GOODHUE COUNTY MINNESOTA

TO EFFECTIVELY PROMOTE THE SAFETY, HEALTH, AND WELL-BEING OF OUR RESIDENTS

# GOODHUE COUNTY
# HEALTH & HUMAN SERVICES (GCHHS)
# AGENDA

**COUNTY BOARD ROOM**
**RED WING, MN**
**OCTOBER 16, 2018**
**10:30 A.M.**

1. CALL TO ORDER
2. REVIEW AND APPROVE BOARD MEETING AGENDA:
3. REVIEW AND APPROVE PREVIOUS MEETING MINUTES:
   a. September 2018 HHS Board Minutes

      Documents:

      SEPTEMBER 2018 HHS BOARD MINUTES.PDF
4. REVIEW AND APPROVE THE FOLLOWING ITEMS ON THE CONSENT AGENDA:
   a. Child Care Licensure Approvals

      Documents:

      CHILD CARE APPROVALS.PDF
5. INTRODUCTION OF NEW & PROMOTED STAFF
6. ACTION ITEMS:
   a. Accounts Payable

      Documents:

      ACCOUNTS PAYABLE SEPTEMBER.PDF

   b. Letter Of Support And MOU-Regional Mental Health Crisis Center

      Documents:

      LETTER OF SUPPORT AND MOU - REGIONAL MENTAL HEALTH CRISIS CENTER.PDF
      LETTER OF SUPPORT - DRAFT.PDF
      CRISIS CENTER MOU - DRAFT.PDF
      CREST REGIONAL CRISIS CENTER - MAIN CONCEPTS.PDF
      CREST REGIONAL CRISIS CENTER PP.PDF
7. INFORMATIONAL ITEMS:

a. Family Home Visting Grant Presentation
Brooke Hawkenson

Documents:

FH BOARD PRESENTATION 10-18.PDF
HFA IMPACT STATS ON COMMUNITIES, CHILDREN, AND FAMILIES.PDF

b. PPMRS-MDH Annual Report
Ruth Greenslade

Documents:

ANNUAL REPORT PRESENTATION.PDF
GOODHUE COUNTY REPORT.PDF

8. FYI-MONTHLY REPORTS:

a. Placement Report

Documents:

PLACEMENT REPORT.PDF

b. Child Protection Report

Documents:

CHILD PROTECTION REPORT SEPTEMBER 2018.PDF

9. ANNOUNCEMENTS/COMMENTS:

10. ADJOURN

a. Next Meeting Will Be November 20, 2018 At 10:30 A.M.

# GOODHUE COUNTY

## HEALTH & HUMAN SERVICES BOARD MEETING

## MINUTES OF SEPTEMBER 18, 2018

The Goodhue County Health and Human Services Board convened their regularly scheduled meeting at 10:50 A.M., Tuesday, September 18, 2018, in the Goodhue County Board Room located in Red Wing, Minnesota.

BOARD MEMBERS PRESENT:

Brad Anderson, Paul Drotos, Jason Majerus, Barney Nesseth, Nina Pagel and Susan Johnson.

STAFF AND OTHERS PRESENT:

Nina Arneson, Mary Heckman, Mike Zorn, Lisa Woodford, Abby Villaran, Jessica Seide, Jessica Schleck, various law enforcement agencies, Ruth Greenslade

AGENDA:

On a motion by J. Majerus and seconded by S. Johnson, the Board unanimously approved the September 18, 2018 Agenda.

MEETING MINUTES:

On a motion by J. Majerus and seconded by P. Drotos, the Board unanimously approved the Minutes of the H&HS Annual Board Meeting on July 2, 2018.

CONSENT AGENDA:

On a motion by J.Majerus and seconded by S. Johnson, the Board unanimously approved all items on the consent agenda.

ACTION ITEMS:

On a motion by P. Drotos and seconded by B. Nesseth, the Board unanimously approved payment of June accounts as presented.

On a motion by J. Majerus and seconded by P. Drotos, the Board unanimously approved payment of July accounts as presented.

On a motion by P. Drotos and seconded by B. Anderson, the Board unanimously approved payment of August accounts as presented.

On a motion by J. Majerus and seconded by N. Pagel, the Board unanimously approved the reclassification of Office Support Specialist to Case Aide.

INFORMATIONAL ITEMS:

Toward Zero Deaths (TZD) presentation by Jessica Seide and Jessica Schleck
DAANES Report given by Abby Villaran
Opioid Epidemic presented by Abby Villaran and Nina Arneson
2nd Quarter 2018 Fiscal Report given by Mike Zorn

FYI & REPORTS:

Placement Report
Child Protection Report
HHS Staffing Update
Trend Report
WIC Loving Support Award
MDH- Health Dept. issues Back-to-school warning on Nicotine and E-Cigarettes
MDH- Despite uptick MN's Adult Obesity Rate Growing Slower than Upper Midwest States

ANNOUNCEMENTS/COMMENTS:

2018 Community Health Conference- Creating Healthy Communities Brings Us Together
October 10-12, 2018 Brainerd, MN

ADJOURN:

On a motion by J. Majerus and seconded by N. Pagel, the Board unanimously approved adjournment of this session of the Health & Human Services Board Meeting at or around 12:00 pm.

