PROCEEDINGS OF THE BROWN COUNTY HUMAN SERVICES BOARD

Pursuant to Section 19.84 Wis. Stats, a regular meeting of the **Brown County Human Services Board** was held on Thursday, August 10, 2017 at Health & Human Services; Sophie Beaumont Building; 111 N. Jefferson St.; Boardroom A; Green Bay, WI 54301

Present: Chairman Tom Lund
Carole Andrews, Bill Clancy, Susan Hyland, Craig Huxford,
Aaron Linssen (arrived 5:33)

Excused: Jesse Brunette, JoAnn Graschberger, Paula Laundrie

Also Present: Erik Pritzl, Executive Director
Nancy Fennema, Deputy Director
Eric Johnson, Finance Manager
Dawn LaPlant, Health Information Management Manager
Luke Schubert, Hospital & Nursing Home Administrator
Chad Weininger, Director of Administration

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1. Call Meeting to Order:
The meeting was called to order by Chairman Tom Lund at 5:15 pm.

2. Approve/Modify Agenda:
HYLAND / ANDREWS moved to modify the agenda to move items 12 and 13 after Item #4 in the Agenda.
The motion was passed unanimously.

3. Approve Minutes of July 13, 2017 Human Services Board Meeting:
CLANCY / HUXFORD moved to approve the minutes dated July 13, 2017.
The motion was passed unanimously.

4. Executive Director's Report:
Executive Director Pritzl deferred his report to the other documents including the 2016 Annual Report and the 2018 Human Services Draft Budget.

CLANCY / ANDREWS moved to receive and place on file.
Motion was carried unanimously.

12. 2017 Quality Assurance Improvement Plan Review:
Hospital & Nursing Home Administrator, Luke Schubert introduced Dawn LaPlant, Health Information Management Manager/QAPI Chair.

The Quality Assurance Plan Improvement (QAPI) has been revised based on suggestions/directives from the CMS and DHS joint site surveys in June of the hospital. The hospital had some areas to be found non-compliant with standards, and will go recertification visit sometime between August 22 and September 13.

A few changes to the 2017 Plan were brought before the Board in regard to grammatical changes (i.e., from Human Services to Health & Human Services);

changing from quarterly to monthly meetings to carry forward initiatives; changes to position titles; as well as the need for the governing body – the Human Services Board – to appoint a member to the Medical Staff Committee. This formal appointment will be addressed at the September Human Services Board meeting.

ANDREWS / HYLAND moved to approve and place on file.
Motion was carried unanimously.

13. QAPI PIP (Performance Improvement Project) Charter Approvals:

Luke Schubert provided information on Performance Improvement Project (PIP) charters in light of the recent CMS survey is to identify cross-functional projects in relation to high risk/high impact areas that affect our organization and the hospital.

The Quality Assurance Committee recommended three projects as charter initiatives:

1. *Discharge Planning and Correlation with Readmission Rates*
   A project identifying trying to move our 11.7% current readmission rate down 3% to 8.7% or less, by focusing on the reasons for readmission tied to the discharge planning elements. Trying to decrease the frequency of people re-presenting and increase their success when discharged into the community.

2. *Treatment Planning Optimization*
   During our CMS health inspection we received feedback that our treatment planning needed to be more person-specific, measurable, attainable, and contained short-term and long-term goals in our planning. That our interventions did not appear too "canned" or generic; that they are specific to the individual based on the problems that the individual presents whether the person is there for 24 hours or 3 months, that our standard remains the same. We are planning to focus on education and follow up with those who are treating the caring for the clients on the unit. This is an interdisciplinary project with Mark Johnson, our Director of Social Service, who will be heading up this project.

   Dawn LaPlant added there will be measurable goals data linked to it because they want to see measurable data to demonstrate how we are improving with the initiative.

CLANCY asked if this was a state or federal request. SCHUBERT said it was a joint visit by state and federal surveyors.

3. *Clients with No Insurance*
   We need to be sure we are doing everything within our power to be sure clients with no insurance follow through on their Medicaid eligibility. We often see people for a short period of time, and it takes time to complete the necessary follow up to their medication application, so gather data, submit it, someone in Economic Support verifies the information and will request follow up to various other information like bank statements specific information to validate the information, etc. If clients are no longer in the hospital, and have been discharged, it becomes a challenge for us to follow up to ensure they have followed through on the follow up criteria for them to get the benefits to long-term help them out in the community

All projects were picked to encompass our high risk/high volume areas and were interdisciplinary to all our members.

