing Home Readmission Rate	↘	10-12%	10.5%	17.8%	12.8%										13.9%	13.5%
Nursing Home Star Rating	↗	★★★★	★★★	★★★	★★★										★★★	★★★
Zero Harm - Patients	↘	Monitoring	0.84	1.06	0.84										0.91	0.74
Zero Harm - Employees	↘	Monitoring	2.26	2.97	4.46										3.13	2.84
COMMUNITY																	
Out of County Placements	↘	230-250	236	140	169										182	269
Client Diversity Composite Index	↗	Monitoring	0.31	0.46	0.47										0.39	N/A
FINANCE																	
Direct Expense/Gross Patient Revenue	↘	64-67%	76.8%	70.2%	70.0%										72.2%	72.4%
Indirect Expense/Direct Expense	↘	44-47%	41.3%	34.7%	38.6%										38.5%	39.0%
Net Income	↗	2-3%	-15.7%	0.1%	-6.9%										-6.9%	0.4%

↗ Higher rates are positive
↘ Lower rates are positive

DASHBOARD MEASUREMENT OUTCOME DEFINITIONS AND DETAILS

PEOPLE	
Vacancy Rate	Monthly calculation: total number of vacant FTE at month end divided by the total authorized FTE as of month end. YTD calculation: Average of each monthly vacancy rate.
Turnover Rate	The monthly rate is determined by the number of separations divided by the average number of employees multiplied by 100. The YTD is the sum of monthly percentages.
Diversity Composite Index	Monthly calculation: A weighted composite of the diversity of NCHC's workforce, management and Board, relative to the demographics of Marathon C YTD calculation: Weighted average of each month's Diversity Composite Index rate.
SERVICE	
Patient Experience (Net Promoter Score)	Monthly calculation: A weighted average of Net Promoter Score. YTD calculation: Weighted average of each month's Net Promoter Score.
QUALITY	
Hospital Readmission Rate	Percent of patients who are readmitted within 30 days of discharge from the Inpatient Behavioral Health hospital for Mental Health primary diagnos *Benchmark: American Health Care Association/National Center for Assistive Living (AHCA/NCAL) Quality Initiative*
Nursing Home Readmission Rate	Number of residents re-hospitalized within 30 days of admission to nursing home / total admissions. *Benchmark: American Health Care Association/Centers for Medicare & Medicaid Services (AHCA/CMS)*
Nursing Home Star Rating	Star rating as determined by CMS Standards for both Pine Crest and MVCC.
Zero Harm Patients	Patient Adverse Event Rate: # of actual harm events that reached patients/number of patient days x1000
Zero Harm Employee	Monthly calculation: # of OSHA reportables in the month x 200,000/payroll hours paid within the month. YTD calculation: # of OSHA reportables YTD x 200,000/payroll hours paid YTD.
COMMUNITY	
Out of County Placement	Number of involuntary days that patients spend in out of county placements who have discharged in month of report.
Diversity, Equity, and Inclusion Access Equity Gap	Identify number of consumers served and index their demographics against the demographics of service area. An access equity gap will be established ba the variability in matching the community to our service population.
FINANCE	
Direct Expense/Gross Patient Revenue	Percentage of total direct expense compared to gross revenue.
Indirect Expense/Direct Revenue	Percentage of total indirect expenses compared to direct expenses.
Net Income	Net earnings after all expenses have been deducted from revenue.

2021 - Primary Dashboard Measure List

↗ Higher rates are positive

↘ Lower rates are positive

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD	2020
North Central Health Care	People	Vacancy Rate	↘	7-9%	8.6%	6.9%	7.8%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	3.3%	34.4%	N/A
		Organization Diversity Composite Index	↗	Monitoring	0.67	0.67	N/A
	Service	Patient Experience (Net Promoter Score)	↗	55-61	65.6	66.4	61.0
	Quality	Hospital Readmission Rate	↘	10-12%	14.4%	13.2%	11.8%
		Nursing Home Readmission Rate	↘	10-12%	12.8%	13.9%	13.5%
		Nursing Home Star Rating	↗	★★★★	★★★	★★★	★★★
		Zero Harm - Patients	↘	Monitoring	0.84	0.91	0.74
		Zero Harm - Employees	↘	Monitoring	4.46	3.13	2.84
	Community	Out of County Placements	↘	230-250	169	182	269
		Client Diversity Composite Index	↗	Monitoring	0.47	0.39	/
	Finance	Direct Expense/Gross Patient Revenue	↘	64-67%	70.0%	72.2%	72.4%
		Indirect Expense/Direct Expense	↘	44-47%	38.6%	38.5%	39.0%
		Net Income	↗	2-3%	-6.9%	-6.9%	0.4%

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Adult Community Treatment	People	Vacancy Rate	↘	7-9%	2.3%	4.3%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	2.2%	8.8%
	Service	Patient Experience (Net Promoter Score)	↗	55-61	100.0*	58.8
	Quality	Zero Harm - Patients	↘	Monitoring	0.26	0.18
		% of Treatment Plans Completed within Required Timelines	↗	96-98%	91.8% (78/85)	95.4%
		Employment rate of Individual Placement and Support (IPS) Clients	↗	46-50%	56.2% (41/73)	48.4%
	Community	% of Eligible CCS and CSP Clients Admitted within 60 Days of Referral	↗	60-70%	33.3% (5/15)	38.1%
		Average Days from Referral to Initial Appointment	↘	55-60 days	72.6 days (1016/14)	73.1 days
		Hospitalization Rate of Active Patients	↘	Monitoring	2.58%	3.03%
	Finance	Direct Expense/Gross Patient Revenue	↘	86.7-90.2%	72.3%	72.1%
		Net Income	↗	$10,457-$15,686 Per Month	$94,920	$110,322

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Adult Crisis Stabilization CBRF	People	Vacancy Rate	↘	5-7%	0.0%	0.0%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	11.4%	66.4%
	Service	Patient Experience (Net Promoter Score)	↗	42-47	42.9*	54.5
	Quality	Zero Harm - Patients	↘	Monitoring	8.23	5.20
		% of Patients who kept their Follow-up Appointment	↗	90-95%	77.8% (7/9)	87.5%
		% of Patients Admitted within 24 hours of Referral	↗	90-95%	100% (31/31)	100.00%
	Finance	Direct Expense/Gross Patient Revenue	↘	30.9-32.2%	59.1%	58.0%
		Net Income	↗	$1,747-$2,620 Per Month	($12,640)	($14,318)

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Adult Inpatient Psychiatric Hospital	People	Vacancy Rate	↘	7-9%	4.5%	6.3%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	2.6%	51.2%
	Service	Patient Experience (Net Promoter Score)	↗	42-47	64.5	56.0
	Quality	Zero Harm - Patients	↘	Monitoring	0.00	3.00
		Hospital Readmission Rate	↘	10-12%	9.9%	11.7%
		Average Days for Initial Counseling Appointment Post-Hospital Discharge	↘	8-10 days	37.7 days	25.4 days
		Average Days for Initial Psychiatry Appointment Post-Hospital Discharge	↘	8-10 days	15.5 days	16.1 days
		Average Days since previous Detox Admission	↗	330-360 days	482.2 days	357.3 days
	Community	Out of County Placements	↘	150-170	152	146
	Finance	Direct Expense/Gross Patient Revenue	↘	78.2-81.4%	79.5%	86.9%
		Net Income	↗	$13,382-$20,073 Per Month	($237,225)	($159,624)

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Aquatic	People	Vacancy Rate	↘	5-7%	8.3%	2.9%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	0.0%	36.4%
	Service	Patient Experience (Net Promoter Score)	↗	83-87	90.0*	85.2
	Quality	Zero Harm - Patients	↘	Monitoring	0.00	14.49
	Finance	Direct Expense/Gross Patient Revenue	↘	43.8-45.6%	64.7%	67.6%
		Net Income	↗	$2,174-$3,261 Per Month	($63,826)	($14,714)

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Clubhouse	People	Vacancy Rate	↘	5-7%	0.0%	0.0%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	0.0%	0.0%
	Service	Patient Experience (Net Promoter Score)	↗	55-61	85.7*	86.2
	Quality	Average Work Order Day Attendance	↗	20-25	19	18
		% of Members Working 15 or More Hours Per Month	↗	80-85%	96.0%	92.7%
	Community	Active Members Per Month	↗	110-120	106	103
	Finance	Direct Expense/Gross Patient Revenue	↘	58.6-61.0%	77.6%	75.4%
		Net Income	↗	$536-$804 Per Month	($5,097)	($3,544)

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Crisis and Emergency Services	People	Vacancy Rate	↘	7-9%	10.7%	5.7%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	3.7%	14.8%
	Service	Patient Experience (Net Promoter Score)	↗	42-47	0.0*	25.0
	Quality	Zero Harm - Patients	↘	Monitoring	5.80	12.66
		% of Crisis Asessments with Documented Linkage and Follow-up within 24 hours	↗	70-75%	63.2%	59.2%
		Avoid Hosptializations (NCHC and Diversions) with a length of stay of less than 72 hours	↘	5-10%	0.0%	0.0%
	Community	Out of County Placements Days	↘	230-250	169	182
		Court Liasion: % of Eligible Individuals with Commitment and Settlement Agreements who are Enrolled in CCS or CSP witihn 60 days	↗	80-85%	100.0% (1/1)	66.7%
	Finance	Direct Expense/Gross Patient Revenue	↘	167.6-174.4%	238.8%	300.8%
		Net Income	↗	$5,370-$8,055 Per Month	($11,451)	($15,407)

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Day Services	People	Vacancy Rate	↘	7-9%	0.0%	0.0%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	7.3%	29.2%
	Service	Patient Experience (Net Promoter Score)	↗	55-61	100.0*	96.6
	Quality	Zero Harm - Patients	↘	Monitoring	1.02	0.74
	Finance	Direct Expense/Gross Patient Revenue	↘	89.3-92.9%	139.6%	121.8%
		Net Income	↗	$5,103-$7,654 Per Month	($92,596)	($71,578)

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Group Homes	People	Vacancy Rate	↘	7-9%	3.3%	2.2%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	6.7%	26.8%
	Service	Patient Experience (Net Promoter Score)	↗	55-61	40.0*	57.1
	Quality	Zero Harm - Patients	↘	Monitoring	2.22	2.27
	Finance	Direct Expense/Gross Patient Revenue	↘	66.3-69.0%	75.1%	76.1%
		Net Income	↗	$2,939-$4,408 Per Month	$28,757	$21,246

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Mount View Care Center	People	Vacancy Rate	↘	7-9%	15.9%	13.3%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	2.4%	44.8%
	Service	Patient Experience (Net Promoter Score)	↗	55-61	57.1*	64.7
	Quality	Nursing Home Readmission Rate	↘	10-12%	4.8%	7.4%
		Zero Harm - Residents	↘	Monitoring	1.69	2.52
		Nursing Home Quality Star Rating	↗	★★★★	★★★	★★★
	Community	Referral Conversion Rate	↗	N/A	N/A	N/A
	Finance	Direct Expense/Gross Patient Revenue	↘	55.5-57.7%	61.6%	64.5%
		Net Income	↗	$30,636-$45,954 Per Month	($55,803)	($121,103)

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Outpatient Services	People	Vacancy Rate	↘	7-9%	5.1%	6.3%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	0.0%	0.0%
	Service	Patient Experience (Net Promoter Score)	↗	55-61	27.3*	38.1
	Quality	Zero Harm - Patients	↘	Monitoring	0.80	1.17
		Average Days for Initial Counseling Appointment Post-Hospital Discharge	↘	8-10 days	33.1 days	23.2 days
		Average Days for Initial Psychiatry Appointment Post-Hospital Discharge	↘	8-10 days	15.1 days	15.3 days
		Day Treatment Program Completion Rate	↗	40-50%	N/A	N/A
		OWI - 5 Year Recividism Rate	↘	13-15%	15.0%	11.1%
	Community	Same Day Cancellation and No-Show Rate	↘	15-18%	17.0%	16.1%
		% of Patients Offered an Appointment within 4 Days of Screening by a Referral Coordinator	↗	20-25%	18.7%	14.2%
		Post-Jail Release Access Rate (Within 4 Days of Release)	↗	20-25%	21.7%	13.4%
		Average Number of Days from Referral to Start of Day Treatment	↘	16-20 days	N/A	N/A
		Hospitalization Rate of Active Patients	↘	Monitoring	0.88%	0.97%
	Finance	Direct Expense/Gross Patient Revenue	↘	93.4-97.2%	114.0%	130.0%
		Net Income	↗	$12,534-$18,802 Per Month	($22,745)	($19,495)