**GOODHUE COUNTY**
**HEALTH & HUMAN SERVICES (HHS)**

# REQUEST FOR BOARD ACTION

| | | | |
|---|---|---|---|
| **Requested Board Date:** | October 16, 2018 | **Staff Lead:** | Kris Johnson |
| **Consent Agenda:** | ☒ Yes<br>☐ No | **Attachments:** | ☐ Yes<br>☒ No |
| **Action Requested:** | Approve Child Care Licensure Actions | | |

**BACKGROUND:**

**Child Care Relicensures**:

| | | | |
|---|---|---|---|
| Suzanne Gora | Red Wing | Fay Crouse | Kenyon |
| Holly Stoppel | Wanamingo | Sara Quinn | Wanamingo |
| Cherie Chaska | Red Wing | Wanda Feldman | Red Wing |
| Erin Lorenson | Lake City | Michelle Walters | Pine Island |
| Elizabeth Burt | Wanamingo | Karen Kieffer | Dennison |
| Wendy Rauk | Nerstrand | Jodie Peterson | Kenyon |
| Nicole Warner | Red Wing | Samantha McChristian | Red Wing |
| Susan Moechnig | Wanamingo | Nancy Fox | Cannon Falls |

United Lutheran Church- Adventures in Learning Preschool Red Wing

**Child Care Licensures:**

Kimberly Harvey Red Wing

Number of Licensed Family Child Care Homes: 84

**RECOMMENDATION:** Goodhue County HHS Department recommends approval of the above.

**GOODHUE COUNTY**
**HEALTH & HUMAN SERVICES (GCHHS)**

## REQUEST FOR BOARD ACTION

| | | | |
|---|---|---|---|
| **Requested Board Date:** | October 16, 2018 | **Staff Lead:** | Mike Zorn |
| **Consent Agenda:** | ☐ Yes<br>☒ No | **Attachments:** | ☐ Yes<br>☒ No |
| **Action Requested:** | Approve September 2018 HHS Warrant Registers | | |

**BACKGROUND:**
This is a summary of Goodhue County Health and Human Services Warrant Registers for September 2018:

| | Date of Warrant | | Check No. Series | | Total Batch |
|---|---|---|---|---|---|
| IFS | September 7, 2018 | ACH | 26161 | 26174 | $ 3,651.74 |
| IFS | September 7, 2018 | | 440515 | 440561 | $ 16,512.45 |
| IFS | September 14, 2018 | ACH | 26187 | 26195 | $ 3,410.70 |
| IFS | September 14, 2018 | | 440615 | 440663 | $ 34,984.22 |
| IFS | September 21, 2018 | ACH | 26222 | 26224 | $ 821.20 |
| IFS | September 21, 2018 | | 440777 | 440804 | $ 26,905.40 |
| IFS | September 28, 2018 | ACH | 26314 | 26319 | $ 1,731.65 |
| IFS | September 28, 2018 | | 440877 | 440977 | $ 25,161.06 |
| SSIS | September 28, 2018 | ACH | 26225 | 26250 | $ 73,550.43 |
| SSIS | September 28, 2018 | | 440805 | 440867 | $ 179,367.49 |
| IFS | September 28, 2018 | ACH | 26251 | 26313 | $ 35,831.19 |
| IFS | September 28, 2018 | | 440868 | 440876 | $ 30,251.01 |
| | | | | total | $432,178.54 |

**RECOMMENDATION:** Goodhue County HHS Recommends Approval as Presented.

**GOODHUE COUNTY**
**HEALTH & HUMAN SERVICES (GCHHS)**

# REQUEST FOR BOARD ACTION

| | | | |
|---|---|---|---|
| **Requested Board Date:** | 10/16/2018 | **Staff Lead:** | Nina Arneson |
| **Consent Agenda:** | ☐ Yes<br>☒ No | **Attachments:** | ☒ Yes<br>☐ No |
| **Action Requested:** | Consider approving and allowing execution of a Letter of Support for the Regional CREST Initiative with the understanding if approved, the MOU will be signed as the CREST region for the RFP application. | | |

**BACKGROUND:**
In 2018 the Minnesota Legislature approved $28.1 million in bond funds to the Department of Human Services to establish new regional mental health centers. This is something Goodhue County along with other Minnesota counties has seen as a great need and all 87 counties supported building and improving mental health services and availability around the state.

In Goodhue County, this included the Goodhue County Health and Human Services Board supporting a resolution for the support for this bond funding - https://www.co.goodhue.mn.us/AgendaCenter/ViewFile/Item/6209?fileID=13489 .

DHS has now issued a request for proposal (RFP) for these regional projects. Under the requirements established by the Legislature, applicants will be required to demonstrate a need for the proposed project, the capacity to sustain the program, and willingness to build on and integrate with the existing service continuum in the area they intend to serve.

Currently, and in the past several years, much work has taken place in our region and the following partners are ready to apply for the RFP and bring this much needed funding, added infrastructure and services to SE MN:

- Olmsted County
- Mayo Clinic
- Olmsted Medical Center
- CREST-Region 10 Counties
- UCare
- South Country Health Alliance
- NAMI of Southeast Minnesota
- Medica
- Blue Cross Blue Shield of Minnesota

The attached draft letter of support and MOU will involve a two phased approach, allowing partners to show the support for the application, and to agree to work and plan together but before moving forward further to Phase 2, each partner will have an opportunity to make final decisions.

Phase 1& 2:
Parties agree to work together, collaborate to plan and apply for the RFP issued by DHS for the bond funding to establish a new regional mental health crisis center in Southeast Minnesota, more than likely

on Olmsted County donated land in Rochester, MN. This includes providing necessary partnership, expertise, and resources to respond to the issued bonding RFP to construct a regional Crisis Center. This is with the understanding that in-kind and/or fiscal contributions to support the ongoing functions of the Crisis Center program would be expected of partners in Phase 2. (Note, for counties, the fiscal contribution will involve integrating currently separately operated a regional "mobile crisis" program with the Regional Crisis Mental Health Center.) The exact obligations for these contributions will be determined during Phase 1. Ongoing commitment will be contingent on the obtainment of bonding dollars to proceed with the build of the Regional Crisis Center, an ability to reach an agreement with each partner on any expected contributions and approval from respective boards.