HUXFORD / ANDREWS moved to approve and place on file.

Motion was carried unanimously.

5. CTC Administrator Report including NPC Monthly Report:
Administrator Luke Schubert deferred his report to items covered later in the agenda.

CLANCY / ANDREWS moved to receive and place on file.
Motion was carried unanimously.

6. Financial Report for Community Treatment Center and Community Services:
Finance Manager Eric Johnson handed out his YTD Report and highlighted:

This month the financial statements themselves don't tell much of a story as they look good on a summary level, and in general, things are.

Community Treatment Center
The CTC is showing revenue at 49% of the annual budget after half of the year. The CBRF revenue is less than we expected due to the change in the DHS required billing. However, for the most part, this is offset by the higher revenue from increased census at the hospital and CBRF unit. The 1% variance is due to an amended budget amount of $476k which is insurance proceeds for the nurse call system, and that revenue will be recorded in July.

The expenses at 51% are primarily due to labor costs driven by 1:1 nursing care and higher census. Strategies have been identified for reducing overtime and temporary help and are being implemented.

Community Services
Community Services revenue is showing at 50% of the annual budget as well as expenses at 50%. Due to an accounting error, there was an understatement of purchase services expense and with the correction of that, we would be at 51% overall for expenses. That 1% variance is due to higher level of purchase services, personnel costs are right at 50% level for half the year. We are looking at what we can do to mitigate some of these expenses in the second half of the year.

PRITZL noted the interdepartmental for BC patients – Nicolet specific – we are now doing a different charge for emergency placement of Adult Protective Services (APS). Historically, people would go to Bayshore Village Nursing Home, but there were people who didn't need the Nursing Home level of care environment. So, we have been using Bayhaven, the CBRF, but no matter where they were placed, historically there was no charge to Community Services for the APS placement. So, now when we do use the CBRF, we are charging back costs to appropriately show the expense and the impact of APS. It will make our budgets look a bit different at the end of the year. We did a budget adjustment; we originally thought it would be about $40k, but now it is closer to $118-120k. It is more days and placements than we expected. It is what we hear from other counties too – "APS placements are an issue," "it is hard to find placements for APS," "there are more than expected," etc.

ANDREWS / HYLAND moved to receive and place on file.
Motion was carried unanimously.

Supervisor Linssen arrived at 5:33 pm

7. 2016 Annual Report:

Copies of the 2016 Annual Report were distributed, and Executive Director Pritzl highlighted some items from his letter in the Report:

Comprehensive Community Services (CCS) – the increase in the number of consumers served in that area as well as the dollar of service that we are able to bring to that population now. The Outpatient Clinic has done a great job of reducing the wait time to substance use services to 5-6 days.

Community Response is in our Children, Youth & Family Services unit and is one social worker who does outreach to families who are not accepted for formal assessment by Child Protection. It is a soft touch, warm contact to those families that has been very successful and we do not see those families return to Child Protection. It has been very helpful as a diversion off of Child Protection.

In terms of the Jail and partnership, there is a lot they have done with mental health services. We also have the re-entry/liaison position that started in 2016 and that program is very successful in terms of recidivism. Of the people that worker had contact with, only 4 out of 199 returned to jail. And we are coupling that with the Economic Support outreach at the Jail to get people signed up for FoodShare and BadgerCare at the time of release.

ANDREWS / HUXFORD moved to receive and place on file.
Motion was carried unanimously.

8. Discussion and Approval of 2018 Draft Budget for Human Services:

Copies of the 2018 Draft Budget for Community Services and the Community Treatment Center were distributed, and Executive Director Pritzl highlighted some items.

It starts with focusing on making sure our mandated services are taken care of, and we don't have a lot of change within the structure of the budget or the staff in 2018.