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Pine Crest Nursing Home	People	Vacancy Rate	↘	7-9%	15.4%	13.8%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	4.0%	61.2%
	Service	Patient Experience (Net Promoter Score)	↗	55-61	28.6*	39.1
	Quality	Zero Harm - Residents	↘	Monitoring	4.79	4.92
		Nursing Home Readmission Rate	↘	10-12%	21.1%	22.0%
		Nursing Home Quality Star Rating	↗	★★★★	★★★	★★★
	Community	Referral Conversion Rate	↗	N/A	N/A	N/A
	Finance	Direct Expense/Gross Patient Revenue	↘	57.0-59.3%	60.9%	64.3%
		Net Income	↗	$20,559-$30,839 Per Month	($132,350)	($172,112)

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Riverview Terrace (RCAC)	People	Vacancy Rate	↘	7-9%	0.0%	0.0%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	11.8%	47.2%
	Service	Patient Experience (Net Promoter Score)	↗	55-61	/	/
	Quality	Zero Harm - Patients	↘	Monitoring	0.00	0.66
	Finance	Direct Expense/Gross Patient Revenue	↘	N/A	0.0%	0.0%
		Net Income	↗	$582-$873 Per Month	$6,851	$6,503

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Supported Apartments	People	Vacancy Rate	↘	7-9%	7.5%	7.3%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	0.0%	20.4%
	Service	Patient Experience (Net Promoter Score)	↗	55-61	50.0*	80.0
	Quality	Zero Harm - Patients	↘	Monitoring	0.85	0.91
	Finance	Direct Expense/Gross Patient Revenue	↘	38.5-41.0%	42.3%	43.7%
		Net Income	↗	$3,364-$5,046 Per Month	($16,105)	($47,479)

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Youth Community Treatment	People	Vacancy Rate	↘	7-9%	0.0%	1.8%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	2.7%	27.2%
	Service	Patient Experience (Net Promoter Score)	↗	55-61	100.0*	85.7*
	Quality	Zero Harm - Patients	↘	Monitoring	0.08	0.09
		% of Treatment Plans Completed within Required Timelines	↗	96-98%	95.2% (60/63)	95.8%
	Community	% of Eligible CCS and CSP Clients Admitted within 60 Days of Referral	↗	60-70%	26.7% (4/15)	42.5%
		Average Days from Referral to Initial Appointment	↘	55-60 days	106.5 days (1171/11)	84.1 days
		Hospitalization Rate of Active Patients	↘	Monitoring	0.00%	0.17%
	Finance	Direct Expense/Gross Patient Revenue	↘	77.2-80.4%	70.0%	65.7%
		Net Income	↗	$14,139-$21,208 Per Month	$103,643	$137,102

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Youth Crisis Stabilization Facility	People	Vacancy Rate	↘	5-7%	N/A	N/A
		Turnover Rate	↘	20-23% (1.7%-1.9%)	N/A	N/A
	Service	Patient Experience (Net Promoter Score)	↗	42-47	N/A	N/A
	Quality	Zero Harm - Patients	↘	Monitoring	N/A	N/A
		% of Patients who kept their Follow-up Outpatient Appointment	↗	90-95%	N/A	N/A
		% of Patients Admitted within 24 hours of Referral	↗	90-95%	N/A	N/A
	Finance	Direct Expense/Gross Patient Revenue	↘	127-130%	N/A	N/A
		Net Income	↗	$1,692-$2,538 Per Month	N/A	N/A

Department	Domain	Outcome Measure	⇵	Target Level	Current Month	Current YTD
Youth Psychiatric Hospital	People	Vacancy Rate	↘	7-9%	0.0%	0.0%
		Turnover Rate	↘	20-23% (1.7%-1.9%)	0.0%	0.0%
	Service	Patient Experience (Net Promoter Score)	↗	42-47	100.0*	100.0
	Quality	Zero Harm - Patients	↘	Monitoring	18.18	10.50
		Hospital Readmission Rate	↘	10-12%	31.6%	17.7%
		Average Days for Initial Counseling Appointment Post-Hospital Discharge	↘	8-10 days	7.5 days	15.7 days
		Average Days for Initial Psychiatry Appointment Post-Hospital Discharge	↘	8-10 days	11.5 days	11.3 days
	Community	Out of County Placements	↘	50-60	17	36
	Finance	Direct Expense/Gross Patient Revenue	↘	61.8-64.4%	65.1%	70.3%
		Net Income	↗	$4,973-$7,459 Per Month	($52,829)	($41,577)

North Central Health Care
Person centered. Outcome focused.

Dashboard Executive Summary

April 2021

Organizational Dashboard Outcomes

People

- **Vacancy Rate**

  The Vacancy Rate target range for 2021 is 7.0-9.0%. For March we met our vacancy target with a rate of 8.6% and a year-to-date average of 7.0%; however, the vacancy rate from February to March increased by 2.5%. We are facing escalating wage inflation pressure, especially in our direct care and front-line staff wages that need to be addressed quickly.

- **Turnover**

  Turnover is a new metric for the Dashboard, replacing retention rate. The reason for the change was to be able to benchmark our organization with industry standard metrics. Our annual target is 20-23%. In March, we experienced a rate of 3.3% which was above target at projected annual rate of 34.4% when you annualize our three-month year-to-date experience. Action plans are being developed in three programs with the highest turnover percentages and 1st quarter reviews with leadership will be occurring. As with the vacancy indicator, competitive wage pressure is driving our turnover experience.

- **Organization Diversity Composite Index**

  Organization diversity composite index is a new monitoring metric for 2021 and does not have a target. We experienced a score of 0.67 for March which is calculated as a weighted composite of the diversity of NCHC's workforce, management, and Board, relative to the demographics of Marathon County. An index score of 1.0 indicates that our workforce matches the community demographics, an index score below 1.0 indicates that there is a gap. We are working to develop an overall Diversity and Inclusion strategy for our workforce to improve this index rate.

Service

- **Patient Experience (Net Promotor Score)**

  For 2021 we are measuring patient experience using net promotor score or NPS. Net promotor score is used in the industry to measure and predict customer loyalty based on one survey question, "Likelihood to Recommend." Our target for 2021 is set at 55-61. For the month of March, we saw the greatest number of surveys returned collectively. As a result, we once again exceeded our target at 65.6 although this was decrease from the previous month. All programs will continue with their action plans to continue to improve response rate and therefore overall NPS and hopefully continue this favorable trend.

Quality

- **Hospital Readmission Rate**

  The Readmission Rate is the percentage of patients who are re-hospitalized within 30 days of admission from the inpatient behavioral health hospital for patients with mental illness as primary diagnosis. March's rate was 14.4% for a YTD rate of 13.2%. This is in part due to the high readmission rate we are experiencing in our Youth Hospital. Please see the program specific summary for more information on this.

- **Nursing Home Readmission Rate**

  The nursing home readmission rate is based on the number of residents re-hospitalized within 30 days of admission to the nursing home. The combined rate for March between the two facilities was a readmission rate of 12.8%. Pine Crest Nursing Home experienced a 21.1% readmission rate causing this metric to be off target. Multiple efforts are being made to improve provider knowledge and partnership at Pine Crest to reduce unnecessary readmissions. These efforts include a stronger partnership with the facilities Medical Director and meetings between the Nursing Home Administration, Director of Nursing, and area providers to educate on the capabilities of Pine Crest.

- **Nursing Home Star Rating**

  We have a target of 4 stars for both buildings using the Nursing Home Star Rating as determined by CMS standards. The current quality star rating for MVCC and Pine Crest is 3 stars. Both facilities are meeting target for short-term stays at 4 stars but under target for long-term at 3 stars. A direct focus on long-term care residents is occurring with top target areas including psychotropic medications, falls, and readmission rate. MVCC did have a strong annual survey which will reflect on quarter 2 updates to the nursing home compare website.

- **Zero Harm – Patient**

  The Zero Harm indicators are a monitoring measure for the organization meaning that we do not set a target, instead we monitor trending data.

  The Patient Adverse Event Rate is calculated by the number of actual harm events that reached patients/number of patient days x 1,000. For the month of March, we saw this decrease from the previous month to .84. Falls with injury and suicide attempts were the primary contributing factors to this rate. We are continuing to focus efforts on developing and implementing action plans to target this rate.

- **Zero Harm – Employees**

  Zero Harm remains a monitoring metric with an experience rate of 4.46 for the month of March. Continued efforts remain for reducing employee injury with the most recent events being related to transferring or individuals served. Learning & Development has rolled out an organizational training to direct care workers to improve proper lifting and transferring techniques. Proper ergonomics and safety efforts are also now a part of our new hire orientation.

Community

- **Out of County Placements**

  For 2021, the target for this measure is 230-250. For the month of March, we once again exceeded this at 169 days with a YTD of 182 days. Efforts surrounding diversions are proving to be effective.

- **Consumer Diversity Composite Index**

  The Consumer Diversity Composite Index is a new metric and does not have a target as it is a monitoring metric. We experienced an index of 0.47for March which is calculated as a weighted composite of the diversity of NCHC's consumers (patients, residents, consumers, and clients, relative to the demographics of Marathon County. A score of 1.0 would mean that the consumers we serve reflect the demographics of our community, a score below 1.0 indicates we have a gap to close to become more diverse.

Finance

- **Direct Expense/Gross Patient Revenue**

  This measure looks at percentage of total direct expense to gross patient revenue which is a productivity/efficiency measure. The 2021 target is 64-67%. This measure for March is 70.0%. This outcome is not within target range. The primary driver for the unfavorable result is gross revenue being under budget further than direct expense which strains how much we capture per each dollar of revenue.

- **Indirect Expense/Direct Expense**
  Indirect Expense/Direct Expense is the percentage of total indirect expenses compared to direct expenses. The 2021 target is 44-47%. The outcome for March is 38.6%, which is favorable to the target. Support areas are below budget expense targets and are helping to alleviate operating losses.

- **Net Income**
  Net Income is the net earnings after all expenses have been deducted from revenue. The target for 2021 is 2-3%. In March, the result is (-6.9%). Net patient revenue unfavorability from budget is driving overall shortfalls from budget.

Program-Specific Dashboard Outcomes - *items not addressed in analysis above.*

The following outcomes reported are measures that were not met target (red) at the program-specific level for the month. The 2021 YTD indicator may be red but if there is no narrative included in this report, that means the most recent month was back at target while the YTD is not. They do not represent all data elements monitored by a given department/program, only the targets that were not met for the month.

Behavioral Health Services Programs

- **Adult Community Treatment:**

  Turnover: The result for March was 2.2% with a monthly target of 1.7%-1.9% to achieve the annual target of 20-23%. The forecasted year-to-date turnover is projecting to exceed the target positively at 8.8%. We had one individual resign in March.

  % of Treatment Plans Completed within Required Timelines: The March result is 91.8 % with a target of 96-98% and YTD result of 95.4%. This equates to seven treatment plans being completed outside the timeframe. There was an error in managing the due dates while an employee was out on FMLA. This outcome will continue to be monitored closely to ensure compliance.

  % Eligible CCS and CSP clients admitted within 60 days of referral: The percentage for March was 33.3% with a target of 60-70% and a YTD result of 38.1%. A PDSA cycle has been initiated and it has been identified that many referrals to Community Treatment are not appropriate and eventually closed. Education to internal referral sources has occurred and the rate of appropriate referrals will continue to be monitored. The appropriate referral volume nearly doubled from February to March. Managers are closely monitoring caseload sizes and rate of discharge. Also, leadership is looking to regionalize the Referral Coordinator position to allocate resources more efficiently and streamline the referral process.