The vision for the Regional Mental Health Crisis Center is to be operational during the year 2020.

- Draft Letter of Support – Regional Mental Health Crisis Center
- Draft MOU
- CREST Regional Crisis Center – Main Concepts
- Regional Crisis Mental Health Center PowerPoint

**RECOMMENDATION:** GCHHS recommends approval as requested.

# Letter of Support - DRAFT

Date

NAME
TITLE
AGENCY
ADDRESS

Dear DHS RFP Review Panel:

The AGENCY is pleased to offer its commitment to the CREST regional partners in support of its application for the state bonding funds to design, construct or rehabilitate, furnish facilities for regional behavioral health crisis centers.

We welcome this opportunity to promote the development of a Regional Crisis Center to support our mental health system and increase access to mental health services to those in need. We have long recognized the need across our communities to provide services to individuals experiencing mental health crises early in the recovery process. Individuals experiencing mental health symptoms struggle to get timely intervention due to overstretched providers with limited capacity to be reactive to acute needs. The puts added stress on other community partners.

The proposed Regional Crisis Center will increase our access to services to services by dedicating staff to individuals experiencing acute mental health symptoms. Through enhancing our mobile response system, engage early to coordinate mental health cares and offering rapid access appointments we hope to see improved outcomes for individuals with mental health symptoms and complex barriers.

This letter represents our commitment to support and collaborate with the CREST region and its partners in order to provide responsive crisis response services to individuals experiencing mental health crises. We acknowledge the need for a safe space for our individuals and families to go for support when in the midst of a crisis.

This is something that our county has supported for many years based on the needs we are seeing with Goodhue County residents and in our region. This included the Goodhue County Health and Human Services Board supporting a resolution for the support for this bond funding - https://www.co.goodhue.mn.us/AgendaCenter/ViewFile/Item/6209?fileID=13489

We urge DHS to provide funding for this important project. Now is indeed the time to support our mental health providers and increase access to services for those in need.

Sincerely,

Board Chair

**MEMORANDUM OF UNDERSTANDING**

**Regional Behavioral Health Crisis Program**

This Memorandum of Understanding ("MOU"), effective as of **the date last signed** ("Effective Date"), is by and between **Olmsted County ("Olmsted")**; **Mayo Clinic ("Mayo")**; **Olmsted Medical Center ("OMC"); CREST-Region 10 Counties** ("**CREST**"); **UCare; South Country Health Alliance ("SCHA"); NAMI of Southeast Minnesota (NAMI); Medica;** and **Blue Cross Blue Shield of Minnesota ("Blue Cross"). Olmsted, Mayo, OMC, CREST, UCare, Medica, SCHA, Blue Cross, and NAMI** may be referred to hereinafter individually as a "Party" and collectively as "Parties".

**BACKGROUND**

A. Blue Cross is a Minnesota corporation that is dedicated to providing quality, cost-effective health plans and unique health programs. Blue Cross works to advance policies that encourage affordable, high quality health care and support healthy communities for all Minnesotans, not just members.

B. UCare is a Minnesota corporation providing health coverage and services to Minnesotans across the state, with a mission to improve the health of their members through innovative services and partnerships across communities.

C. CREST is a Minnesota regional collaborative made up of ten County Human Services departments which works on identifying challenges, priorities, and solutions with a regional lens.

D. Olmsted County is a is a political subdivision of the State of Minnesota with a mission of partnering for the safety, well-being, and stability of children, families, and adults in Olmsted County.

E. Olmsted Medical Center is a Minnesota corporation with a mission of delivering exceptional patient care focusing on caring, quality, safety, and service. OMC's 160 clinicians join over 1,200 other healthcare professionals serving at 20 locations, including two multi-specialty clinics, a Level IV trauma hospital with 24-hour emergency room, two FastCare retail clinics in Rochester Shopko stores, two Acute Care clinics, a Skyway Clinic in downtown Rochester, and 11 community branch clinics.

F. Mayo Clinic is a Minnesota corporation contributing to health and well-being by providing the best care to every patient through integrated clinical practice, education and research. Mayo Clinic Health System is a network of clinics and hospitals serving more than 60 communities in Iowa, Minnesota, and Wisconsin. Mayo's community-based doctors and their patients are supported by the highly specialized expertise and resources of Mayo Clinic. This partnership is dedicated to providing quality health care close to home.

G. South Country Health Alliance is a Minnesota Corporation providing health coverage with a mission to empower and engage our members to be as healthy as they can be, build connections with local agencies and providers who deliver quality services, and be an accountable partner to the counties we serve.

H. Medica is a  Minnesota Corporation providing health services with a vision is to become the community's health plan of choice, trusted for its integrity, respected for its service, and admired for its commitment to innovation and efficiency.

The Parties desire to collaborate and combine their individual functions as determined by the agreed upon service delivery model necessary for a regionally responsive Behavioral Health Crisis Center Program.

The Parties to this MOU acknowledge and agree as follows:

**AGREEMENT**

1. **Purpose.**

The Parties agree to collaborate and combine their respective functions and resources to develop and support a Regional Behavioral Health Crisis Program ("Program") in order to achieve efficiencies, expand access to care, coordinate, improve the quality of essential mental health services, and strengthen the mental health care system as a whole in the region they serve.