The only position we are proposing to add is a Crisis Coordinator tied to our Crisis Services Initiative. We want to take a good look at Crisis Services/Emergency Mental Health services – especially detentions. We have done work with the Crisis Center looking at what are mandated and non-mandated services. We know they provide a lot of contact and service – they receive over 22-25,000 calls a year. We want to focus on what is the emergency detention piece of that work. We are looking to get a coordinator to work better with the system: there is the Crisis Center which is contracted; Nicolet is a receiving facility; Bellin is a receiving facility; Willow Creek; Winnebago; Law Enforcement; Emergency Departments; etc. We need a coordinator for the system to look at how we get the system, partners and players to work together. Also the EM1 Committee is not as functional as it could be, so to change that structure to a Crisis Coordinating Committee. What is the best competitive process to ensure we are getting the best service? It could be an RFP or RFQ for crisis services. We would need to look at two different components – the mandated as well as the non-mandated.

Another initiative to highlight is Children's Long-Term Support (CLTS). This is an unknown at this point, but as of today (August 10) some new information has been released suggesting we should be prepared because in the Governor's proposed budget, he wants to eliminate the CLTS waitlist. This would mean we would enroll children, have Case Managers provide service, and then get reimbursement for the billable time. To take all of the children off of the waitlist, we estimate it would require an additional three Case Managers and a Supervisor – positions that are not included in the 2018 budget, because the State budget is not passed, and needs to survive the

legislative process. This is something to be aware of as we would need to find a way to take approximately 146 children off of the list and provide services. The timeframe may be 15 months; could be the last 3 months of 2017 and the 12 of 2018. It is a big endeavor and we will need to add staff to do it.

Another initiative is the move of the electronic healthcare records to a hosted environment – in other words, the vendor hosts it, not us locally. Disaster recovery, downtime is reduced; updates are taken care of by the vendor. This system is helping us gather data better for example for billable time and how that is generated as a report. We will change our local support as well, as we move to a Business Analyst function vs programmer function. It is going to be a big project for next 6 months.

Projections are also included. We have seen better results with Wisconsin Medicaid Cost Reporting (WIMCR). We saw a dip for a couple of years, where that amount really went down, but we seem to be on the back on the positive trend with that. We are projecting a better result with WIMCR reporting. That is helping our budget as it absorbs some of the costs.

No staff reductions are planned with the exception of Lab Services at the CTC.

CLANCY: What does it mean when you “age a child out?”

PRITZL: We can provide care up to age 21; but some children decide to leave care at age 18. We are obligated to offer and provide up to age 21.

LUND: How do you provide care if the family makes them leave? What are you doing for them? Just because you turn 18 doesn’t mean they are not self-supporting

PRITZL: They can continue in their foster home.

FENNEMA: There is a program called Independent Living that is significantly State run. We have an employee who has worked with it for 5 years and does an excellent job. She works with the young adults who “age out,” and are no longer children and cannot stay in foster care. She works alongside local providers to help these young adults learn things like balancing a checkbook, interview skills, finding an apartment, paying rent/bills, independent living skills. There is no money in this program for housing, so they work with existing landlords to find them places to live. We take pride in this voluntary program. They also help connect them to local colleges and tech schools.

HYLAND: Are these kids with handicaps?

FENNEMA: No, they are kids who were in foster care, but the foster families are no longer receiving monetary support.

PRITZL: The other point to note is these young adults must be enrolled in school in this program.

ANDREWS: Might there be some value in getting kids involved in this type of program – whether or not they “age out” – to learn these types of skills well before they turn 18?

LUND: There would be value in going to the school districts and getting them back to teaching these skills in high school. I have talked with Damian LaCroix (Superintendent of Howard-Suamico schools), to bring light to those kids who are not going on to college, and to work with local businesses to find out what skills these kids need to get jobs out there. Need to work with local schools like NWTC -- not everyone is going to college or the military. With some skill training in their senior year, those kids would be far ahead, lots of jobs would be open to them; they could enter the workforce, and return to school later to get a degree a couple years down the line.

FENNEMA: I would suggest we have Sheri Konitzer come to a Board meeting and do a presentation to speak on this program.

LUND: I would like to have a summit with the school districts on what is needed for these (Independent Living Program) kids other kids that are not college bound.

LUND: There is a problem with filling up the jail. Some of these kids are going to get in trouble because they have no direction. We can stop filling up the jail by working with kids that might fall into those cracks, and seriously getting them into jobs and they won't fall into the system.