  Average days from referral to initial appointment: In March, the average was 72.6 days with a target of 55-60 days and YTD result is 73.1 days. A PDSA cycle has been initiated and it has been identified that many referrals to Community Treatment are not appropriate and eventually closed. Education to internal referral sources has occurred and the rate of appropriate referrals will continue to be monitored. The appropriate referral volume nearly doubled from February to March. Managers are closely monitoring caseload sizes and rate of discharge. Also, leadership is looking to regionalize the Referral Coordinator position to allocate resources more efficiently and streamline the referral process.

- **Adult Crisis Stabilization CBRF:**

  Turnover: The Adult Crisis CBRF had a turnover rate of 11.4% in March, due to one employee moving to another NCHC program and the Operations Manager vacating the position. The addition of a Clinical Coordinator to co-lead the ACSF given the increase in acute care clients and hospital step-downs should improve guidance and support for ACSF staff, as well as the Operations Manager who has been hired.

  % of Patients that kept their Follow Up Appointment: March showed a dip below target at 77.8% which equates to 7 out of 9 individuals that did keep their follow up appointment. We will work with linkage workers and service facilitators to ensure encouragement of keeping appointments; also, with Cerner coming, we hope to be able to have patients utilize patient portals and reminder texts/emails for patient appointments.

  Direct Expense/Gross Patient Revenue: Average census on the ACSF in March was below the target of 12 at an average census of 7.87 for the month. The hospital unit is utilizing the ACSF for additional stabilization more frequently, however, there has been a recent decrease in walk-in clients needing this level of care in March.

  Net Income:
  We expect to see a stabilization of this measure for March, given that the MMT staff have now been relocated to other programs.

- **Adult Inpatient Psychiatric Hospital:**

  Turnover: The March turnover rate of 2.6% remains over target range. One Behavioral Health Technician finished nursing school and took a position elsewhere; one RN finished her Nurse Practitioner degree and took a position elsewhere given there were no open NP position on the hospital unit.

  Average days for initial counseling appointment post-hospital discharge: This measure did not meet target, with an average of 37.7 days until outpatient therapy appointment. The Outpatient clinic is seeing minimal availability within their schedules and so inpatient clinicians are working to get appointments for patients at outside clinics if there is a need for immediate post-discharge appointments.

  Average days for initial psychiatry appointment post-hospital discharge: This measure did not meet target, with an average of 15.5 days post-discharge for an outpatient psychiatry appointment. While this did not meet target, it is far superior to wait times for psychiatry at outside clinics, which at many are 2-3 months. Also, having psychiatry daily while hospitalized, generally patients are not ready for medication review, monthly injections, etc. in less than one month's time. We will continue to prioritize high risk discharges in scheduling outpatient post-discharge appointments.

  Net Income: The adult behavioral health hospital saw a loss of $237,225 in March. Diversions contributed to the loss based on the available budget despite improved diversion days, due to diverted patient stays that we later get some reimbursement for as the external facilities get reimbursed by patients' insurance companies. Revenue was far less than projected due to an average census well below target census for March. Staffing plans to adjust to the newer census rates are being developed, so that personnel overages alleviate some of the loss. An analysis of inpatient hospital billing will be conducted to determine whether we are capturing all possible billing for services in the hospital.

- **Clubhouse:**

  Average Work Order Day Attendance: The March was result was 19 with a target of 20-25 and YTD result of 18. The member outreach calls will be increased to continue to encourage participation. Staff will be reaching out to 3-6 members per week.

  Active Members per month: The March was result was 106 with a target of 110-120 and YTD result of 103. The member outreach calls will be increased as stated above.

  Direct Expense/Gross Patient Revenue: The opportunity for revenue is limited by the number of members attending each day. Actions are in place to increase attendance, which would have a positive impact on gross patient revenue. Direct expenses are being managed and have a positive budget variance.

  Net Income: The opportunity for revenue is limited by the number of members attending each day. Actions are in place to increase attendance, which would have a positive impact on gross patient revenue. Direct expenses are being managed and have a positive budget variance.

- **Aquatic Services**

  Vacancy Rate: Aquatics opened a lifeguard position in March to accommodate a growing census and opening to the public. This position has already been filled and the vacancy rate for April will be 0%.

  Net Income: Program was off target with a loss of ($16,105) on a target of $3,364. Revenue is the major factor for the variance with all expenses at or exceeding target. Revenue opportunities include opening to community members for open swim and group activities which is anticipated to occur in April. April will see a major variance for revenue due to a required closure for warranty purposes for the new building.

- **Crisis & Emergency Services**

  Vacancy: The rate in March Is 10.7%, a significant increase, as the Operations Manager position became open as well as a Linkage Coordinator position. The Linkage Coordinator who vacated the position accepted the open Court Liaison position.

  Turnover: Turnover was 3.7% in March, as the Operations Manager had her last day. Interviews are in progress for the position, with six potential candidates interviewing.

  Patient Experience: It appears that, for the Crisis program, despite having surveys being returned for March, we had one returned with a score of “fair” and one returned with a score of “very good” essentially cancelling each other out, resulting in a score of 0% for patient experience. With Cerner implementation, it is hoped that patient portals and ability to text/email will improve the ability to get surveys returned more effectively and action plans are designed to target both return and scores.

  % of Crisis Assessments with Documented Linkage and follow up within 24 hours: This rate increased to 63.2% in March but did not yet meet target. Root Cause Analysis results to determine barriers to completion include difficulty finding time on exceptionally busy days in the center and inconsistency in the hand-off and completion rate from worker to worker. Next step is development of action plans to target these areas.

  Direct Expense/Gross Patient Revenue: This measure of 238.8% was over target for March, as revenues gained for crisis billing were less than was projected for the month. An area of opportunity for Crisis revenue will be to ensure improvement of follow-up call completion so that revenue is captured for this service.

Net Income: Crisis experienced a loss of $11,451 in March, with primary contributing factors being the less-than-projected billing revenue, and the allocated revenues were well under target as well. The management team will look at all aspects of crisis services, to determine if there are additional areas in which there is opportunity for increased revenue, such as CART team billing productivity and linkage/follow-up services. Allocated revenues will be reviewed by the finance department.

- **Adult Day Services**

  Turnover Rate: Adult Day and Prevocational Services experienced one employee resignation due to a retirement which caused a turnover rate of 7.3%. No further retirements or turnover is expected for April and we anticipate this metric hitting target for 2021.

  Net Income: Adult Day and Prevocational Services had a loss of $92,596 with year-to-date loss of $71.578. This loss is directly attributed to Covid-19 continued impacts for census and billable hours. For April we are anticipating a significant increase across all counties for ADS and prevocational services with members returning after receiving vaccinations. Evaluation continues for community opportunities with prevocational services with headway being made in Lincoln County. April will see a significant correction for net income.

- **Group Homes**

  Turnover Rate: Group Homes were off target for turnover rate with two employees resigning causing a turnover rate of 6.7%. Engagement interviews have started to work on retention strategies and implement a personalized approach to each employee.

  Patient Experience: March experienced a drop in patient experience due to a relatively low return rate. The low evaluation score was reviewed, and an action plan was put into place to address the issue. The action plan including improved communication to family of their loved one's health and condition.

- **MVCC**

  Vacancy Rate: The month of March showed a 15.9% vacancy rate with a target range of 7-9%. Focus remains on ongoing recruitment to fill openings. We currently have 27 open CNA positions, 1 open respiratory therapy position, and 8 open nurse positions. Our recruitment challenge continues largely related to a small applicant pool, with our last CNA hire in September. In March we hired a full-time nurse on the vent unit. Pine Crest received approval to facilitate emergency CNA course training which should positively impact our efforts in recruitment. We are currently interviewing candidates for this CNA program and bringing them onboard as hospitality assistants until the class starts. This will assist in taking some of the non-direct care tasks off the current CNAs workload.

  Turnover Rate: The month of March showed a 2.4% turnover rate with a target of 1.7%-1.9%. We had two occasional employees that left because they were not meeting the requirements of picking up hours. One CNA was an involuntary termination due to an attendance issue, one nurse left to work somewhere else, and two CNA stopped reporting to work. We have also experienced several staff reduce their FTE status which typically indicates they have taken a job elsewhere. We will be holding employee focus groups the middle of April to get feedback on retention strategies going forward.

  Nursing Home Quality Star Rating: Nursing Home Quality Star Rating for Mount View is a 3 Star with a target goal of 4 stars. The biggest opportunity for improvement appears to be in our long term stays and is specific to antipsychotics and activities of daily living. With COVID, we had several residents that were moving less and not leaving their rooms like they used to which triggered change in conditions. With the increased visitations, small group activities and nice weather, we should see this improve as residents are getting out of their room more. The antipsychotic is related to our large population of

dementia residents and mental illness.

Net Income: MVCC experienced a loss of ($55,803.00) for the month of March. Revenue was improved for the month with the highest average census to date and a stronger payer mix. Expenses continued off target, specific to salaries and wages with a variance of $168,670 year to date. Recruitment and retention efforts continue with stay interviews being conducted however applicant pools have sharply declined and wages remain extremely competitive with market increases occurring throughout the year. Expenses are being managed with a proposal to reduce rental equipment by purchasing this equipment with a payoff in 6 months or less. April census is anticipated to stay strong however efforts to reduce salaries and wages expenses are not anticipated to make a major impact at this time.

- **Outpatient Services**

Patient Experience: The result for March was 27.3% with a target of 55-61% and YTD result of 38.1%. The focus for Patient Experience is return rate. Now that we are providing in-person services we can hand the surveys directly to clients at the time of service and encourage their participation. Employees will be engaged in the survey process by having a conversation with consumers about the purpose of the survey and encouraging them to complete the survey. The survey comments will be shared with employees during rounding and/or operational meetings.

Average Days for Initial Counseling Appointment Post-Hospital Discharge: The result for March is 33.1 days with a target of 8-10 days and a YTD result of 23.2 days. With many providers' caseloads being at capacity they are not accepting new clients. However, we are working to blocking time each week for hospital discharges to address this specific access need.

Average Days for Initial Psychiatry Appointment Post-Hospital Discharge: The result for March is 15.1 days with a target of 8-10 days and YTD result of 15.3 days. There is some improvement with the new psychiatry provider starting to accept patients. We will be looking at reallocating resources to support both inpatient and outpatient to address the need for hospital discharge appointments.

% of Patients Offered an Appointment within 4 Days of Screening by a Referral Coordinator: The result for March is 18.7% with a target of 20-25%. To improve therapy access we are increasing group offerings to begin in the second quarter of 2021. By providing services through groups the access to individual therapy appointments will improve. There are three active groups currently. The two groups that are being developed at this time include OWI Group for individuals on a Driver Safety Plan and a CBT (Cognitive Behavioral Therapy) group.

Direct Expense/Gross Patient Revenue & Net Income: Revenue remains under target. There are three Outpatient Providers that are in the process of being credentialed. Two of the three providers became fully credentialed mid-month and can begin building their caseload. Expenses are being managed and have a positive budget variance. One contracted service is no longer needed, which will further reduce expenses.

- **Pine Crest**

Vacancy Rate: The 15.4% vacancy rate that occurred during the month exceeded our target of 7%-9%. These vacancies are tied to both floor nursing and nursing assistant positions, which we have struggled to fill given the competitive wages offered by other healthcare providers and local manufacturing entities. Pine Crest is continuing to work towards hosting Northcentral Technical College affiliated nursing assistant program clinicals, which will serve as an applicant pool. NCHC applied to the state to manage its own nursing assistant program at the beginning of April, with clinicals being at Pine Crest. This will serve as an additional venue to recruit applicants from.

Turnover Rate: Experienced turnover rate for the month of March trended slightly down at 4% on a target of 1.7%-1.9%. 6 positions termed for the following reasons: focus on school; pursue a career outside healthcare (X2); retirement; competitor offering higher wage; and other. Program will be rolling out stay interviews in the month of April that will assist in our management of employee perception of their work experience. Employee Appreciation Committee will continue as an established forum to address moral and engagement related measures.

Patient Experience: Eight survey responses were received during the month with a resulting net promoter score of 28.6 on a target of 55-61. This is a slight decline month over month and is attributed to one rating of "poor". No significant concerns were noted in the survey responses outside of general comments related to limited visitation and dining services. Both items are actively being addressed as we lessen our restrictions based on updated CMS guidelines and the decline in our community's positivity rates.