Parties agree to collaborate in a two-phased process for the development of a Regional Crisis Center. Phase 1 includes providing necessary partnership, expertise, and resources to respond to the issued bonding RFP to construct a regional Crisis Center. Parties understands that in-kind and/or fiscal contributions to support the ongoing functions of the Crisis Center program would be expected of partners in Phase 2. The exact obligations for these contributions will be determined during Phase 1. Ongoing commitment will be contingent on the obtainment of bonding dollars to proceed with the build of the Regional Crisis Center, an ability to reach an agreement with each partner on any expected contributions and approval from respective boards.

**2. Governance.**

Behavioral Health Leadership Group.

To facilitate development of the Program, through this MOU the Parties hereby appoint a Behavioral Health Leadership Group, the purpose of which is to represent the Parties in discussions and negotiations regarding the Program and to recommend action to the Parties. The Behavioral Health Leadership Group shall not have authority to bind the Parties or any single Party to any obligation or course of action. The Behavioral Health Leadership Group comprises at least one representative each from Olmsted County, CREST, OMC, UCare, Blue Cross, SCHA, NAMI, Medica and Mayo. The Behavioral Health Leadership Group shall be facilitated by Brooke Carlson (North Sky Health Consulting) and shall determine its own internal operating procedures which will provide further detail on role, responsibilities, and expectations. The Behavioral Health Leadership Group shall automatically dissolve upon creation of the Program and its governing body.

Program Form.

The Parties agree the Crisis Center program may take any form legally authorized by Minnesota law, best designed to further the Program purpose, utilizing one or more agreements among the Parties depending upon each Party's statutory or other authority including, but not limited to, a joint venture or a Program created as an exercise of joint powers under MINN. STAT. § 471.59.

Management of the Crisis Center program.

Consistent with form, the Parties intend that the Program shall be governed by a governing body which ideally will include representation by all Program members and will operate according to organizational

bylaws approved by the governing body. The governing body shall be ultimately responsible for all financial and clinical decisions in conjunction with the selected service provider via Request for Proposals.

3. **Additional Goals and Responsibilities.** The Parties further agree they will endeavor to work together to:

- Develop, construct, furnish and equip a facility for the Crisis Center programming.
- Provide a continuum of crisis services including but not limited to screening, assessment, intervention, stabilization, peer-support, and care coordination services for persons with mental illness or co-occurring disorders.
- Develop evidence-based suicide prevention services and outreach methods for the Southeast Minnesota Region.
- Improve same day access to mental health assessments, resources, and treatment.
- Improve availability of inpatient services through earlier intervention and less restrictive recovery options.
- Support expanded, less restrictive mental health and co-occurring services at point and time of care.
- Strengthen the healthcare delivery model through developing infrastructure to expand capability to address social and behavioral needs in the community.
- Improve population and public program tracking and referral management without duplicated effort.
- Improve population mental health through integrated care.
- Improve patient engagement in decision making.
- Advance mutually agreeable community goals and strategies for the Crisis Center programming.
- Provide non-client specific data regarding needs and desired outcomes of the Crisis Center programming.

4. **Definitive Agreements.** The Parties agree to work in good faith to negotiate and prepare additional definitive agreements required to further the goals and purposes described in this MOU, including, without limitation, Program organizational bylaws and business associate agreements [as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")] and related agreements.

5. **Compliance.** Each Party has in place a compliance program or comparable policy ("Compliance Program"), the goal of which is to ensure that all federal, state, and local laws and regulations are followed. Each Party's Compliance Program includes a commitment to uphold a high standard of ethical and legal business practices to prevent misconduct. Through the implementation of this MOU, each Party acknowledges its commitment to corporate compliance and agrees to conduct all transactions which occur pursuant to this MOU in accordance with all applicable laws, rules, and regulations and with the underlying philosophy and objectives of each Party's Compliance Program. By signing this MOU, each Party represents and warrants that it is not, and has not been, excluded form participation in any federally or state funded healthcare programs, including Medicare and Medicaid. In the event a Party is excluded from participation in any federally of state funded healthcare program during the term of this MOU, that excluded Party agrees to notify all other Parties with in five (5) business days or less of the exclusion.

6. **Term and Termination.** This MOU shall continue in effect for one (1) year from the Effective Date, and shall automatically renew for successive one (1) year terms unless sooner terminated as set forth herein. Any Party may terminate this MOU at any time by giving the other Parties thirty (30) days prior written notice of such termination without dissolving the entire MOU.

The parties have executed this Memorandum of Understanding to be effective as of the Effective Date set forth above.

[Signature Page to follow]

**Contact Information**
Partner name:
Authorized partner representative:
Position:
Address:
Telephone:
E-mail

_____Date:
(Partner signature)
(Partner name, organization, position)

**CREST Regional Crisis Center – Main Concepts**
Dodge, Steele, Waseca, Olmsted, Goodhue, Wabasha, Fillmore, Winona, Mower, & Houston Counties.

In 2018, the Legislature passed bonding that allows for the development of crisis centers across the state of Minnesota. As a region, we viewed this as an opportunity to address our many gaps in the behavioral health service continuum of care. Through a collaborative approach by key organizations across the region, we developed a service model to divert individuals with mental health needs away from our Emergency Departments and Law Enforcement unless the need was truly an emergency. We focused on a patient-centered approach, with reactive services intended to the needs of each individual in their time of crisis.