FENNEMA: Sheri (Konitzer) was a former employee at Shelter Care, and through some of our own resources, helped to promote this position. We have this one position that works with the kids/adults.

LUND: I'd really like to promote that (the Independent Living Program) because it would help the future of the community a lot, because I am sure there are a lot of children that would fall under those categories.

HYLAND: Some of those skills are taught even in middle school, but if the kids don't acquire them, or move on, once they get to high school there are so many choices (electives). In the Special Education course they have lots of training in these skills.

LUND: I'm talking about the kids who are not in Special Ed. They are the "C" students, moving along every year. That kid might be a great welder or mechanic, or so many things that pay pretty good money, but we don't value it.

HYLAND: Those types of programs are not being offered anymore, like Tech Ed.

LUND: Moving on… I do have some questions on this budget. In the Behavioral Health Summary, in the amended budget for 2017, there was $7,900,000, you estimated you would spend only $8,154,000 and then you came down to $7,991,000; so you are lower than what you spend by $150,000. So where are you going to find savings?

PRITZL: The trend on the 2017 amended budget – the $7.9M is the amount of levy that would be required and we are estimating $8.1M for next year. Next year, we are increasing a small amount over 2017. We are looking at Mental Health stays.

LUND: You are looking at some ways to control, reducing what is being spent.

PRITZL: We are seeing that in the first 4-5 months of 2017, in terms of institutional placements in mental health stays was higher than expected. June-July has been a little bit better. It is difficult to predict from year to year, but we do not expect another year like this.

FENNEMA: I would like to add that it was not just Brown County. Many other counties experienced the same – for whatever reason this Spring -- a high need for institutional care.

LUND: Another question… On the Children, Youth and Family Services – there is an amended budget of $6M, we figured we are going to use $7.1M roughly. So now we have a budget of $5,771,000; that seems like it is $1M less than what we spent. Where are we going to get the savings that we can come down that far?

PRITZL: This unit picks up a couple different units, so is the variance in Child Protection, or CLTS or some institutional costs that are associated with children and adolescents here, too. So there are some changes with personnel costs; a $300,000 projected change there. Not because of position elimination, more due to turn over where there is a lower personnel costs. Operating expenses are being projected to be a bit lower. We are really optimistic about placements I think more than anything. In terms of the other variance and what can be responsible for the estimated vs 2018, the difference between

the two, there is a $1M increase in revenue. We are projecting some inter-governmental revenues to be higher than expected.

LUND: And what about Long Term Care? We had a budget of $4,073,000 and we figured we would spend around $4,009,000. But we have a 2018 budget of $3.5M.

JOHNSON: This is the difference in the Family Care Maintenance of Effort payment. It goes down about $600,000 each year.

LUND: Community Services – we have a budget of zero for this coming year, and last year we had a budget of $75,000 but we spent $742,000?

PRITZL: This is in excess of what we budgeted the levy at. So the 2017 amended budget had the $75,000 which was the housing study that was set aside, so that one would have been zero otherwise. The 2017 estimated is basically as of the time of these reports; this is what we think the year will end like, which is a deficit like that, although that has improved a bit recently. We are still going to present the 2018 budget treating certain things that happened this year as an unusual occurrence (i.e., inpatient stays) and thinking 2018 is not going to look quite like 2017.

LUND: So we are on budget for zero, and we are going to have revenues and expenditures roughly the same.

PRITZL: Between property taxes, revenue we can earn, public charges…that is how it is constructed. It is not a lot of wiggle room. Any variance – even a 1% budget variance – is a significant amount. So if we are off by 10 institutional placements, that is going to change everything.

ANDREWS: Since the county has put itself in a position regarding raising taxes in future years, might it be worth our while to clean up that CLTS waitlist now since the Governor might make us do it anyway? Just go ahead and do it since it is a good idea anyway not to have a waitlist?

PRITZL: So when the time comes to do that, we will need a small amount of levy to ramp Case Managers up to the point where they are 100% productive. There is a time from when you hire someone until they reach full productivity where we would need to cover training time. Counties are pushing the state hard to get money for that period of time. Once we get going, the revenue will offset the cost of the positions. The services themselves are funded through state and federal dollars.