Hospital Readmission Rate: Program experienced a 21.1% rehospitalization rate for the month of March, exceeding the target of 10%-12%. Of the 11 hospitalizations that occurred, all were deemed unavoidable. Four of the hospitalizations were on the same patient who experienced uncontrolled bleeding from his dialysis site. Concern was expressed with the hospital case workers on the questionable stability of the patient.

Nursing Home Quality Star Rating: The quality star rating remained unchanged month of month, being at a 3 star. As reviewed previously, the current rating accounts for an assessment window that ended in June of 2020. We are anticipating improvement to the rating, which will be updated in late April based on additional clinical process measures that were implemented in Q3 of 2020.

Net Income: The program experienced a loss of ($132,350.00) for the month of March. The negative variance is attributed to number of items that include, but are not limited to, having an average daily census below budget at 94; and incurring unbudgeted therapy and bed-tax expenses of $49,924.00 and $6,800.00, respectively. This does not include agency expense that amounted to $78,396.00. The program has made progress of decreasing agency use month over month. Program has also participated in reforecasting efforts which will address unbudgeted expense items and will adjust revenue projections based on the anticipated market demands for the remainder of the year.

- **Supported Apartments**

  Patient Experience: Supported apartments patient experience dropped below target at 50. This was due to one poor submission with opportunities provided to improve. These opportunities included the care of the client and condition of the apartment. Both issues have been addressed and will be applying solutions across the entire program to avoid similar dissatisfaction in the future.

- **Youth Community Treatment:**

  Turnover: The result for March was 2.7% with a monthly target of 1.7%-1.9% to achieve the annual target of 20-23%. The YTD result is 27.2%. There were two employees that resigned to take other opportunities at outside organizations. We expect this to be time limited experience that will not result in the final year-to-date turnover to be below target.

  % of Treatment Plans Completed within Required Timelines: The March result is 95.2% with a target of 96-98% and YTD result of 95.8%. This equates to three treatment plans being completed outside the timeframe and missing the target by one treatment plan. There is not a pattern of non-compliance. This outcome will continue to be monitored closely to ensure compliance.

  % of Eligible CCS and CSP Clients Admitted within 60 Days of Referral: The percentage for March was 26.7% with a target of 60-70% and a YTD result of 42.5%. A PDSA cycle has been initiated and it has been

identified that many referrals to Community Treatment are not appropriate and eventually closed. The appropriate referral volume nearly doubled from February to March. Managers are closely monitoring caseload sizes and rate of discharge. Also, leadership is looking to regionalize the Referral Coordinator position to allocate resources more efficiently and streamline the referral process.

Average Days from Referral to Initial Appointment: In March, the average was 106.5 days with a target of 55-60 days and YTD result is 84.1 days. A PDSA cycle has been initiated and it has been identified that many referrals to Community Treatment are not appropriate and eventually closed. Education to internal referral sources has occurred and the rate of appropriate referrals will continue to be monitored. The appropriate referral volume nearly doubled from February to March. Managers are closely monitoring caseload sizes and rate of discharge. Also, leadership is looking to regionalize the Referral Coordinator position to allocate resources more efficiently and streamline the referral process.

- **Youth Crisis Stabilization Facility:**
  Opening of this facility is pending approval and site visit from DHS.

- **Youth Psychiatric Hospital:**
  Hospital Readmission Rate: Readmission rate was 31.6%, above our target of 10-12% and significantly increased from prior months. Our team identified some factors contributing to this increase. Factors identified include: outpatient services not effectively begun/put into place due to family barriers or access issues, admissions of youth who could have been served safely by the Youth Crisis Stabilization program, readmission of youth who may have been able to be safe in less restrictive environments or with outpatient support, youth with emerging personality disorder traits who get positive reinforcement from hospital admission, and youth who need longer-term treatment or placement and the lack of availability of those options. We have followed up with specific outpatient resources to discuss how to streamline the referral process and expedite referrals and have increased the number of youths being served in NCHC's 23-hour Youth Crisis program as a means of preventing hospital readmission. Implementation planning for our Youth Crisis Stabilization program continues and this program will be used as both a step-down from hospitalization and an alternative to hospitalization when it can be done safely. We have also begun evaluating and refining our programming to ensure our treatment schedule is best meeting youth needs while here. We will now, additionally, be identifying and tracking each individual patient readmitted and gathering information about factors contributing to the readmission to identify additional themes that we can target with action.

  Average Days for Initial Psychiatry Appointment Post-Hospital Discharge: Target is 8-10 days, and the average length was 11.5 days in March and 11.3 YTD. This is a promising decrease from February but still short of target. Before a youth is discharged from the hospital, we ensure that they have a scheduled first-available psychiatry appointment with either an existing or new provider. We have begun to track additional data related to this measure with the aim of better identifying the barriers to outcome achievement. Since beginning this tracking, we have determined that the length of time to see a NCHC provider is 15.2 days and length for external provider is 10.2 days. There is ongoing effort to increase child psychiatry time at NCHC and this will occur with a new Child Psychiatrist onboarding this summer. Our Social Worker now begins any initial Psychiatry referral with parents and the youth as early as possible during the hospital stay as paperwork from the youth, parent, and school are required before an appointment is scheduled. Frequent prompts and support to parents, youth and school staff have been helpful in getting this referral packet completed and referrals submitted as quickly as possible.

  Financial Measures: These measures not meeting target are a direct result of not meeting revenue targets as expenses have been under budget. Youth Hospital needs to maintain a census of 6 kids to generate budgeted revenue. January monthly average census was 3.94, February increased to 5.36 and March decreased to 3.47 for a quarterly average of 4.24. To increase average census further, we are

pursuing and, have made progress on, two specific actions. We are working towards accepting youth ages 12-17 versus 13-17. We have identified a need to serve 12-year-olds and believe we can meet their needs in our setting. Making this change involves working with the credentialing and privileging of medical and psychiatric providers and this effort is underway. We are currently accepting 12-year-olds on a case-by-case basis with medical evaluation being handled when possible, by our Psychiatrist/Medical Director. We will be able to accept all eligible 12-year-olds once we identify a physician to supervise our medical staff (of Physician's Assistants and Nurse Practitioners). A candidate to fill this role has been identified. Secondly, we plan to expand our service area to include additional counties so that we can accept youth from other counties when our census is low. An agreement has been developed by Corporation Counsel and is being finalized.

North Central Health Care
Person centered. Outcome focused.

MEMORANDUM

DATE: April 19, 2021
TO: North Central Community Services Program Board
FROM: Jill Meschke, Chief Financial Officer
RE: Monthly CFO Report

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 show a loss for March of ($480,101), compared to the targeted loss of ($220,443) resulting in a negative variance of ($259,658). Year-to-date, NCHC has experienced a loss of ($1,363,669).

2) **Revenue Key Points:**
- Overall revenue for March was below budgeted target by ($681,822). Net patient revenue was unfavorable to plan by ($493,255). Year-to-date, revenue is short of plan by ($2,800,669).
- Mount View Care Center census averaged 133 in March compared to a target of 145. March's census average is 6 ahead of January and February. Medicare census is 19 compared to a budget of 20.
- Pine Crest census averaged 94 in March compared to a target of 100. The census is up 3 compared to February. Medicare census averages 13 versus a target of 16.
- Revenue shortfall in the nursing homes represents 21 percent of the overall year-to-date net patient revenue unfavorable variance. Volume is the primary driver of the net patient revenue shortfall as both facilities are close to targeted Medicare census.
- The Adult Acute Care Hospital census averaged 11 in March to a budget of 14. The hospital with the Adult Crisis Stabilization Facility experienced a net revenue shortfall of ($58,606) for the month.
- The Youth Acute Care Hospital census averaged three for March compared to a target census of six resulting in a negative net patient revenue variance of ($26,746).
- The inability to open the Youth Crisis Stabilization Facility contributed ($28,805) to the net patient revenue shortfall from budget for March.
- For March, net patient revenue for the Outpatient was short from plan by ($54,307).
- Administrative and bad debt write offs totaled ($39,992) for March.

3) **Expense Key Points:**
- Overall expenses for March were favorable to plan $456,128.
- Salaries are $76,929 favorable to budget for March. Benefits expenses are favorable to plan by $203,101 driven by health insurance favorability of $190,627.
- Contracted services of providers and staff were favorable to plan by $32,545.
- Diversion expense is ($27,532) unfavorable to plan.

North Central Health Care
Income Statement by Month
For the Period Ending March 31, 2021

	January	February	March	April	May	June	July	August	September	October	November	December	Year-to-Date
Revenues													
Patient Gross Revenues	6,663,759	6,732,434	7,633,491	-	-	-	-	-	-	-	-	-	21,029,685
Patient Contractual Adjustments	(2,554,693)	(2,350,978)	(2,650,090)	-	-	-	-	-	-	-	-	-	(7,555,761)
Net Patient Revenue	4,109,066	4,381,456	4,983,402	-	-	-	-	-	-	-	-	-	13,473,924
County Revenue	597,973	597,973	597,973	-	-	-	-	-	-	-	-	-	1,793,918
Contracted Service Revenue	100,880	105,859	114,011	-	-	-	-	-	-	-	-	-	320,750
Grant Revenues and Contractuals	353,804	250,451	229,622	-	-	-	-	-	-	-	-	-	833,877
Appropriations	502,687	502,687	502,687	-	-	-	-	-	-	-	-	-	1,508,061
COVID-19 Relief Funding	23,200	3,550	-	-	-	-	-	-	-	-	-	-	26,750
Other Revenue	645,513	532,408	503,366	-	-	-	-	-	-	-	-	-	1,681,287
Allocated Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Net Revenue	6,333,123	6,374,384	6,931,060	-	-	-	-	-	-	-	-	-	19,638,567
Expenses													
Personnel Expenses	4,657,559	3,858,309	4,536,129	-	-	-	-	-	-	-	-	-	13,051,998
Contracted Services Expenses	580,297	917,018	885,874	-	-	-	-	-	-	-	-	-	2,383,189
Supplies Expenses	83,826	68,710	96,120	-	-	-	-	-	-	-	-	-	248,656
Drugs Expenses	457,602	506,607	578,900	-	-	-	-	-	-	-	-	-	1,543,109
Program Expenses	122,956	56,163	118,725	-	-	-	-	-	-	-	-	-	297,844
Land & Facility Expenses	365,907	394,418	331,981	-	-	-	-	-	-	-	-	-	1,092,306
Equipment & Vehicle Expenses	159,573	154,015	171,968	-	-	-	-	-	-	-	-	-	485,556
Diversions Expenses	146,869	98,018	107,032	-	-	-	-	-	-	-	-	-	351,918
Other Operating Expenses	622,215	364,941	581,302	-	-	-	-	-	-	-	-	-	1,568,457
Allocated Expense	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Expenses	7,196,805	6,418,199	7,408,030	-	-	-	-	-	-	-	-	-	21,023,034
Operating Income/(Loss)	(863,682)	(43,815)	(476,970)	-	-	-	-	-	-	-	-	-	(1,384,467)
Non-Operating Income/Expense													
Interest Income/Expense	17,724	1,019	(4,261)	-	-	-	-	-	-	-	-	-	14,482
Donations Income	3,446	1,761	1,130	-	-	-	-	-	-	-	-	-	6,338
Other Non-Operating	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Non-Operating	21,171	2,780	(3,131)	-	-	-	-	-	-	-	-	-	20,819
Net Income (Loss)	(842,511)	(41,035)	(480,101)	-	-	-	-	-	-	-	-	-	(1,363,647)