**The problem worth solving**

- Our current mental health system has identified gaps and short comings that result in drastic outcomes for individuals facing behavioral health symptoms.
- 168 suicides were completed over the past 3 years across region 10.
- Emergency Departments and Law Enforcement agencies have become the first call for help by individuals facing mental health symptoms.
- Across the region, there are few alternative care settings resulting in inefficient utilization of Emergency Departments, inpatient units, and jails.
- The cost of the current inadequacies in services is felt across systems and seen in psychiatric boarding, commitment stays, child placements, and high medical costs.
- Youth and adults are currently transported out of their communities to receive stabilization care and mental health services.

**Proposed Solutions**

- A crisis response system that allows services to start at the point of need.
- A Crisis Center that accepts all individuals no matter the complexity of barriers and is able to work in an integrated manner to triage and provide services efficiently and effectively.
- A Crisis Center with a continuum of services starting with a warm and welcoming environment and equipped with necessary safety features.
- Recovery-oriented services connected to community care teams and services across the region.
- Creation of new services and space to offer more alternatives for our youth and families experiencing behavioral health symptoms.

**Building and Location**

- Crisis Center must be owned and operated by a governmental agency.
- Olmsted County has been open to ownership and identified a location on the county campus for the project.
- Olmsted County has the highest population and is relatively centrally located in the region.
- Mayo Clinic Emergency Department experiences the most behavioral health patients.
- Location is close to Olmsted Medical Center for any emergency medical needs.
- Location is close to local law enforcement for support as needed for client interactions.

**Impact**

- Earlier and more cost-effective interventions for high service utilizers living with chronic mental health conditions.
- Better integrated care system able to react with the appropriate level of care to individuals as they present in a time of need.
- Expanded crisis services to support individuals in crisis along and their caregivers to better aid in **sustainable recovery.**

- Fewer individuals completing suicides through early affordable access to evidence-based, effective services.

**Integration across systems**

- The key to success is commitment across community stakeholders and payers to oversee programmatic elements and financial sustainability.
- A more integrated system between our community mental health and medical systems allows for a common language surrounding mental health crises resulting in the appropriate level of care at the right time.
- Space available for Law Enforcement to get supported in working with individuals with mental health symptoms.
- Programming supports the mobile response system through offering aftercare resources, more robust staffing, psychiatric support, and rapid access to outpatient services.

**Data**

- Suicide Data
    - 2235 completed suicides in the past 3 years across the state of Minnesota
    - 168 completed suicides in our ten county Southeast Minnesota Region.
- Crisis Intervention Teams in Olmsted County
    - 865 CIT referrals in 2017 (Increasing from 677 CIT referrals in 2015)
    - 81% of these people were transported to the St. Mary's ED
    - Mental health professional review shows that around half of these could be served in the proposed Crisis Center avoiding hospital care
    - Olmsted is only 1 of 10 counties in the proposed service area
- 3rd Judicial District (includes Dodge, Fillmore, Freeborn, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Waseca, and Winona Counties)
    - More than 250 commitment cases in each of the past 3 years
- Mobile Crisis Teams in the ten county Southeast Minnesota Region.
    - 1797 phone calls to our current crisis line in 2017
    - 358 mobile team responses to community locations
- Youth Services
    - Currently 0 crisis stabilization units for youth outside of inpatient level of care

**Fiscal Highlights**

- Estimated $3 million in operations costs annually.
- Estimated $1.6 million in revenue annually.
- Children's residential stabilization units currently not a MA billable service
- No reimbursement for medical triage and nursing support
- In-kind support from Olmsted County through 1 FTE of a mental health professional and 16 hours of psychiatric support.

**Needed Support**

- Regional partners across systems to enter into a MOU for continued development of the project.
- Fiscal support above the billable services to best meet the needs of our clients.
- Per diem for counties for utilization of crisis units for youth of approximately $225
    - Working on this cost meeting the requirements for IV-E reimbursement
- County support for the mobile crisis program for expansion and support based on the need after grant is fully expended.
- For this project, the county support will be the counties' mobile crisis contribution which currently operated separately but will be integrated to the Crisis Center Services.

# CREST REGIONAL CRISIS CENTER

GCHHS

October 16, 2018

# BEHAVIORAL HEALTH ACCESS GROUP

- Who has been involved
  - Olmsted, Fillmore, Dodge, Steele, Waseca, Goodhue, Wabasha, Winona, Mower, and Houston Counties
  - Mayo Clinic
  - Olmsted Medical Center
  - Mental Health Providers
  - Local Law Enforcement
  - Managed Care Plans
- Identified gaps
  - Few services for individual experiencing mental health crises aside from Law Enforcement and Emergency Departments
  - Difficulty finding alternatives to inpatient beds causing utilization for individuals that could be potentially served in a safe community setting
  - No crisis stabilization bed options for youth

# POPULATION SERVED

- Our goal is to provide a no wrong door philosophy offering a continuum of services to anyone experiencing a mental health crisis and seeking help. This is inclusive of individuals of all ages, those living with mental illness, co-occurring disorders, substance use disorders, and cognitive challenges. There is no requirement of previous diagnoses, or history of mental health service utilization. Health insurance is not a requirement for seeking services. Our services may not be appropriate for everyone seeking help, but those in need of a different level of care will be connected with the appropriate service.
- DHS emphasizes a mental health crisis is defined by the individual experiencing the crisis

# POTENTIAL SERVICE USERS

- Individuals struggling to cope with a variety of mental health symptoms
  - Anxiety, Depression, Schizophrenia, etc.
- Suicidal ideations
- Parents of youth/children experiencing dysregulated mood
- Service bridging due to limited providers
- Individuals unable to cope with life's stressors
  - Relationships, Housing, Grief, etc.
- Referrals from outpatient providers, schools, county social workers, CTSS/ARMHS, etc.