ANDREWS: So we won't be in a bind if we try to do it?

PRITZL: No, we shouldn't be. We would do a budget adjustment that would say we are going to increase revenues this much, and increase expenses this much; those should be equal. But there is that intervening first period and we have looked at different ways to manage that so it isn't as much of an impact, but we would probably have a small amount

LUND: And with Family Care, the next two years should be lower, right?

PRTIZL: So another $600,000 decrease in 2019.

WEININGER: Then it goes down $300,000 in 2020

ANDREWS: I hate waitlists.

LUND: But it is all prioritized, right?

ANDREWS: If someone out there needs something and they have to wait to get it, what happens to them in between now and then?

LUND: It is prioritized by need, right?

PRITZL: They are supposed to have a priority policy. That is the expectation with those programs. We have waitlists in a couple areas of the department.

LUND: I think you are always going to have a waitlist; even if you are fully staffed. You are always going to have some kind of waitlist. Look at the veterans and their care; that's horrible. If you have cancer, you shouldn't be on a waitlist.

PRITZL: At the CTC we are exploring having other counties use our facility. The hospital is not really an option right now. We are serving Brown County residents – over 80% of those at NPC are Brown County residents. The CBRF is where we could do some emergency protective placements; how do we potentially open that door to other counties. We would need to be sensitive to how much do we know about that person, how much risk are we taking on by having that person in our facility – both from a cost and safety perspective. We are going to do targeted outreach to specific counties. We met with one county that is very interested and already wanting to sign a contract. We would work primarily with smaller counties who don't necessarily have the resources.

LUND: So you are looking at the northern and eastern counties?

PRITZL: Door, Kewaunee, Oconto… We do believe we will get some of those placements going in 2018.

LUND: We have some synergies in Shawano County.

JOHNSON: Those other counties are clearly comfortable paying us our full costs including administrative costs.

LUND: Because they don't want to do brick and mortar.

JOHNSON: The alternatives are less costly.

LUND: Once you do brick and mortar then you have set costs; you have to provide staff even if you don't have enough people to utilize it.

CLANCY: Erik, would you comment on your Crisis Center. How it is improving?

PRITZL: It is improving. We are hitting our benchmarks. Our benchmark was 80% or more of the contacts are made within 30 minutes of the call. I know they are getting out and doing mobile assessments. In the past two months, we have gotten in all Emergency departments now; previously they did not have access in all Emergency Departments. We are seeing more contacts outside of Crisis Center. We are still seeing crisis contacts at the Crisis Center, but there is an increase and are seeing people at different locations. Emergency detentions are still high, but people are getting assessed, and they are getting assessed outside the Crisis Center.

LINSSEN: With the Children, Youth and Family Services expenditures, if you don't have the answers tonight, would you be willing to get those for us? When you are talking about a $1.5M reduction in expenditures, I would be curious to know where we are getting those cuts specifically.

PRITZL: Because these charts are collapsing, I need to look at where those are specifically being identified. Yes, we will get that for you.

HYLAND / ANDREWS moved to approve and place on file.
Motion was carried unanimously.

9. Discussion and Approval of Amended By-Laws of Medical Staff of Brown County Community Treatment Center:

Copies of the Amended By-Laws were distributed, and Luke Schubert, Hospital & Nursing Home Administrator, provided information.

We made some updates to the by-laws and they were approved at the Medical Staff meeting this month, and needed to move forward to the governing body here.

PRITZL: We handed out “clean” copies of the by-laws, Luke and I have marked up versions of the by-laws showing the changes if you’d like to look at them. It would be very confusing if you saw some of the marked up pieces.

LUND: This is the first approval of this policy.

PRITZL: The Board signed off on a few changes last month, but now there are substantial changes

SCHUBERT: I will walk through the highlighted changes:

The first three pages of definitions – beyond grammatical changes -- the big changes are in philosophy making sure to point out the Clinical Director directs and oversees ultimately all the care that happens on the unit. There are other consulting physicians and nurse practitioners that will care for a patient, but in the by-laws it should reflect that the Clinical Director ultimately oversees anyone else that provides care and services to residents on the psychiatric hospital. Along those same lines, #5, the Medical Director works as an assistant to the Clinical Director in overseeing medical services, but underneath the Clinical Director’s guidance.