North Central Health Care
Income Statement
For the Period Ending March 31, 2021

	MTD Actual	MTD Budget	$ Variance	% Variance	YTD Actual	YTD Budget	$ Variance	% Variance
Direct Revenues								
Patient Gross Revenues	7,633,030	8,430,699	(797,669)	-9.5%	21,028,297	24,675,107	(3,646,809)	-14.8%
Patient Contractual Adjustments	(2,650,090)	(2,954,503)	304,414	-10.3%	(7,555,911)	(8,661,190)	1,105,279	-12.8%
Net Patient Revenue	4,982,941	5,476,196	(493,255)	-9.0%	13,472,386	16,013,917	(2,541,530)	-15.9%
County Revenue	427,764	427,764	-	0.0%	1,283,292	1,283,292	-	0.0%
Contracted Service Revenue	111,761	103,116	8,645	8.4%	314,000	309,900	4,100	1.3%
Grant Revenues and Contractuals	229,622	334,369	(104,747)	-31.3%	801,977	1,000,906	(198,929)	-19.9%
Appropriations	502,687	502,687	-	0.0%	1,508,061	1,508,061	-	0.0%
COVID-19 Relief Funding	-	-	-	0.0%	26,750	-	26,750	0.0%
Other Revenue	466,760	552,481	(85,722)	-15.5%	1,575,223	1,658,944	(83,721)	-5.0%
Total Direct Revenue	6,721,534	7,396,613	(675,079)	-9.1%	18,981,690	21,775,020	(2,793,330)	-12.8%
Indirect Revenues								
County Revenue	170,209	171,802	(1,593)	-0.9%	510,626	515,406	(4,780)	-0.9%
Contracted Service Revenue	2,250	3,000	(750)	-25.0%	6,750	9,000	(2,250)	-25.0%
Grant Revenues and Contractuals	-	-	-	0.0%	31,900	-	31,900	0.0%
Appropriations	-	-	-	0.0%	-	-	-	0.0%
Other Revenue	36,606	41,467	(4,860)	-11.7%	106,064	139,810	(33,746)	-24.1%
Allocated Revenue	-	-	-	0.0%	-	-	-	0.0%
Total Indirect Revenue	209,526	216,269	(6,743)	-3.1%	656,877	664,216	(7,338)	-1.1%
Total Operating Revenue	6,931,060	7,612,882	(681,822)	-9.0%	19,638,567	22,439,236	(2,800,669)	-12.5%
Direct Expenses								
Personnel Expenses	3,390,174	3,613,854	223,680	6.2%	9,803,232	10,136,452	333,220	3.3%
Contracted Services Expenses	816,543	908,023	91,479	10.1%	2,216,647	2,672,265	455,618	17.0%
Supplies Expenses	69,576	58,978	(10,598)	-18.0%	179,973	175,354	(4,619)	-2.6%
Drugs Expenses	577,638	572,597	(5,042)	-0.9%	1,539,810	1,663,761	123,951	7.5%
Program Expenses	106,140	72,300	(33,840)	-46.8%	246,630	218,999	(27,632)	-12.6%
Land & Facility Expenses	65,576	71,083	5,506	7.7%	192,121	210,498	18,376	8.7%
Equipment & Vehicle Expenses	64,437	64,135	(302)	-0.5%	150,561	214,350	63,790	29.8%
Diversions Expenses	107,032	79,500	(27,532)	-34.6%	351,918	238,500	(113,418)	-47.6%
Other Operating Expenses	149,437	174,746	25,309	14.5%	501,406	525,903	24,496	4.7%
Total Direct Expenses	5,346,553	5,615,215	268,662	4.8%	15,182,298	16,056,082	873,783	5.4%
Indirect Expenses								
Personnel Expenses	1,145,955	1,202,305	56,350	4.7%	3,248,766	3,374,415	125,649	3.7%
Contracted Services Expenses	10,615	3,500	(7,115)	-203.3%	26,617	10,500	(16,117)	-153.5%
Supplies Expenses	85,259	71,003	(14,256)	-20.1%	208,608	233,109	24,501	10.5%
Drugs Expenses	1,262	-	(1,262)	0.0%	3,299	-	(3,299)	0.0%
Program Expenses	12,585	26,690	14,105	52.8%	51,214	68,732	17,518	25.5%
Land & Facility Expenses	266,405	270,298	3,894	1.4%	900,185	812,395	(87,789)	-10.8%
Equipment & Vehicle Expenses	107,531	94,910	(12,621)	-13.3%	334,996	291,184	(43,812)	-15.0%
Diversions Expenses	-	-	-	0.0%	-	-	-	0.0%
Other Operating Expenses	431,865	580,237	148,372	25.6%	1,067,073	1,556,567	489,494	31.4%
Allocated Expense	-	-	-	0.0%	-	-	-	0.0%
Total Indirect Expenses	2,061,477	2,248,943	187,466	8.3%	5,840,757	6,346,902	506,145	8.0%
Total Operating Expenses	7,408,030	7,864,158	456,128	5.8%	21,023,055	22,402,983	1,379,928	6.2%
Metrics								
Indirect Expenses/Direct Expenses	*38.6%*	*40.1%*			*38.5%*	*39.5%*		
Direct Expense/Gross Patient Revenue	*70.0%*	*66.6%*			*72.2%*	*65.1%*		
Non-Operating Income/Expense								
Interest Income/Expense	4,261	(30,833)	35,095	-113.8%	(14,482)	(92,500)	78,018	-84.3%
Donations Income	(1,130)	-	(1,130)	0.0%	(6,338)	-	(6,338)	0.0%
Other Non-Operating	-	-	-	0.0%	-	-	-	0.0%
Total Non-Operating	3,131	(30,833)	33,965	-110.2%	(20,819)	(92,500)	71,681	-77.5%
Net Income (Loss)	(480,101)	(220,443)	(259,658)	117.8%	(1,363,669)	128,753	(1,492,422)	-1159.1%
Net Income	*-6.9%*	*-2.9%*			*-6.9%*	*0.6%*		

North Central Health Care
Balance Sheet
For the Period Ending March 31, 2021

			Prior Month YTD	Current YTD	Prior YTD
ASSETS					
Current Assets					
Cash and Cash Equivalents			2,813,466	1,294,873	1,866,178
Accounts Receivable					
Net Patient Receivable			4,197,984	4,593,017	7,203,299
Outpatient WIMCR & CCS			2,499,699	2,690,099	3,301,250
Nursing Home Supplemental Payment			500,511	750,767	1,128,750
County Appropriations Receivable			1,202,136	594,443	(1)
Net State Receivable			353,394	435,964	451,479
Other Accounts Receivable			455,110	439,932	602,729
Inventory			429,330	429,330	409,844
Prepaid Expenses			1,252,102	1,101,080	1,164,324
Total Current Assets			13,703,733	12,329,504	16,127,852
Noncurrent Assets					
Investments			10,625,550	10,625,550	13,774,000
Contingency Funds			1,000,000	1,000,000	1,000,000
Patient Trust Funds			81,267	76,182	43,924
Pool Project Receivable			1,732,590	1,732,590	1,732,590
Net Pension Assets			7,280,177	7,280,177	-
	1500	1500 - Contruction ir	12,745,174	12,799,387	6,426,703
	1600	1600 - Land	65,133	65,133	51,300
Nondepreciable Capital Assets			12,810,307	12,864,520	6,478,003
	1605	1605 - Land Improve	1,782,870	1,782,870	1,331,887
	1610	1610 - Buildings	43,054,650	43,054,650	15,917,415
	1615	1615 - Building Impr	11,546,269	11,546,269	11,456,432
	1620	1620 - Fixed Equipm	7,778,660	7,778,660	5,056,477
	1625	1625 - Moveable Eq	17,935,969	17,952,519	15,942,007
	1630	1630 - Automobiles	1,541,658	1,506,986	1,402,374
	1635	1635 - Capital Lease	130,361	130,361	130,361
	1640	1640 - Dietary Equip	-	-	-
	1705	1705 - AD - Land Im	(1,472,951)	(1,477,036)	(1,108,606)
	1710	1710 - AD - Building	(21,883,392)	(21,989,668)	(14,124,914)
	1715	1715 - AD - Building	(8,647,799)	(8,701,814)	(7,832,138)
	1720	1720 - AD - Fixed Ec	(5,750,747)	(5,772,612)	(4,797,888)
	1725	1725 - AD - Moveabl	(14,653,543)	(14,724,487)	(12,943,716)
	1730	1730 - AD - Automol	(833,188)	(808,313)	(727,906)
	1735	1735 - Accumulated	(60,530)	(62,858)	(34,921)
	1740	1740 - Accumulated	-	-	-
Net Depreciable Capital Assets			30,468,289	30,215,528	9,666,864
Total Noncurrent Assets			63,998,180	63,794,547	32,695,381
Deferred Outflows of Resources (Pensions)			18,262,408	18,262,408	18,283,534
TOTAL ASSETS			95,964,320	94,386,459	67,106,767

	Prior Month YTD	Current YTD	Prior YTD
LIABILITIES			
Current Liabilities			
Current Portion of Capital Lease Liability	27,987	27,987	29,249
Trade Accounts Payable	811,581	244,580	623,500
Accrued Liabilites			
Salaries and Retirement	2,031,429	1,960,152	1,652,981
Compensated Absences	2,367,962	2,441,085	2,005,400
Health and Dental Insurance	753,000	753,000	670,000
Bonds	-	-	-
Interest Payable	65,513	87,350	-
Other Payables and Accruals	689,896	684,030	1,025,931
Payable to Reimbursement Programs	220,000	220,000	220,000
Unearned Revenue	(2,608,673)	(3,061,806)	(468,394)
Total Current Liabilities	4,358,696	3,356,378	5,758,668
Noncurrent Liabilities			
Net Pension Liability	2,506,809	2,506,809	7,524,802
Long-Term Portion of Capital Lease Liability	43,280	40,961	67,269
Long-Term Projects in Progress	17,990,939	17,990,939	4,580,552
Long-Term Debt and Bond Premiums	9,132,884	9,130,340	-
Patient Trust Funds	50,620	48,311	43,924
Total Noncurrent Liabilities	29,724,532	29,717,360	12,216,548
Deferred Inflows of Resources (Pensions)	22,225,906	22,225,906	9,439,717
TOTAL LIABILITIES	56,309,134	55,299,644	27,414,932
NET POSITION			
Net Investment in Capital Assets	43,278,596	43,080,048	16,144,867
Pool Project Restricted Capital Assets	1,732,590	1,732,590	1,732,590
Unrestricted			
Board Designated for Contingency	1,000,000	1,000,000	1,000,000
Board Designated for Capital Assets	990,604	200,000	1,741,845
Undesignated	(6,459,409)	(5,553,209)	19,746,845
Net Income / (Loss)	(887,195)	(1,372,614)	(674,312)
TOTAL NET POSITION	39,655,187	39,086,815	39,691,835
TOTAL LIABILITIES AND NET POSITION	95,964,320	94,386,459	67,106,767

North Central Health Care
Statement of Cash Flows
For Month Ending March 31, 2021

Cash, Beginning of Period (February 28, 2021)			2,813,466
Operating Activities			
Net Income (Loss)	(480,101)		
Adjustments to Reconcile Net Income			
Depreciation	232,311		
Interest Expense	19,412		
(Increase) or Decrease in Current Assets			
Inventories	-		
Accounts Receivable	(295,387)		
Prepaid Expenses	151,023		
Increase or (Decrease) in Current Liabilities			
Accounts Payable	(506,205)		
Accrued Current Liabilities	(4,021)		
Net Change in Patient Trust Funds	(5,085)		
Unearned Revenue	(613,743)		
Net Cash from Operating Activites		(1,501,797)	
Investing Activites			
Net Change in Contingency Funds	-		
Purchases of Property and Equipment	(70,763)		
Disposal of Assets	34,672		
Pool Project Receivable	-		
Net Change in Long-Term Projects in Progress	-		
Net Cash from Investing Activites		(36,091)	
Financing Activies			
Bonds and Interest	19,294		
Net Change in Purchase/Sale of Investments	-		
Net Cash from Financing Activities		19,294	
Net Increase (Decrease) in Cash During Period			(1,518,594)
Cash, End of Period (March 31, 2021)			1,294,872

North Central Health Care
Programs by Service Line
For the Period Ending March 31, 2021