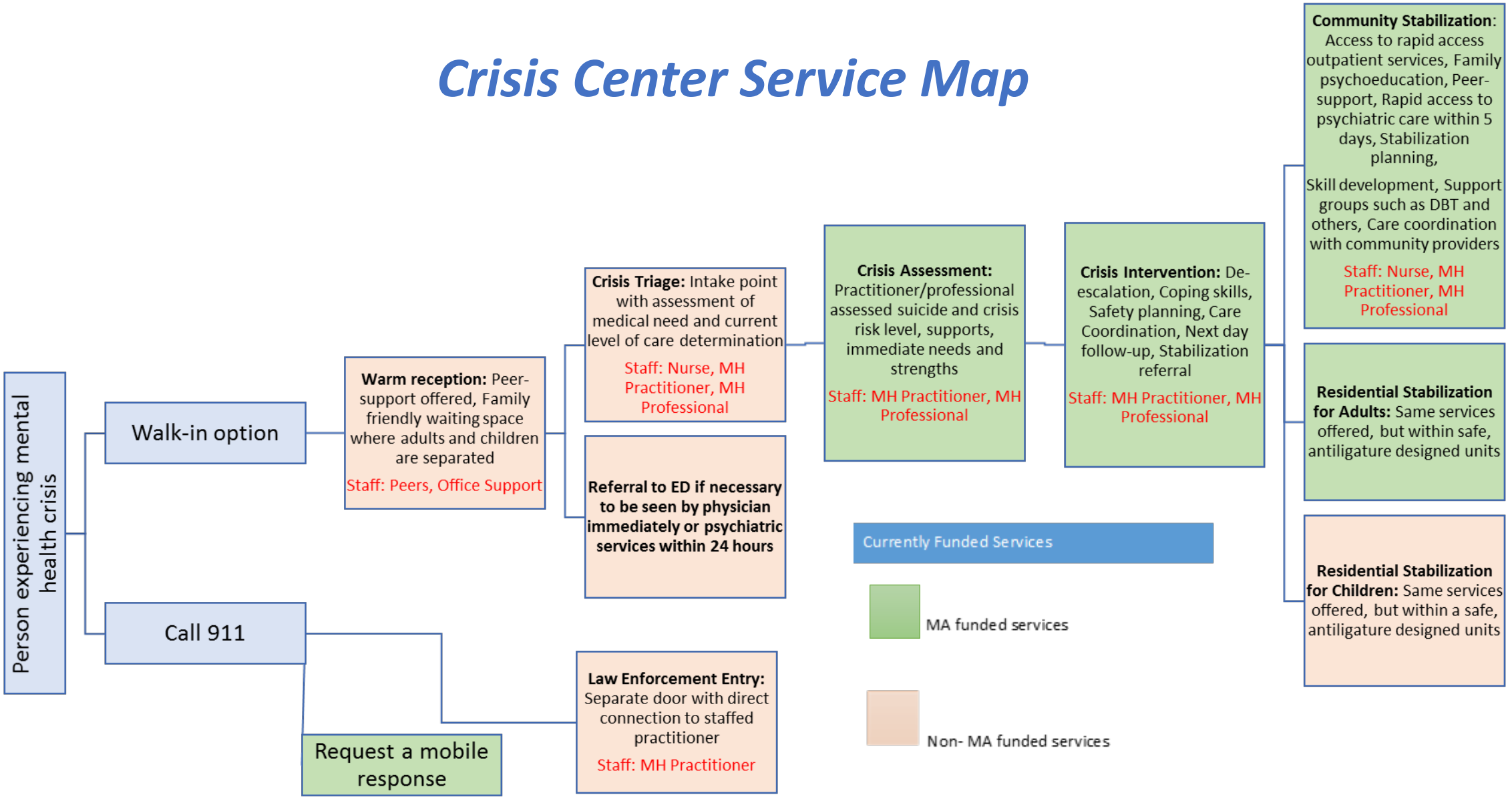
# PRELIMINARY NUMBERS

- 8 individuals a day roughly that currently visit the ED for behavioral health needs
- 865 Law Enforcement CIT referrals in 2017 (Olmsted County)
  - Only 1 % resulting in an arrest
- 1797 calls to the mobile teams in 2017 (showing an upward trend)
  - 358 Mobile responses
- Estimated utilization 11 individuals per day
  - 4015 users per year
- Mobile teams seeing 65% of population receiving MA