Another change is the title of Associate Clinical Director. The area where we were cited for non-compliance by CMS is that our by-laws did not speak to how the Clinical Director would get appointed and credentialed and an appeal made to his decisions because the Clinical Director is the person primarily involved in the appointment process of a physician. But how do you appoint the appointer? They wanted to see the loop closed for that individual and language added showing the Associate Clinical Director will be appointed for those situations that act as the role of the Clinical Director in the Clinical Director’s absence.

Mid-Level Practitioner – adding a definition as to what a mid-level nurse practitioner and physician assistant can do with prescribing medications without the consent of a medical doctor. This has changed over time, so we needed to reflect it in our by-laws.

There have been other general definition updates on the first three pages, but these three were the most substantial changes.

Some language updates are done throughout to be sure we caught any grammatical to make this document as well constructed as possible.

PRITZL: The categories of Medical Staff on Page 7, is another place changes were made. We eliminated what was the honorary title of medical staff and better defined Active Medical Staff and Courtesy/On-Call Medical Staff. We had a title there that was used infrequently which could cause some confusion, so it was removed.

ANDREWS: Will this make CMS happy?

LUND: This is based on what the recommendations were.

SCHUBERT: The regulatory issue was really the Clinical Directors appointment and evaluation, that there’s a check and balance of appointing and monitoring that individual’s performance from a medical staff point.

PRITZL: Clinical Director understands that he/she is responsible for all services. So how we had this constructed and how it was playing out operationally, we had a Clinical Director and a Medical Director, and the Medical Director took care of all medical issues, and the Clinical Director handled the psychiatric issues. That was not what the CMS wanted to see. It was confusing.

LUND: They wanted someone who was in charge of the whole deal and then a second in command.

PRITZL: A psychiatrist is a MD. In their view, they are responsible for all of the care. So that was cleaned up, and then making sure it was clear what the governing body

function is, which is this body here (Human Services Board). We had transitioned from an individual governing body to this governing body last time. They just wanted to be sure there was some clarity in those areaa. And we will talk later about how someone from this body should be part of the Medical Staff Committee too.

CLANCY: An observation… any chance of them coming here and firing us?

PRITZL: No. But it was interesting as they asked who was on our governing body. Describe them. What types of experience do they have? So there were questions in the interview that Luke and I had about that. I don't think it is outside the realm of possibility that the person who is appointed from this group to attend the Medical Staff Committee and Quality Assurance (at this point Carole Andrews) that they wouldn't want to interview you at some point. Or potentially you (Tom Lund) as the governing board chair. I don't see that happening at their re-visit, but maybe during the next survey.

LUND: In appointments, I think we need to look for a user of services. We always had people in the past, and also if we had somebody that was a provider of services in the future, but somebody that wouldn't have a conflict of interest with the County would be good to beef up our level of knowledge. I think statutorily we are supposed to have somebody who is a past user of services.

PRITZL: I think you are supposed to have a consumer.

ANDREWS / HUXFORD moved to approve and place on file.
Motion was carried unanimously.

10. Discussion and Approval of Community Treatment Center Grievance Policy:
Copies of the Community Treatment Center Grievance Policy were distributed.

Schubert said this was another area pointed out in our CMS inspection. The actual citation was because the policy didn't have the wording that the average grievance would be responded to in seven (7) days or less. This prompted to look at the whole system around CMS guidelines for grievance policy and procedures. I noticed some other things that were not investigated or pointed out, but proactively should have in place.

I took the time to make this policy a bit more extensive to our process. On Page 3, the part under citation -- Resolution, Number 1 -- "The Facility will strive for prompt resolution outcome for all grievances or complaints rendered. Grievances are expected to be resolved within 7 days of the date filed." And that if the time needed to be extended, we would have valid grounds for the extension and would document that within our grievance procedures. This is the main part of this policy change.

I also added at the end, Page 4, Item C – Quality Assurance that we want to review, track, trend and analyze grievances, and we would discuss the patterns and take actions as needed.

CLANCY / HYLAND moved to approve and place on file.
Motion was carried unanimously.

11. Discussion and Approval of Community Treatment Center Grievance Committee Policy:
Copies of the Community Treatment Center Grievance Committee Policy were distributed.