	Revenue			Expense			Net Income/	Variance
	Actual	Budget	Variance	Actual	Budget	Variance	(Loss)	From Budget
BEHAVIORAL HEALTH SERVICES								
Adult Behavioral Health Hospital	1,400,997	1,559,431	(158,433)	1,879,869	2,013,101	133,232	(478,872)	(25,201)
Adult Crisis Stabilization Facility	275,074	366,974	(91,900)	318,026	257,286	(60,741)	(42,953)	(152,641)
Lakeside Recovery MMT	191,190	403,683	(212,493)	69,627	327,792	258,165	121,563	45,672
Youth Behavioral Health Hospital	461,175	532,270	(71,095)	585,907	735,334	149,427	(124,732)	78,332
Youth Crisis Stabilization Facility	73,461	189,945	(116,484)	107,842	248,932	141,090	(34,381)	24,606
Crisis Services	706,086	760,599	(54,513)	752,308	794,929	42,622	(46,221)	(11,891)
Psychiatry Residency	69,579	113,481	(43,902)	104,541	69,814	(34,727)	(34,962)	(78,629)
	3,177,562	3,926,383	(748,821)	3,818,121	4,447,190	629,069	(640,558)	(119,752)
COMMUNITY SERVICES								
Outpatient Services (Marathon)	673,707	625,279	48,428	1,222,153	687,881	(534,272)	(548,446)	(485,844)
Outpatient Services (Lincoln)	275,880	329,435	(53,555)	225,615	263,754	38,140	50,265	(15,415)
Outpatient Services (Langlade)	639,895	893,682	(253,786)	200,201	874,281	674,080	439,694	420,293
Community Treatment Adult (Marathon)	1,214,676	1,316,516	(101,841)	1,008,599	1,207,027	198,429	206,077	96,588
Community Treatment Adult (Lincoln)	252,983	257,380	(4,397)	162,666	201,002	38,337	90,317	33,939
Community Treatment Adult (Langlade)	148,523	168,334	(19,811)	113,951	139,489	25,538	34,572	5,727
Community Treatment Youth (Marathon)	1,328,724	1,419,224	(90,499)	1,127,650	1,296,110	168,461	201,075	77,961
Community Treatment Youth (Lincoln)	429,151	650,872	(221,721)	320,450	465,899	145,449	108,700	(76,272)
Community Treatment Youth (Langlade)	383,402	438,841	(55,439)	281,871	342,439	60,568	101,532	5,130
Community Corner Clubhouse	62,221	74,336	(12,114)	72,854	79,314	6,460	(10,633)	(5,654)
	5,409,163	6,173,899	(764,735)	4,736,009	5,557,198	821,189	673,155	56,454
COMMUNITY LIVING								
Adult Day Services (Marathon)	124,638	198,435	(73,797)	135,052	147,446	12,394	(10,414)	(61,402)
Prevocational Services (Marathon)	104,289	132,514	(28,225)	169,999	199,252	29,253	(65,710)	1,028
Lincoln Industries	122,999	317,392	(194,394)	235,525	332,426	96,901	(112,527)	(97,493)
Day Services (Langlade)	55,662	73,812	(18,149)	81,745	78,426	(3,319)	(26,083)	(21,468)
Prevocational Services (Langlade)	-	-	-	-	-	-	-	-
Andrea St Group Home	131,699	129,302	2,397	109,171	102,652	(6,519)	22,528	(4,121)
Chadwick Group Home	132,596	158,655	(26,059)	120,000	121,369	1,369	12,596	(24,690)
Bissell Street Group Home	143,356	139,941	3,415	106,231	113,419	7,188	37,125	10,602
Heather Street Group Home	101,662	113,173	(11,512)	110,171	104,396	(5,775)	(8,509)	(17,286)
Jelinek Apartments	165,413	194,269	(28,856)	172,559	177,003	4,444	(7,146)	(24,412)
River View Apartments	165,047	164,273	774	162,017	136,665	(25,352)	3,030	(24,578)
Forest Street Apartments	20,837	87,176	(66,339)	113,854	117,615	3,761	(93,017)	(62,578)
Fulton Street Apartments	49,481	62,507	(13,026)	94,784	70,849	(23,936)	(45,303)	(36,961)
Riverview Terrace	89,053	89,651	(598)	69,543	85,978	16,434	19,509	15,836
Hope House (Sober Living Marathon)	1,451	1,572	(121)	10,553	13,544	2,991	(9,103)	2,870
Sober Living (Langlade)	5,381	12,980	(7,599)	28,917	31,826	2,909	(23,536)	(4,690)
	1,413,563	1,875,651	(462,088)	1,720,122	1,832,867	112,744	(306,559)	(349,344)
NURSING HOMES								
Mount View Care Center	4,349,444	4,723,154	(373,710)	4,712,754	4,470,866	(241,887)	(363,310)	(615,597)
Pine Crest Nursing Home	2,765,548	2,777,696	(12,148)	3,281,882	3,044,137	(237,745)	(516,335)	(249,893)
	7,114,992	7,500,850	(385,858)	7,994,636	7,515,004	479,632	(879,644)	93,774
Pharmacy	1,881,252	2,179,235	(297,984)	2,015,978	2,195,332	179,354	(134,726)	(118,630)
OTHER PROGRAMS								
Aquatic Services	257,991	376,453	(118,462)	302,132	306,990	4,858	(44,142)	(113,605)
Birth To Three	108,103	191,732	(83,629)	108,103	191,732	83,629	-	-
Adult Protective Services	208,529	201,584	6,945	247,561	250,141	2,580	(39,032)	9,525
Demand Transportation	88,231	119,448	(31,216)	83,771	94,921	11,149	4,460	(20,067)
	662,854	889,217	(226,363)	741,568	843,784	102,216	(78,714)	(124,147)
Total NCHC Service Programs	19,659,386	22,531,736	(2,872,350)	21,023,055	22,402,983	1,379,928	(1,363,669)	(1,492,422)

North Central Health Care
Fund Balance Review
For the Period Ending March 31, 2021

	Marathon	Langlade	Lincoln	Total
Total Operating Expenses, Year-to-Date	14,980,814	1,193,354	4,852,264	21,026,433
General Fund Balance Targets				
Minimum (20% Operating Expenses)	2,996,163	238,671	970,453	4,205,287
Maximum (35% Operating Expenses)	5,243,285	417,674	1,698,293	7,359,252
Risk Reserve Fund	250,000	250,000	250,000	
Total Fund Balance				
Minimum Target	3,246,163	488,671	1,220,453	4,955,287
Maximum Target	5,493,285	667,674	1,948,293	8,109,252
Total Net Position at Period End	13,681,273	1,594,497	4,383,616	19,659,386
Fund Balance Above/(Below)				
Minimum Target	10,435,110	1,105,826	3,163,164	14,704,100
Maximum Target	8,187,988	926,823	2,435,324	11,550,135
County Percent of Total Net Position	*69.6%*	*8.1%*	*22.3%*	
Share of Invested Cash Reserves	7,047,919	821,407	2,258,224	10,127,549
Days Invested Cash on Hand	*43*	*63*	*42*	*44*
Targeted Days Invested Cash on Hand	*90*	*90*	*90*	*90*
Required Invested Cash to Meet Target	14,775,598	1,177,007	4,785,795	20,738,400
Invested Cash Reserves Above/(Below) Target	(7,727,679)	(355,601)	(2,527,571)	(10,610,851)

North Central Health Care
Review of Services in Marathon County
For the Period Ending March 31, 2021

	Revenue			Expense			Net Income/	Variance
	Actual	Budget	Variance	Actual	Budget	Variance	(Loss)	From Budget
Direct Services								
Outpatient Services	492,706	444,279	48,428	1,222,153	687,881	(534,272)	(729,447)	(485,844)
Community Treatment-Adult	1,194,676	1,296,516	(101,841)	1,008,599	1,207,027	198,429	186,077	96,588
Community Treatment-Youth	1,328,724	1,419,224	(90,499)	1,127,650	1,296,110	168,461	201,075	77,961
Day Services	228,927	330,949	(102,022)	305,051	346,698	41,648	(76,124)	(60,374)
Clubhouse	39,221	51,336	(12,114)	72,854	79,314	6,460	(33,633)	(5,654)
Hope House Sober Living	1,451	1,572	(121)	10,553	13,544	2,991	(9,103)	2,870
Riverview Terrace	89,053	89,651	(598)	69,543	85,978	16,434	19,509	15,836
Demand Transportation	88,231	119,448	(31,216)	83,771	94,921	11,149	4,460	(20,067)
Aquatic Services	172,404	290,867	(118,462)	302,132	306,990	4,858	(129,728)	(113,605)
Pharmacy	1,881,252	2,179,235	(297,984)	2,015,978	2,195,332	179,354	(134,726)	(118,630)
	5,516,645	6,223,075	(706,430)	6,218,284	6,313,796	95,512	(701,639)	(610,919)
Shared Services								
Adult Behavioral Health Hospital	670,090	787,331	(117,241)	1,391,103	1,489,695	98,592	(721,013)	(18,649)
Youth Behavioral Health Hospital	332,019	384,630	(52,610)	433,571	544,147	110,576	(101,552)	57,966
Residency Program	105,491	83,976	21,515	77,360	51,663	(25,698)	28,131	(4,183)
Crisis Services	146,695	187,034	(40,340)	556,708	588,248	31,540	(410,013)	(8,799)
Adult Crisis Stabilization Facility	203,555	271,561	(68,006)	235,340	190,391	(44,948)	(31,785)	(112,954)
Youth Crisis Stabilization Facility	359	140,559	(140,201)	79,803	184,210	104,407	(79,445)	(35,794)
Lakeside Recovery MMT	31,687	188,932	(157,245)	51,524	242,566	191,042	(19,837)	33,797
Residential	883,973	1,019,182	(135,210)	960,411	916,877	(43,533)	(76,438)	(178,743)
Adult Protective Services	54,564	49,425	5,139	183,195	185,105	1,909	(128,632)	7,049
Birth To Three	80,762	143,239	(62,477)	80,762	143,239	62,477	-	-
	2,509,194	3,255,869	(746,676)	4,049,777	4,536,141	486,365	(1,540,583)	(260,311)
Total NCHC Programming	8,025,839	9,478,945	(1,453,106)	10,268,061	10,849,937	581,877	(2,242,222)	(871,229)
Base County Allocation	485,689	485,689	-				485,689	-
County Appropriation	820,301	820,301	-				820,301	-
Excess Revenue/(Expense)	9,331,828	10,784,934	(1,453,106)	10,268,061	10,849,937	581,877	(936,232)	(871,229)

North Central Health Care
Review of Services in Lincoln County
For the Period Ending March 31, 2021

	Revenue			Expense			Net Income/	Variance
	Actual	Budget	Variance	Actual	Budget	Variance	(Loss)	From Budget
Direct Services								
Outpatient Services	117,221	170,775	(53,555)	225,615	263,754	38,140	(108,394)	(15,415)
Community Treatment-Adult	250,733	255,130	(4,397)	162,666	201,002	38,337	88,067	33,939
Community Treatment-Youth	429,151	650,872	(221,721)	320,450	465,899	145,449	108,700	(76,272)
Lincoln Industries	122,999	317,392	(194,394)	235,525	332,426	96,901	(112,527)	(97,493)
	920,103	1,394,170	(474,067)	944,256	1,263,083	318,827	(24,153)	(155,240)
Shared Services								
Adult Behavioral Health Hospital	135,829	159,594	(23,765)	281,980	301,965	19,985	(146,151)	(3,780)
Youth Behavioral Health Hospital	67,301	77,966	(10,664)	87,886	110,300	22,414	(20,585)	11,750
Residency Program	21,383	17,022	4,361	15,681	10,472	(5,209)	5,702	(848)
Crisis Services	29,735	37,912	(8,177)	112,846	119,239	6,393	(83,111)	(1,784)
Adult Crisis Stabilization Facility	41,261	55,046	(13,785)	47,704	38,593	(9,111)	(6,443)	(22,896)
Youth Crisis Stabilization Facility	73	28,492	(28,419)	16,176	37,340	21,164	(16,104)	(7,256)
Lakeside Recovery MMT	6,423	38,297	(31,874)	10,444	49,169	38,725	(4,021)	6,851
Residential	-	-	-	-	-	-	-	-
Adult Protective Services	11,060	10,018	1,042	37,134	37,521	387	(26,074)	1,429
Birth To Three	16,274	28,863	(12,589)	16,274	28,863	12,589	-	-
	329,340	453,210	(123,871)	626,126	733,463	107,337	(296,786)	(16,534)
Total NCHC Programming	1,249,443	1,847,380	(597,938)	1,570,382	1,996,545	426,163	(320,939)	(171,774)
Base County Allocation	218,617	218,617	-			-	218,617	-
County Appropriation	150,010	150,010	-			-	150,010	-
Excess Revenue/(Expense)	1,618,069	2,216,006	(597,938)	1,570,382	1,996,545	426,163	47,687	(171,774)

