# COUNTY OF MILWAUKEE

Inter-Office Communication

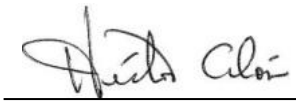
DATE: July 2, 2013

TO: Supervisor Peggy Romo-West, Chairwoman – Health & Human Needs Committee

FROM: Héctor Colón, Director – Department of Health and Human Services

SUBJECT: **From the Director, Department of Health and Human Services, submitting information relating to the termination of the Community Advocates North Side Crisis Resource Center contract**

Attached, please find information for the July 8, 2013 Special Health and Human Needs Committee meeting relating to the termination of the Community Advocates North Side Crisis Resource Center contract.



Héctor Colón, Director
Department of Health and Human Services

attachments

- December 12 & 13, 2012-first audit completed at Community Advocates (C.A.) North Side Crisis Resource Center (CRC).
- January 10, 2013-Letter to C.A. informing them of the results of the audit and informing them that they needed to complete a correction action plan (CAP) and submit this plan within 45 days.
- February 10, 2013-C.A. submits **first** version of CAP.
- March 1, 2013-Letter to C.A. informing them that "the decision not to accept your agency's Correction Action Plan due to lack of specificity and, return it to you for further development".
- March 8, 2013-C.A. submits a revised CAP **(second attempt).**
- March 25, 2013-Letter to C.A. informing them that "At this time, your submission will not be fully accepted, as there are areas within your agency's plan that need further clarification and development".
- April 9, 2013-C.A. submits "response to the Milwaukee County review of Amended Corrective Action Plan" **(third attempt).**
- April 11, 2013-BHD and C.A. leadership meet to discuss their third CAP and give verbal direction/information as to what is needed to be able to accept the CAP.
- May 2, 2013-C.A. submits "revised correction action plan" **(fourth attempt).**
- May 23, 2013-Letter to CA. informing that "we will accept the plan in its entirety" **(fourth version).**
- May 29, 2013-Second audit completed at C.A.'s north side CRC.

Please note that between the audits, letters, and versions of the plan of correction, there were additional working meetings between BHD and C.A. to assist them in fulfilling the requirements of DHS 34.

DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION

# Milwaukee County

HÉCTOR COLÓN • Director
KATHIE EILERS • Interim Division Administrator

June 13, 2013

Joe Volk, Chief Executive Officer
Community Advocates
728 N. James Lovell St.
Milwaukee, WI 53233

RE: Discontinuation of Purchase of Service Contract for 2013

Dear Mr. Volk:

After considerable review and careful consideration, it is the decision of the Milwaukee County, Department of Health and Human Services, Behavioral Health Division (BHD) that its current Purchase of Service Contract with Community Advocates for the Crisis Resource Center North, will be terminated as of Midnight, Monday, July 15, 2013. This decision was made based upon Community Advocates' continued non-compliance and adherence to DHS 34 requirements and the recent audit findings that demonstrated the agency's failure to comply with the corrective action plan submitted to BHD.

Per the terms of your 2013 Purchase of Service Contract with the Department:

> ***SCOPE OF SERVICES***
>
> Contractor shall specifically perform all of the services and achieve the objectives as set forth in its application submitted to County, and as indicated in the Attachment I, Schedule of Services to be Purchased. The *Milwaukee County Department of Health and Human Services Year 2013 Purchase of Service Guidelines - Program* and *Technical Requirements, the provisions of Contractor's proposal,* and the *Milwaukee County Department of Health and Human Services Administrative Probation Policy for Noncompliance with Contract and Fee-for-Service Requirements,* are incorporated herein by reference and made a part of this Contract as if physically attached hereto and Contractor shall comply therewith.

In December of 2012 and May of 2013, the Milwaukee County Behavioral Health Division's Community Services Branch and Crisis Services conducted audits of your agency's consumer and personnel files and policies and procedures to ensure compliance and adherence to DHS 34. The results of these audits show your agency's continued deficiencies in being compliant.