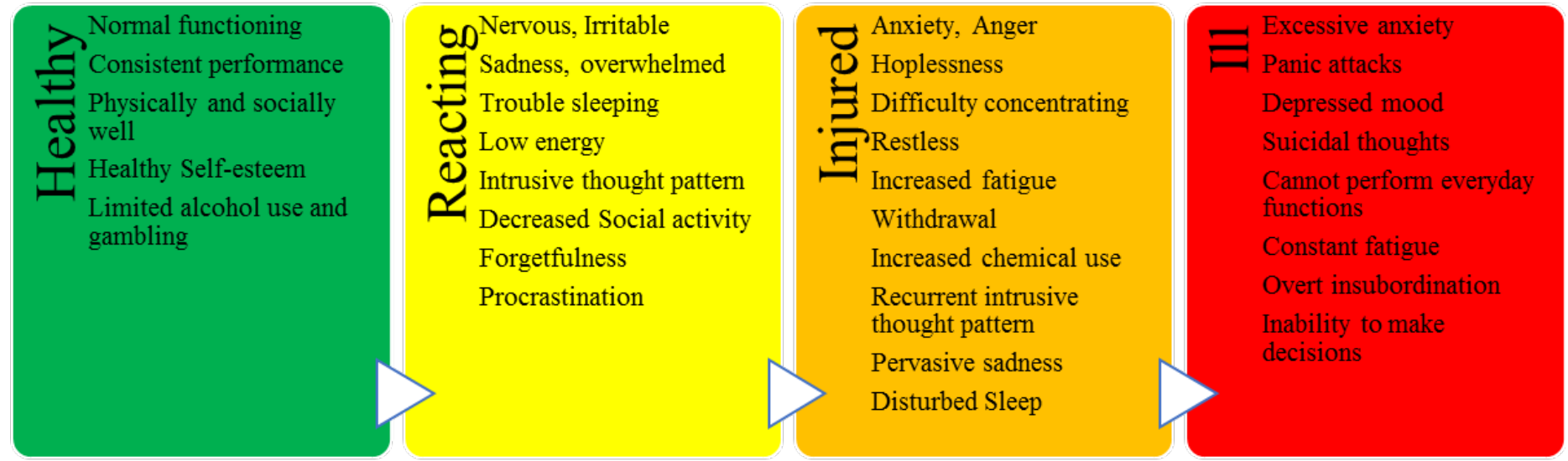
# SERVICE PHILOSOPHY

- Our facility in SE Minnesota will be able to provide services at the time of need for those requiring urgent mental health attention. This is a mental health situation, that is non-life threatening, in which an individual is exhibiting emotional disturbance or behavioral distress, considering harm to self or others, disoriented or out of touch with reality, has a compromised ability to function, or is otherwise agitated and difficult to be calmed, and willing to seek help.
- Beyond crisis services
  - Peer-support, Psychoeducation, Care Coordination, Triage, Diagnostic Assessments
- Services should focus on the individual in crisis by providing a safe, recovery oriented space
- Services should be strengths focused and utilize least restrictive intervention methods