Schubert said this was not a citation area, but after looking at the guidance on grievance from CMS, it speaks to evidence that the governing body either is involved in resolving grievances within 7 days or we appoint a committee that is responsible on your behalf to come to resolution within 7 days. Because this Board does not meet on a frequency that would allow grievances to be resolved within 7 days, I would suggest you would consider approving a committee to do this on behalf of the Human Services Board.

In talking with Erik Pritzl, it would be important that the appointed committee membership would include individuals directly involved with the operation, but also members outside of it to be sure the integrity of the process review is upheld.

Individuals we thought could be on the committee would be Director of Nursing for the Hospital (Amanda Woodward), myself (Hospital and Nursing Home Administrator, Luke Schubert), Health Information Manager (Dawn LaPlant) who is outside of a direct care role for where grievances are coming, and then a Community Services representative who is someone outside of the inpatient area and could come sit in on the grievance reviews that is not connected to the service in any way. It could be Outpatient Services Manager, Erik Pritzl, Nancy Fennema…

LUND: How often do you have these grievances?

SCHUBERT: We have not had what I would call a high frequency or number of grievances; on average maybe 1-2 per month. I am still bringing the grievance summary on my report here for trends, but it is just gathering the committee. Say someone files a grievance on a Friday and the Client Rights Specialist that would do the investigation works Monday-Friday, if they come in on Monday, they are already on day 3 of following up on the grievance and someone may have already been discharged, so they need to track them down, track the staff that was working down, sometimes it might take 5 days to gather information, and then you only have 48 hours to pull a group together to review medical records, the Clients Rights report, and look at all that information to determine a decision and then get back in touch and issue a letter to the person who filed the grievance. Sometimes it is a tight timeframe.

LUND: I'm just thinking about the County's liability on the grievance procedure. If all the members work for the County, it is going to maybe look like a "stacked deck." I'm wondering if maybe an elected official would be less biased toward the County or if there is some other way of doing this that you would have somebody who works for the City of Green Bay, and they could use a County worker on their grievance procedures. Someone who wouldn't be under the payroll of the County as that third member; just so that it shows it is not all County employees who are deciding the grievance. I'm not saying that they (County employees) wouldn't be fair, I'm saying that the look/integrity of the process would look better if we could use others. What do you think, Chad? You do that with employee grievances.

WEININGER: We do it internal, but then they can go to an outside. We do exchange it with the City of Green Bay once in a great while. We use a number of other people, that person makes the final decision.

ANDREWS: Would it be more useful to do it with someone from another psychiatric facility in the city; where we could even send someone to their grievance committee. They would know what good practice is and what is not.

LUND: That is a really great idea, Carole. Maybe Bellin? We have a very good relationship with Bellin.

PRITZL: And they might have a need for us to help them too. It has never been brought up to us before.

LUND: Can we hold this?

SCHUBERT: Yes, this was not an area that was cited. I was reading the code and realized we don't have this.

LUND: Let's hold on this, and send it back to staff for revision.

LINSSEN / ANDREWS moved to send back to staff for revision to be addressed again in one month. Motion was carried unanimously.

14. Statistical Reports:
Please refer to the packet which includes this information.

HUXFORD / ANDREWS moved to receive and place on file.
Motion was carried unanimously.

15. Request for New Non-Continuous Provider & New Provider Contract:
Please refer to the packet which includes this information.

ANDREWS / CLANCY moved to receive and place on file.
Motion was carried unanimously.

16. Other Matters:
Executive Director, Erik Pritzl brought the need for a member from the governing body – the Human Services Board -- to serve on the bi-monthly Medical Staff Committee at the CTC. It would be beneficial if the same Board member served on the QAPI committee. A formal appointment will be made at the September board meeting.

Next Meeting: Thursday, September 14, 2017 at 5:15 p.m.
Brown County Community Treatment Center
3150 Gershwin Drive;
Green Bay, WI 54311

17. Adjourn Business Meeting:
ANDREWS / HYLAND moved to adjourn.
Motion passed unanimously.
Chairman Lund adjourned the meeting at 6:21 p.m.

Respectfully Submitted,
Catherine Foss, Office Manager