Per the terms of your 2013 Purchase of Service Contract with the Department:

> ***TERMINATION***
>
> Contractor may have any or all Agreements with County terminated for cause for commission of, but not limited to, the following offenses: Commission of Fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing under a contract or agreement with DHHS; violation of federal or state antitrust statutes; commission of embezzlement, theft, forgery or bribery; falsification or destruction of records including, but not limited to, case records, financial records, or billing records; making false statements; receiving stolen property;

engaging in conduct or practices that endanger the health or safety of participants/families; failure to comply/cooperate with DHHS Quality Assurance Site Reviews or audits; failure to permit access to or provide documents and records requested by the DHHS; failure to correct findings or other conditions identified in a Quality Assurance Site Review, County audit or annual independent audit; any other breaches of this Agreement.

This contract may be terminated thirty (30) days following written notice by County for any reason, with or without cause, unless an earlier date is determined by County to be essential to the safety and well-being of the clients and patients covered by this Contract with the exception of those facilities which must meet the notification requirements as applicable in Chapter 50 licensing. Termination shall not release the Contractor of its obligation to complete treatment of Participants receiving treatment until transfer of the Participant/Service Recipient can be accomplished for which County shall pay for Covered Services as provided. Failure to maintain in good standing required licenses, permits and/or certifications, may, at the option of the County, result in immediate termination of this contract. Failure to comply with any part of this Contract may be considered cause for early termination by the offended party.

On June 4, 2013, the Milwaukee County Behavioral Health Division received a letter from Community Advocates indicating that if Milwaukee County wishes to transition the Crisis Resource Center contract to another agency, Community Advocates would be willing to assist in that transition to ensure seamless service delivery. BHD staff will begin working immediately with Community Advocates to initiate the transition of services. Further decision will be conveyed to key staff within your agency on the next steps regarding this transition of care.

Sincerely,

Kathie Eilers

Kathie Eilers
Interim Division Administrator

cc: Hector Colon, DHHS Director
Amy Lorenz, BHD Crisis Director
Susan Gadacz, BHD,CSB Director

# *Community Advocates*
# *North Side Crisis Resource Center – Crisis Stabilization Audit Report*
# *For May 29, 2013*
# *9 Client Records Reviewed*

The North Side Crisis Resource Center audit comprised of reviewing the contents of client records, the agency's policy and procedures, and personnel files. The Behavioral Health Division (BHD) Quality Assurance Audit Team members included Beth Collier, Melody Joiner, and Amy Lorenz.

**CLIENT RECORD REVIEW:**

To complete this audit, the BHD Quality Assurance staff referred to DHS 34 of the State of Wisconsin– Emergency Mental Health Service Programs. A total of 9 client records were reviewed at the North Side Crisis Resource Center on May 29, 2013. Each client record is expected to have an assessment, a crisis plan, a response plan, and service notes as required in DHS 34. The client's assessment indicates that it is medically necessary for the client to be in crisis stabilization and is signed by a licensed treatment professional. A crisis plan is defined as a plan prepared under s. DHS 34.23 (7) for an individual at high risk of experiencing a mental health crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the person's individual service needs. The response plan is defined as the plan of action developed by program staff under DHS 34.23 (5) (a) to assist a person experiencing a mental health crisis. Service notes need to meet the requirements as outlined in DHS 34.23 (8).