North Central Health Care
Review of Services in Langlade County
For the Period Ending March 31, 2021

	Revenue			Expense			Net Income/	Variance
	Actual	Budget	Variance	Actual	Budget	Variance	(Loss)	From Budget
Direct Services								
Outpatient Services	110,476	364,263	(253,786)	200,201	874,281	674,080	(89,724)	(343,511)
Community Treatment-Adult	146,273	166,084	(19,811)	113,951	139,489	25,538	32,322	12,511
Community Treatment-Youth	383,402	438,841	(55,439)	281,871	342,439	60,568	101,532	46,093
Sober Living	381	7,980	(7,599)	28,917	31,826	2,909	(28,536)	(36,135)
Day Services	55,662	73,812	(18,149)	81,745	78,426	(3,319)	(26,083)	(44,232)
	696,196	1,050,979	(354,784)	706,685	1,466,461	759,776	(10,489)	(365,273)
Shared Services								
Adult Behavioral Health Hospital	99,608	117,036	(17,428)	206,786	221,441	14,656	(107,178)	(124,605)
Youth Behavioral Health Hospital	49,354	57,175	(7,820)	64,450	80,887	16,437	(15,096)	(22,916)
Residency Program	15,681	12,483	3,198	11,500	7,680	(3,820)	4,182	7,380
Crisis Services	21,806	27,802	(5,996)	82,754	87,442	4,688	(60,948)	(66,944)
Adult Crisis Stabilization Facility	30,258	40,367	(10,109)	34,983	28,301	(6,681)	(4,725)	(14,834)
Youth Crisis Stabilization Facility	53	20,894	(20,841)	11,863	27,383	15,520	(11,809)	(32,650)
Lakeside Recovery MMT	4,710	28,085	(23,374)	7,659	36,057	28,398	(2,949)	(26,323)
Residential	26,118	30,113	(3,995)	28,377	27,090	(1,286)	(2,258)	(6,253)
Adult Protective Services	8,111	7,347	764	27,232	27,516	284	(19,121)	(18,357)
Birth To Three	11,068	19,630	(8,562)	11,068	19,630	8,562	-	(8,562)
	266,768	360,932	(94,164)	486,670	563,427	76,757	(219,902)	(314,065)
Total NCHC Programming	962,964	1,411,911	(448,947)	1,193,354	2,029,888	836,533	(230,391)	(679,338)
Base County Allocation	578,987	578,987	-				578,987	578,987
County Appropriation	52,547	52,547	-				52,547	52,547
Excess Revenue/(Expense)	1,594,497	2,043,445	(448,947)	1,193,354	2,029,888	836,533	401,143	(47,805)

North Central Health Care
Review of Services in Mount View Care Center
For the Period Ending March 31, 2021

	Revenue			Expense			Net Income/	Variance
	Actual	Budget	Variance	Actual	Budget	Variance	(Loss)	From Budget
Direct Services								
Post-Acute Care	782,119	615,861	166,259	664,454	642,106	(22,348)	117,665	143,910
Long-Term Care	303,834	843,319	(539,485)	1,094,913	976,192	(118,720)	(791,078)	(658,205)
Memory Care	1,769,384	1,411,867	357,517	1,657,989	1,518,656	(139,333)	111,395	218,184
Vent Unit	918,702	961,337	(42,635)	1,021,748	1,069,428	47,680	(103,046)	5,044
Nursing Home Ancillary	7,133	14,223	(7,090)	19,449	8,978	(10,470)	(12,315)	(17,560)
Rehab Services	193,271	501,547	(308,276)	254,201	255,506	1,305	(60,930)	(306,971)
Total NCHC Programming	3,974,444	4,348,154	(373,710)	4,712,754	4,470,866	(241,887)	(738,310)	(615,597)
County Appropriation	375,000	375,000	-				375,000	-
Excess Revenue/(Expense)	4,349,444	4,723,154	(373,710)	4,712,754	4,470,866	(241,887)	(363,310)	(615,597)

North Central Health Care
Review of Services in Pine Crest Nursing Home
For the Period Ending March 31, 2021

	Revenue			Expense			Net Income/	Variance
	Actual	Budget	Variance	Actual	Budget	Variance	(Loss)	From Budget
Direct Services								
Post-Acute Care	319,583	428,714	(109,131)	544,031	674,779	130,748	(224,448)	21,617
Long-Term Care	1,585,245	1,655,026	(69,781)	2,046,807	1,880,789	(166,019)	(461,563)	(235,800)
Special Care	365,400	407,618	(42,218)	485,946	491,649	5,703	(120,546)	(36,515)
Nursing Home Ancillary	123,108	-	123,108	8,083	-	(8,083)	115,025	115,025
Rehab Services	262,008	176,134	85,874	197,015	1,240	(195,775)	64,993	(109,900)
Total NCHC Programming	2,655,344	2,667,492	(12,148)	3,281,882	3,048,457	(233,425)	(626,538)	(245,573)
County Appropriation	110,204	110,204	-				110,204	-
Excess Revenue/(Expense)	2,765,548	2,777,696	(12,148)	3,281,882	3,048,457	(233,425)	(516,335)	(245,573)

North Central Health Care
Report on the Availability of Invested Funds
March 31, 2021

Bank	Length	Maturity Date	Interest Rate	Amount
BMO Harris	365 Days	5/28/2021	0.15%	500,000
People's State Bank	365 Days	5/29/2021	0.75%	350,000
People's State Bank	365 Days	5/30/2021	0.75%	500,000
PFM Investments	270 Days	6/7/2021	0.25%	248,000
PFM Investments	270 Days	6/7/2021	0.20%	248,000
PFM Investments	365 Days	6/16/2021	0.55%	248,000
PFM Investments	365 Days	6/16/2021	0.50%	248,000
PFM Investments	365 Days	7/8/2021	0.45%	248,000
Abby Bank	730 Days	7/19/2021	2.45%	500,000
People's State Bank	365 Days	8/21/2021	0.45%	500,000
Abby Bank	365 Days	8/29/2021	0.60%	500,000
PFM Investments	270 Days	8/31/2021	0.20%	248,000
BMO Harris	273 Days	10/26/2021	0.15%	500,000
Abby Bank	365 Days	11/1/2021	0.40%	500,000
PFM Investments	365 Days	12/6/2021	0.20%	248,000
CoVantage Credit Union	365 Days	12/9/2021	0.80%	500,000
PFM Investments	365 Days	12/30/2021	0.20%	248,000
PFM Investments	365 Days	12/30/2021	0.30%	248,000
Abby Bank	365 Days	1/6/2022	0.30%	500,000
CoVantage Credit Union	365 Days	1/29/2022	0.50%	299,550
PFM Investments	365 Days	2/18/2022	0.25%	248,000
PFM Investments	365 Days	2/18/2022	0.18%	248,000
CoVantage Credit Union	365 Days	2/19/2022	0.50%	500,000
Abby Bank	546 Days	3/1/2022	0.65%	500,000
CoVantage Credit Union	365 Days	3/3/2022	0.50%	500,000
PFM Investments	365 Days	4/5/2022	0.20%	248,000
Abby Bank	730 Days	2/25/2023	0.40%	500,000
CoVantage Credit Union	730 Days	3/8/2023	0.60%	500,000
Invested Funds				10,625,550
Weighted Average	397 Days		0.53%	

North Central Health Care
Summary of Revenue Write-Offs
For the Period Ending March 31, 2021

	MTD	YTD
Adult Behavioral Health		
Administrative Write-Off	19,808	31,554
Bad Debt	338	1,214
Youth Behvioral Health		
Administrative Write-Off	442	1,317
Bad Debt	-	-
Outpatient & Community Treatment		
Administrative Write-Off	4,220	16,287
Bad Debt	214	965
Nursing Home Services		
Administrative Write-Off	7,868	12,066
Bad Debt	-	20,260
Pharmacy		
Administrative Write-Off	1,437	1,489
Bad Debt	-	-
Other Services		
Administrative Write-Off	6,216	15,125
Bad Debt	92	144
Grand Total		
Administrative Write-Off	39,992	77,837
Bad Debt	643	22,582

North Central Health Care
Person centered. Outcome focused.

MEMORANDUM

DATE: April 23rd, 2021
TO: North Central Community Services Program Board
FROM: Jarret Nickel, Operations Executive
RE: Contract with Aegis for Restorative Nursing Program

The new CMS Patient Driving Payment Model (PDPM) has increased focus on Value-Based Payment (VBP), which rewards facilities for having restorative services. Facilities have the opportunity to run this program in house or contract with their therapy provider to complete the same service with less risk. For Mount View Care Center, we are proposing to contract with our current therapy services provider Aegis for our restorative nursing services program.

Restorative nursing services refers the nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. The service actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. These services are captured for reimbursement through our Case Mix Index (CMI). The higher your CMI the more dollars per Medicaid resident per day. Beyond just financial gains from the program, the quality of life will be improved for our residents will be improved further as well.

The cost of the program is $7,761 per month which covers the labor for restorative aides, therapy management, and overall program management. Well-run, this program will pay for itself and provide additional revenue by increasing our CMI rate. As an example, an 80 Medicaid resident facility who implemented a similar program showed an increase of $15.02 per day per resident which comes out to $36,549 per month. MVCC has a Medicaid population of about 100 which if we achieved similar results, we would result in a monthly increase of $46,562. If this increase is experienced the program will provide another source of revenue for MVCC while offsetting the expense.

Outside of cost benefits to MVCC, the program will also likely lead to a reduction in falls with most facilities seeing a 15% reduction in falls and 30% reduction in falls with injury. Enhanced resident engagement with 91% of participants reporting that the program made them much more satisfied with their overall facility and 73% agreed that the program was one of the primary reasons for selecting the facility. The amendment to our contract to add these services would take effect on June 1st and would follow the termination clauses and guidelines from our master agreement that renews annually in May.

North Central Health Care
Person centered. Outcome focused.

MEMORANDUM

DATE: April 23, 2020
TO: North Central Community Services Program Board
FROM: Dejan Adzic, Asst. Corporation Counsel and Michael Loy, CEO
RE: Contract Management Software

North Central Health Care ("NCHC") is in search of a solution to organize, standardize, and streamline contracting processes and workflows currently utilized within the organization. To do so, NCHC will need to implement a contract management software that will enable the organization to effectively manage and maintain all its contracts within one easy to use and easy to access contract repository. Some of the anticipated benefits that the utilization of the contracting software will provide to NCHC are as follows:

- Streamline contracting workflow built into the system that will enable pre-authorized staff to request contracts for their respective departments and track the status of each contract in real-time.

- Enable quick and efficient legal and executive review of every contract and allow for easy modification of contract terms thus greatly increasing productivity by eliminating the need to search for each contract in a physical repository;

- Increase standardization of Vendor and Provider contracts by enabling the legal department to maintain a database of common contract provisions that can be added to contract templates provided by outside organizations;

- Provide an easy to access contract repository that will enable staff, executives, and legal counsel to effectively manage contracts with outside organizations and ensure that the contracting parties are meeting their obligations to NCHC;

- Enable customizable alerts for key dates that will ensure that renewal or expiration deadlines are never missed;

- Increase staff productivity and reduce costs through automation, specifically this position is intended to replace one full-time position; and

- Improve and maintain compliance.

To accomplish this goal, NCHC is requesting that this board authorize an unbudgeted expenditure not to exceed $40,000 for the first year of implementation and $25,000 for each year thereafter. The anticipated initial expenditure includes costs associated with implementation of the software and required staff training. The new expenses will be offset with the reduction of the position that previously managed contracting and contract workflows.

Policy Title: Strategic Planning	North Central Health Care Person centered. Outcome focused.
Policy #: 105-0006	**Program:** Administration 105
Date Issued: 04/25/2019	**Policy Contact:** Chief Executive Officer

Related Forms
None

1. **Purpose**
   To provide guidance for the North Central Health Care (NCHC) Board in carrying out its responsibility to set direction for the organization through strategic planning. The Strategic Plan will be the main reference point for any work undertaken by NCHC by outlining the key goals and objectives of NCHC, as well as broad strategies to meet those objectives.