| Crisis Plan | Yes | No | N/A * |
|---|---|---|---|
| 1. Includes name, address, and phone number of the case manager. (If any) | 56% (5) | | 44% (4) |
| Comments: | | | |
| 2. Includes the address and phone number where the person currently lives and the names of the individuals with whom the client is living. | 44% (4) | | 56% (5) |
| Comments: N/A clients were homeless prior to admission | | | |
| 3. Includes the usual work, school, or activity schedule followed by the client. | 100% (9) | | |
| Comments: | | | |

| | | | |
|---|---|---|---|
| 4. Includes a description of the client's strength's, needs, and important people or things in the client's life. | 89% (8) | 11% (1) | |
| Comments: | | | |
| 5. Includes the names and addresses of the person's medical and mental health service providers. | 78% (7) | | 22% (2) |
| Comments: N/A indicates client's that do not have medical or mental health providers | | | |
| 6. Includes regularly updated information about previous mental health services provided to the client. | 56% (5) | 22% (2) | 22% (2) |
| Comments: N/A indicates client's that did not have previous mental health services | | | |
| 7. Includes the client's diagnosis and any medications the client is receiving and the physician prescribing them. | 78% (7) | 22% (2) | |
| Comments: | | | |
| 8. Includes specific concerns that the person or persons providing support to the client may have about situations in which it is possible or likely that the client would experience a crisis. | 33% (3) | 67% (6) | |
| Comments: | | | |
| 9. Includes a description of strategies which should be considered by program staff when the client is experiencing distress, to help de-escalate inappropriate behaviors, or when responding to situations in which the client or others are at risk. | 100% (9) | | |
| Comments: | | | |
| 10. Includes a list of individuals who may be able to assist the client in the event of a mental health crisis. | 100% (9) | | |
| Comments: | | | |
| 11. Includes approval by a licensed treatment professional as being medically necessary as evidenced by a signature. | 100% (9) | | |
| Comments: | | | |
| 12. Crisis plan is reviewed and modified as necessary, but at least once every 6 months. | | | 100% (9) |
| Comments: | | | |
| 13. Crisis plan entered into the electronic health record. | | 100% (9) | |
| Comments: | | | |
| Service Notes | Yes | No | N/A * |
| 1. Content of service note indicates the time, place, and nature of the contact and the person initiating the contact. | 89% (8) | 11% (1) | |
| Comments: | | | |

| | | | |
|---|---|---|---|
| 2. Content of service note identifies the person seeking a referral for emergency mental health services and describes the crisis. | 44% (4) | 56% (5) | |
| Comments: | | | |
| 3. Content of service notes identifies the staff person(s) and any non-staff person(s) present or involved. | 89% (8) | 11% (1) | |
| Comments: | | | |
| 4. Content of service note contains an assessment of the client's need for emergency mental health services and the response plan developed. | 22% (2) | 78% (7) | |
| Comments: | | | |
| 5. Content of service note contains the emergency mental health services provided to the client and the outcome achieved. | 33% (3) | 67% (6) | |
| Comments: | | | |
| 6. Content of service note identifies any provider, agency, or individual to whom a referral was made on behalf of the client. | 56% (5) | | 44% (4) |
| Comments: N/A indicates that no referrals were made on behalf of the client | | | |
| 7. Content of service note includes any follow-up and linkage services provided on behalf of the client. | 56% (5) | | 44% (4) |
| Comments: | | | |
| 8. Content of service note includes any proposed amendments to the client's crisis plan. | | 100% (9) | |
| Comments: | | | |
| 9. Daily service notes are present in client's chart documenting contacts. | 33% (3) | 67% (6) | |
| Comments: | | | |
| 10. The DAP format is utilized for service notes entered into the electronic health record. | | 100% (9) | |
| Comments: The corrective action plan dated 3/8/2013 indicated that the electronic health record would not allow an individual entering the note to skip any necessary fields including the fields related specifically to the DAP service note. Review of the notes in the electronic health record indicates that this is not the case. | | | |
| 11. Service notes will include the results of clinical tests (i.e. Beck Depression inventory, MMSE, etc.) including the results of the test, relationship to the treatment plan, and the individuals' response. | | 100% (9) | |
| Comments: | | | |

| Response Plan | Yes | No | N/A * |
|---|---|---|---|
| 1. Includes services and referrals necessary to reduce or eliminate the client's immediate distress and that helps the client return to a safe and more stable level of functioning. | 44% (4) | 56% (5) | |
| Comments: | | | |
| 2. Includes de-escalation techniques to use for the present crisis. | 78% (7) | 22% (2) | |
| Comments: | | | |
| 3. Has been approved as medically necessary by a licensed treatment professional either before services are rendered or within 14 days after delivery of services as evidenced by a signature. | 100% (9) | | |
| Comments: | | | |

| General Indicators | Yes | No | N/A * |
|---|---|---|---|
| 1. Evidence of weekly reviews to support ongoing crisis stabilization services that include all of the following:<br>• Continued risk of self-harm<br>• Continued risk of harm to others<br>• Impaired functioning due to hx of a mood or thought disorder<br>• Recent failure of less restrictive options<br>• Lack of available/effective supports to maintain functioning and safety<br>• Need for intensive monitoring<br>• Recent history of the above that supports the belief that if supports are withdrawn, the risk for a more restrictive setting would be imminent | 22% (2) | 67% (6) | 11% (1) |
| Comments:<br>• N/A applies to a client that had been in services less than one week | | | |
| 2. Assessment of client is in file that indicates that it is medically necessary for client to be in crisis stabilization services and person completing assessment and a licensed treatment professional agrees that crisis stabilization services are medically necessary signs assessment. | | 89% (8) | 11% (1) |
| Comments:<br>• N/A applies to a client that appeared to have been admitted late the day before | | | |
| 3. Are any peer support services identified in the client's file? | 89% (8) | | 11% (1) |

| | | | |
|---|---|---|---|
| Comments:<br>• N/A applies to a client that appeared to have been admitted late the day before | | | |
| 4. MMSE in file and completed | 100% (9) | | |
| 5. Beck Depression Inventory in file and completed | 100% (9) | | |
| 6. Suicide Risk Assessment in file and completed daily | 33% (3) | 67% (6) | |
| 7. WRAP is completed once the clinician assesses the client and the Crisis Plan is completed. | | 100% (9) | |

**AUDITS**

The corrective action plan submitted on May 2, 2013 stated that Community Advocates would be completing internal audits in regard to services provided and documentation. Of the 9 client files reviewed:

- **None had documentation that the Program Director randomly audited 5% of service notes on a weekly basis.**
- **None had documentation that an audit of the CA ECHO system was completed daily to ensure completion of intake, assessment, and daily clinical notes.**
- **None had documentation that the clinical supervisor and/or the program director reviewed the content of clinical/service notes.**
- **None had documentation that the clinical supervisor had reviewed the crisis plan for the need for continued services or appropriate referrals.**

During the review Latrice Buck-Hogan indicated that a Client Support Staff person reviews the files in the evening and then an email is sent out indicating what is missing from the charts. This email is then followed up on by another support staff person that creates a spreadsheet of what is missing. This spreadsheet only indicates if something is in the file and not the quality and does not include whether it was reviewed by the clinical supervisor or the program director. Latrice indicated that she is shown the spreadsheet "but does not fully understand what she is looking at" and then initials a form. Latrice was unable to produce this form during the audit and she indicated that she does not review the files as was indicated on the corrective action plan submitted May 2, 2013.

**PERSONNEL FILES**

The personnel records for the North side Crisis Resource Center were reviewed at the time of the agency audit. Julie Murdock, General Operations Manager, delivered the personnel files to the

audit location, as the files are stored at their administrative offices. The supplied personnel files were reviewed for caregiver background information, licensure, education, and training requirements.