2. **Definitions**
   None

3. **Policy**
   It is the policy of the Board of Directors to plan effectively for both NCHC's short and long-term future to ensure that the organization is continuously positioned to effectively meet its mission, the needs of our partner counties, and to serve the North Central Wisconsin region. Accordingly, NCHC will establish an ongoing strategic planning process translating community need and mission into measurable strategies, initiatives, and objectives. The Board of Directors will always have, in place, a defined strategic plan. This plan will be updated regularly, but not less than every three years.

4. **General Procedure**

   4.1 Strategic Planning Process Framework:
   - Review of current Mission, Vision, Values, and End Statements.
   - A review of available community health assessments, environmental factors, and critical assumptions about the future.
   - Engagement of outside resources to ensure that objective insight is incorporated into the planning process.
   - Expert insight and opinion from the Board, organizational stakeholders, community, and industry leaders.
   - Review of the process for cascading and monitoring overall strategic plans, initiatives, and objectives into aligned plans for NCHC programs and services.

4.2 Annual Strategic Plan Development Timeline:

- Environmental Scan and Needs Assessment: February – May
- Board Strategy Retreat: May
- Annual Budgeting Process: April – August
- Board Approval of Strategic Plan and Annual Budget: September

4.3 Continuous Monitoring: The Strategic Plan will identify clear objectives and indicators of success that will be tracked and reported to the Board by the Chief Executive Officer on a regular basis. Further, management will continuously monitor changes in critical assumption underpinning the strategic plan as well as the organization's actual performance in achieving its strategic goals.

5 References

5.1 CMS: None

5.2 Joint Commission: None

5.3 Other: None

Related Policies, Procedures and Documents

Policy Title: Budget	North Central Health Care Person centered. Outcome focused.
Policy #: 105-300	**Program:** Administration 105
Date Issued: 04/29/2021	**Policy Contact:** Chief Financial Officer

Related Forms

None

1. **Purpose**

   The annual budget provides financial direction and operational priorities for program management. The individual program budgets provide an accountability tool to review how resources are being utilized. A budget is designed to protect the resources of the organization, ensure maintenance of accurate records of the organization's financial activities, and provide a frame-work for operational decision making.

2. **Definitions**

   Budget: an estimation of revenues and expenditures over a specified period of time.

   Generally Accepted Accounting Principles (GAAP): the common set of accounting principles, standards, and procedures issued by the Financial Accounting Standards Board (FASB).

   Operating Budget: the annual budget stated in terms of classifications such as programs which contains estimates of resources required for the operations and is stated in categories by revenue and expense accounts.

   Capital Budget: the budget for long term investments such as building and equipment. Capital investments meet a dollar and a useful life threshold as set by policy.

3. **Policy**

   It is the policy of North Central Health Care (NCHC) to establish an annual budget that maintains control of the use of resources and provides direction of how the resources will be utilized based on the mission of the organization and the strategic plan. The annual budget includes an operating budget and a capital budget which are approved by the Board of Directors. The budget is prepared in accordance with Generally Accepted Accounting Principles (GAAP). Throughout the fiscal year, the CFO will report to the NCHC Board of Directors the status of the budget compared to actual results. Program directors are responsible throughout the year to manage their budgets.

4. General Procedure

4.1. Prior to the May NCCSP Board Meeting, the Executive Committee meets to discuss and direct staff on budget guidelines, priorities, and objectives.

4.2. The Chief Financial Officer (CFO) works together with the Chief Executive Officer (CEO), NCHC Executive Team, and Program Management to develop an annual Budget that is an accurate reflection of the Executive Committee's direction.

4.3. The Budget is developed using the organization's standard revenue recognition and cost allocation procedures. The cost allocation methods are approved by the Board annually.

4.4. A proposed Budget will be presented to the NCHC Board in September for approval. The Budget is then forwarded to each of the partner counties for approval through each Retained County Official. Once approved by each of the partner County Boards, the proposed Budget will become the final approved Budget and will be distributed to Management for implementation.

5. References

5.1. **CMS:**

5.2. **Joint Commission:**

5.3. **Other:**

Related Policies, Procedures, and Documents

State of Wisconsin
2021 - 2022 LEGISLATURE

LRB-0113/1
TJD:wlj

2021 SENATE BILL 239

March 24, 2021 - Introduced by Senators JACQUE and MARKLEIN, cosponsored by Representatives TITTL, JAMES, DITTRICH, MOSES, MURPHY, MURSAU, ROZAR, SKOWRONSKI and WICHGERS. Referred to Committee on Judiciary and Public Safety.

AN ACT ***to amend*** 51.15 (5) of the statutes; **relating to:** excluding time for evaluation and treatment of certain medical conditions from the time limit for emergency detention without a hearing.

Analysis by the Legislative Reference Bureau

Current law establishes a procedure for emergency detention of an individual who is believed to be mentally ill, drug dependent, or developmentally disabled and who demonstrates a substantial probability of physical harm to himself or herself or others or impairment or injury to himself or herself due to impaired judgment, or inability to satisfy certain basic needs due to mental illness. Currently, in Milwaukee County, the treatment director of a facility has 24 hours from the time the individual is delivered to the facility to determine whether or not the individual must be detained for purposes of emergency detention. Once the treatment director makes a determination that an individual is being detained, the individual may not be detained for longer than 72 hours without a court hearing. The 24-hour period in which the treatment director must make the determination may be extended by any period that the determination is delayed that is directly attributable to evaluation or stabilizing treatment of nonpsychiatric medical conditions. Currently, in counties other than Milwaukee County, there is no 24-hour period for determination by a treatment director, and the 72-hour period during which the individual may be held without a hearing begins when the individual is taken into custody by law enforcement or another authorized person and continues upon transfer of the individual to the treatment facility. This bill excludes from the 72-hour time limit

that an individual may be detained without a hearing for the purposes of emergency detention any period during which the individual's behavior is not observable that is directly attributable to evaluation or stabilizing treatment of a nonpsychiatric medical condition.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 51.15 (5) of the statutes is amended to read:

51.15 **(5)** DETENTION PROCEDURE; OTHER COUNTIES. In counties having a population of less than 750,000, the law enforcement officer or other person authorized to take a child into custody under ch. 48 or to take a juvenile into custody under ch. 938 shall sign a statement of emergency detention that shall provide detailed specific information concerning the recent overt act, attempt, or threat to act or omission on which the belief under sub. (1) is based and the names of persons observing or reporting the recent overt act, attempt, or threat to act or omission. The law enforcement officer or other person is not required to designate in the statement whether the subject individual is mentally ill, developmentally disabled, or drug dependent, but shall allege that he or she has cause to believe that the individual evidences one or more of these conditions. The statement of emergency detention shall be filed by the officer or other person with the detention facility at the time of admission, and with the court immediately thereafter. The filing of the statement has the same effect as a petition for commitment under s. 51.20. When, upon the advice of the treatment staff, the director of a facility specified in sub. (2) (d) determines that the grounds for detention no longer exist, he or she shall discharge the individual detained under this section. Unless a hearing is held under s. 51.20 (7) or 55.135, the subject individual may not be detained by the law enforcement officer or other person and the facility for more than a total of 72 hours after the

individual is taken into custody for the purposes of emergency detention, exclusive of Saturdays, Sundays, and legal holidays. When calculating the 72 hours for which an individual may be detained under this subsection, any period during which the individual's behavior is not observable that is directly attributable to evaluation or stabilizing treatment of a nonpsychiatric medical condition of the individual is excluded from the calculation.

(END)

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A Resolution in Endorsement of 2021 Senate Bill 239

WHEREAS, on March 24, 2021, Senate Bill 239 was introduced by Senators Jacque and Marklein and cosponsored by Representatives Tittl, James, Dittrich, Moses, Murphy, Mursau, Rozar, Skowronski and Wichgers; and

WHEREAS, on that same date, Senate Bill 239 was read for the first time and referred to the Committee on Judiciary and Public Safety; and

WHEREAS, Senate Bill 239 constitutes a legislative proposal to amend § 51.15 (5) of Wisconsin Statutes to "exclude[e] time for evaluation and treatment of certain medical conditions from the time limit for emergency detention without a hearing"; and

WHEREAS, this bill excludes from the 72-hour time limit that an individual may be detained without a hearing for the purposes of emergency detention for any period during which the individual's behavior is not observable that is directly attributable to evaluation or stabilizing treatment of a nonpsychiatric medical condition; and

WHEREAS, upon initiating an emergency detention of any subject individual believed to be dangerous to themselves or others, law enforcement officer on scene must transport the subject individual to a local hospital for medical clearance; and

WHEREAS, medical clearance is necessary prior to admission into a mental health or emergency detention facility; and

WHEREAS, under current law, the 72-hour hold period under § 51.15 starts running at the time the subject individual is detained by law enforcement officers and continues running for the duration of the time that is necessary to obtain a medical clearance and ensure stabilization of any underlying non-psychiatric medical condition, before the subject individual is actually admitted at the mental health institution or detention facility; and

WHEREAS, due to the fact that the 72-hour hold period commences prior to subject individual's admission to the mental health institution or detention facility, this can greatly reduce time for evaluation and root cause diagnosis of the underlying psychiatric condition; and

WHEREAS, for reasons described above, time lost during the medical clearance process can lead to the undesirable consequences such as rushed psychiatric and legal evaluations of the individual subject's condition, release of individual back into the community without proper support for undiagnosed mental health condition, unnecessary utilization of resources; and

WHEREAS, North Central Health Care and partner counties support the proposed changes to § 51.15 and anticipate the proposed changes to have a positive impact on the mental health commitment process and ultimate treatment outcomes; and

WHEREAS, the anticipated positive impact of the proposed changes on the mental health commitment process include, but are not limited to, the following:

- Decrease in unnecessary resource utilization;
- Allow time for improved psychiatric and legal evaluation generally resulting in overall improvement in patient outcomes; and
- Allow more time for psychiatric observation of subject individuals thus increasing the likelihood of determination of root cause and more effective treatment of the underlying mental health condition.

NOW, THEREFORE BE IT RESOLVED, that the NCCSP Board does hereby endorse the legislative enactment of proposed amendments to § 51.15 (5) as contemplated by 2021 Senate Bill 239.

_____

Kurt Gibbs, Chair, NCCSP Board

2021 NCCSP BOARD CALENDAR

May 27, 2021 – 12:00 PM – 5:00 PM (Annual Meeting & Board Retreat)

Elections: Election of Directors and Officers.

Board Policy to Review

- Board Strategic Planning Policy
- Budget Policy
- Capital Asset Management Policy
- Cash Management Policy
- Fund Balance Policy
- Investment Policy
- Risk Reserve Guidelines Policy
- Write-off of Accounts Receivable Policy

Board Policy Discussion Generative Topic: Focus on the strategic plan, environment, competition, and opportunities for collaboration.

Review Mission and Vision – Reflect on the organization's mission, vision, end statements and compare them against its activities, governing documents, and communications.

Review Strategic Plan – Review progress on the strategic plan, update as necessary.

Board and Committees – Review the Board's composition; appoint and authorize committees, as necessary; delegate duties; discuss board training/development; determine adequacy of oversight and planning activities.

Budget Assumptions & Priorities – Develop the upcoming budget assumptions and priorities in collaboration with the Executive Committee. Approve capital projects.

Thursday June 24, 2021 – 3:00 PM – 5:00 PM

Educational Presentation: Corporate Compliance and Quality Obligations of the NCCSP Board – Emerging Compliance Trends

Agenda Items

- Report of investigations related to corporate compliance activities and significant events.

Board Policy to Review

- Business Associates Policy
- Contract Review and Approval Policy
- Contracting with Excluded Individuals and Entities Policy
- Purchasing Policy

Program Review: Crisis and Emergency Services

Board Policy Discussion Generative Topic: Effectiveness of the Corporate Compliance Program

2021 NCCSP BOARD CALENDAR

Thursday July 29, 2021 – 3:00 PM – 5:00 PM

Educational Presentation: Current practices and performance around the human capital management of the organization.

Agenda Items

- Review of Employee Compensation Plan Effectiveness
- Review Employee Benefit Plan Performance
- Review Diversity, Equity and Inclusion Plan

Board Policy to Review

- Employee Compensation Policy

Program Review: Medically Monitored Treatment

Board Policy Discussion Generative Topic: Effectiveness of Human Capital and Talent Management Programs