***CAREGIVER BACKGROUND INFO:***

As specified in the Fee-For-Service-Agreement and the SAIL Quality Assurance General Requirements, the agency must ensure that all required Caregiver Background Checks are completed on all personnel prior to the provision of services. Three documents are required to be completed on all personnel at the time of hire and a minimum of once every four years: 1) The Background Information Disclosure Form, 2) The Department of Justice Crime Information Bureau Report, 3) The Department of Health and Family Services/Response to Caregiver Background Check letter. These documents must be included in each employee's personnel file. In the event that an employee has resided outside the state of Wisconsin within the last three years, other background clearings are required. All staff information was reviewed for the required Caregiver Background Information. Of the 21 personnel files reviewed:

- 17 of the files contained all required documents
- 2 of the files were missing at least 1 of the required documents.
- 2 of the files needed the staff member's alias to be run for the Caregiver Background Check/Crime Information Bureau Report.

***LICENSURE:***

As required by DHS 34.21 (3), clinical staff is required to have appropriate licensure for their role within the agency. Of the 8 clinical staff personnel files reviewed:

- 1 did not have the required proof of licensure (either DSPS print out or a copy of the actual license.)
- There is no medical director (either a M.D. or D.O.) employed to provide supervision to nursing staff.

***EDUCATION:***

As required by DHS 34.21, personnel are required to have the appropriate level of education for their role within the agency. Of the 21 personnel files reviewed:

- Only 4 files had proof of education. Unofficial transcripts do not meet the requirements.

***TRAINING REQUIREMENTS:***

As required by DHS 34.21 (8), personnel is required to receive either 20 or 40 hours of orientation training as determined by their previous experience providing emergency health services. Of the 21 personnel files reviewed

- Only 13 of the files had proof of orientation training.

Community advocates indicated in the corrective action plan submitted on May 2, 2013 that all CRC employees were oriented and trained on the Crisis and Response Plan form on January 11, 2013. The corrective action plan stated that all CRC employees trained signed an acknowledgement form and that the forms were kept in the personnel file. Of the 21 personnel files reviewed:

- **None contained an acknowledgement form regarding Crisis & Response Plans**

***CLINICAL SUPERVISION***

As required by DHS 34.21 (7) clinical supervision is to be provided to all staff dependent upon their credential and position for their role within the agency.

- Clinical supervision logs that were provided at the time of the audit were not dated and could not be matched to listings of clients that were provided as being "staffed" on particular dates.
- As required by Community Advocates P&P for Clinical Supervision a case note is to be written for all supervision and treatment reviews. These were not present in the 9 client files reviewed.

**POLICIES AND PROCEDURES**

The policies and procedures for the North side Crisis Resource Center were reviewed after the agency audit on ~~December 12 and 13th 2012~~ 5/29/2013. The audit team, consisting of Amy Lorenz, Beth Collier, and Melody Joiner, arrived at the North Side CRC at 0800 on that day and requested all needed materials required for audit be provided to the audit team for review. The policy and procedures were not produced at that time.

At 0845, a large document was printed in the room in which the audit team was stationed. When Client Support Staff (CSS), Betty, came in to collect the document, Amy Lorenz saw the first page of the document, which was the Northside Crisis Resource Center Policy and Procedures Manual (non-draft version).

At approximately 0915, Amy Lorenz approached the staff office and requested the CRC policy and procedure manual from CSS, Betty and Katherine. CSS Betty did not respond and went to the office of Program Manager, LaTrice Buck-Hogan. CSS Katherine did attempt to locate the P&P manual. She searched several drawers and areas within the office but could not locate the manual.

Amy Lorenz then went to the office of LaTrice Buck-Hogan to inquire about the P&P manual. Todd Campbell, Clinical Supervisor, was also present in the office for the discussion regarding the P&P's. LaTrice reported that the P&P manual could not be located. She reported that CRC staff is diligently looking for it. At that time, she also stated that the P&P manual the staff have and are reviewing/utilizing contains the last draft version of the P&P. Per LaTrice, the manual does not contain the latest revised non-draft version.

At approximately 1110, LaTrice gave a purple binder containing the CRC policies and procedures to Beth Collier. She reported that a nurse had the manual and had been working on it. It should be noted that this binder contained a non-draft version of the policies and procedures, which contradicts what was reported earlier that morning. This policy and procedure manual is what was reviewed for the purposes of the audit.

**According to the audit conducted on December 12th and 13th, 2012:**

**Ten policies and procedures are in need of being created to reflect DHS 34.23(2)-DHS 34.22(4)(3); DHS 34.23(2) a, b, d, e, g, h, l and k, DHS 34.21(7). Below is the outcome regarding the review of the requested policies and procedures.**

1. Delivery of Services-Accepted.
2. Clinical Supervision-Not accepted as there was no case notes in clients' files "for all supervision and treatment reviews" as per the P&P.

3. Determination of Need & Response Plan-Not Accepted. On 4/18/13, Amy Lorenz submitted recommended revisions to LaTrice Buck-Hogan regarding this P&P. Below are the specific recommendations that were made:
   a. "Individual is in need of emergency mental health services as evidenced by:" That is how the sentence in the P&P ends. It was recommended that a list be included/provided.
   b. "Interventions necessary to reduce to eliminate the individual's immediate distress". 4/18/13 recommendation to include "What are the interventions?"
   c. 4/18/13 recommendations that the P&P specifically:
      - "needs to state that the response plan is completed"
      - "How is the information from the assessed needs (emergency mental health needs) used for planning and implementing an appropriate response?"
   d. P&P states "Follow-up with the consumer in how she/he is following the WRAP Plan or if the WRAP Plan need to be revised". 4/18/13 recommendation was that if not all consumers are completing WRAP plans, this sentence needs to include something to the effect of "as appropriate/needed". During audit completed on 5/29/13, there was no evidence or reference in any client documentation that WRAP plans are being completed with clients as stated in this P&P.
4. Adaptive Communication-Not Accepted. As per DHS 34.23(2)(b), the P&P must also address how services will be delivered for individuals with a cognitive impairment. This was not included in the P&P. The recommendation on 4/18/13 specifically stated, "Also address for cognitive limitations".
5. Information Needed from Consumer Seeking Services-Accepted.
6. Type of Service to be Provided-Not Accepted. There is no P&P in the Northside CRC P&P Manual that addresses this requirement as per DHS 34.23(2)(d). On 4/18/13, it was recommended that this requirement needed to be met.

7. Referrals to Other Programs-Accepted.
8. Immediate Back-Up-Accepted.
9. Referrals, Backup, and Exchanging Information-Not Accepted. The P&P does not address two areas as required by DHS 34.23(2)(g): exchanging information with other mental health service providers and referencing the developmental of crisis plans for individuals who are at high risk for crisis. On 4/18/13, it was recommended that both of these requirements be included in this P&P.
10. Face-to-Face Response-Accepted.
11. Notification of Others-Accepted.
12. Medications-Not Accepted. The P&P does not address monitoring client's reaction to their medications as required in DHS 34.23(2)(j). On 4/18/13, it was recommended that this requirement by covered in this P&P.
13. Reporting Deaths-Accepted.

Other Deficiencies in the Northside CRC Policy & Procedure Manual:

1. Three policies and procedures (Referrals, Grievance, & Fire Evacuation Procedures) all listed attachments that were not in the P&P manual (see attached).
2. In the Admission Criteria for CRC Level of Care P&P, sexual assault is listed under the medical exclusion criteria.
3. The Collecting and Recording Client Satisfaction P&P is incomplete and contains sentences that are not even finished (see attached).
4. Policies and Procedures were only acknowledged as being received by 17 of the 21 staff on 4/1/2013. There was no other documentation to show that staff had been trained on the updated policies and procedures.

Elizabeth Collier, MSW
Quality Assurance Specialist

6/14/13
Date

Melody Joiner, M.S.
Quality Assurance Specialist

6/14/13
Date

Amy Lorenz, MSSW
Director of Crisis Services

6-14-13
Date