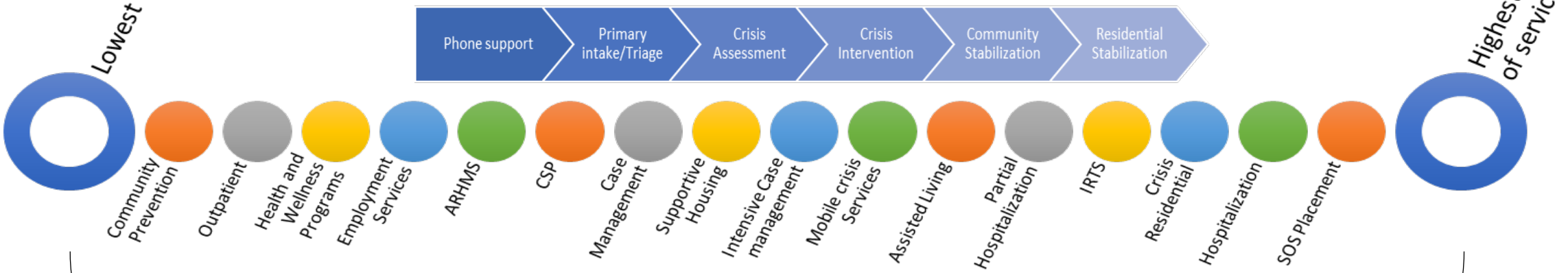
# Crisis Center Service Map



# Mental Health Continuum




## The Crisis Center




# Mental Health Service Continuum

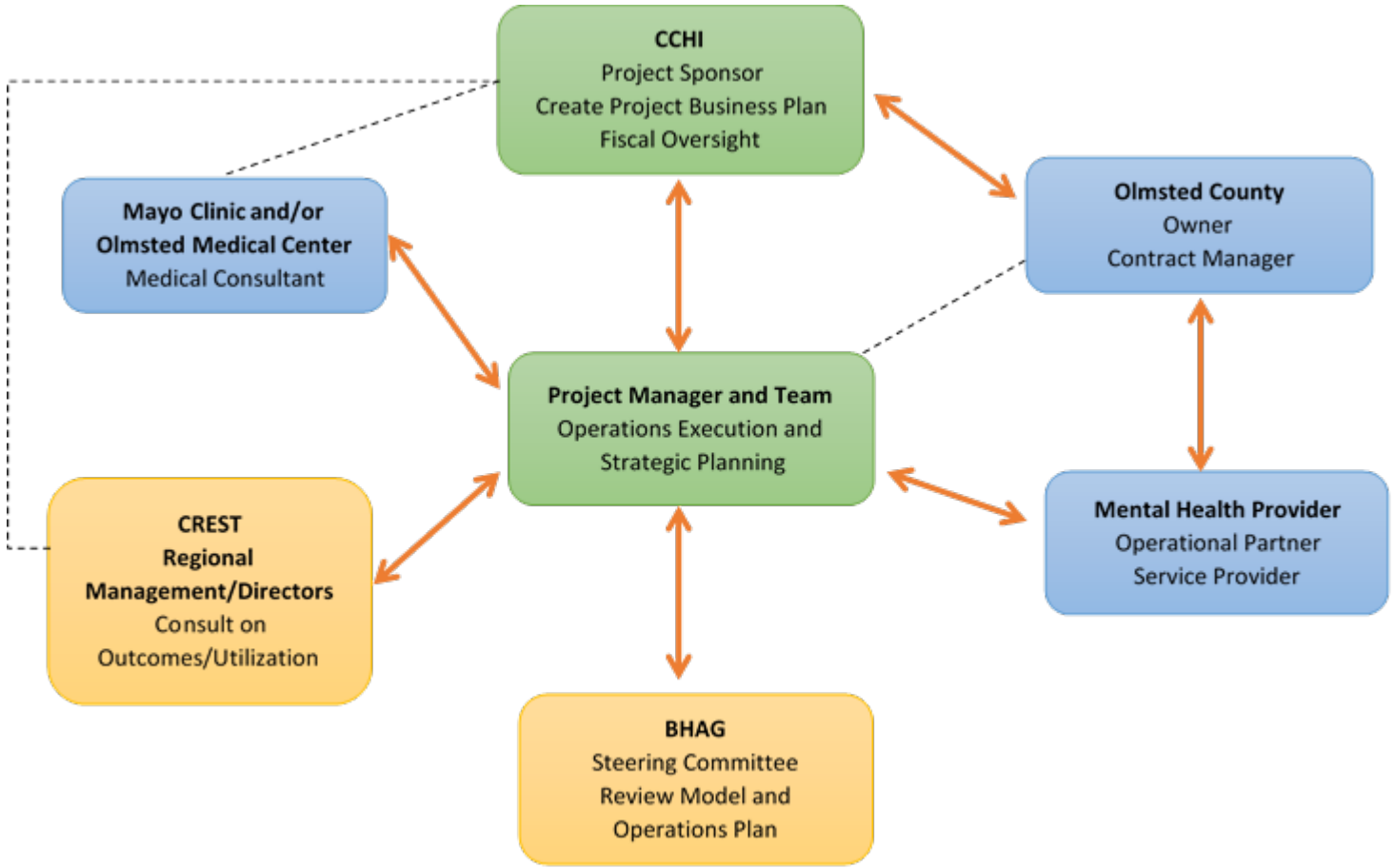
# HOW THIS SUPPORTS CURRENT INFRASTRUCTURE

- Becomes the front door to the Emergency Department for behavioral health needs
  - Non-institutional setting with a recovery oriented, person-centered focus
- Enhances our current mobile crisis response teams allowing for greater access to crisis services
- Adds additional billable service options to crisis services in our region
- Strong connection with regional county resources/partners resulting in more successful transitions back to community
- Offers a bridge to mental health services for those that experience gaps in service or are on waitlists
- Can increase speed of access to other services such as Targeted Mental Health Case management

# FINANCIAL VIABILITY

- Billable Service infrastructure provided by DHS for crisis services
- Approximately 65% of current crisis users through the mobile teams are MA recipients
- Estimated 2.4 Million dollars in staffing costs
- Current mobile crisis infrastructure allowing for grant dollars and billing revenue
- Estimated 1.6 million dollars in revenue from service billing
  - This does not take into consideration in-kind investments which have been acquired through community partners

# COLLABORATIVE GOVERNANCE



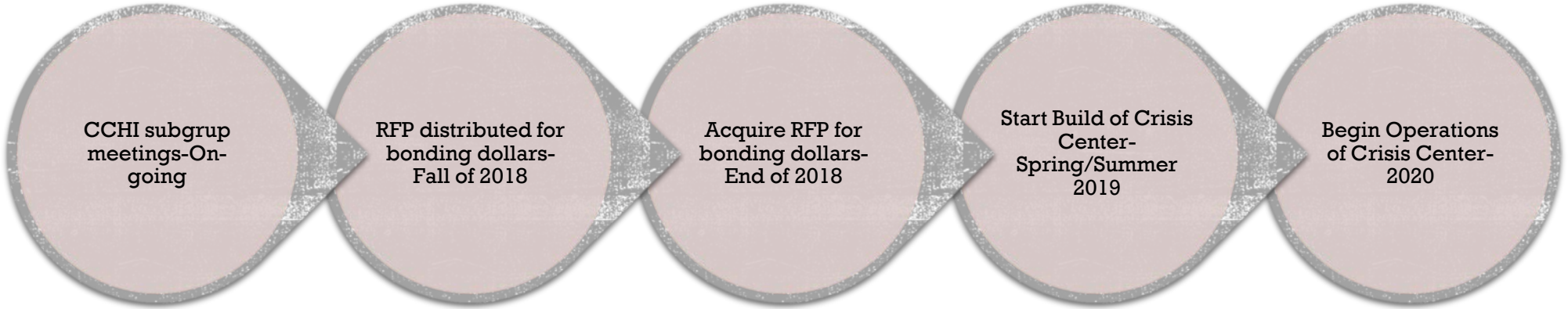
# CHALLENGES TO CONSIDER

- Large geographical coverage area
  - Transportation, training on resources, etc.
- Lack of funding for all services
  - MA funding falls short of fully covering services
- Changing current system utilization
  - How do we ensure individuals don't go directly to ED?
- Staffing challenges
  - Overnight/weekend staffing can be difficult

# CRITICAL PARTNERSHIPS

- Emergency Rooms
- Regional Law Enforcement
- Regional mental health providers
- DHS (rate setting, certifications)
- Counties
- Gold Cross (transportation)

# TIMELINE




- Agreement on Fiscal reinvestiments
- Draft a Joint Powers Agreeement

- Distribute RFP for operations partners
- Respond to state RFP for bonding funds

- Execute JPA
- Select operational partners
- Distribute RFP for site development

- Select build developer
- Acquire and train staff
- Contract and MOU development
- Community outreach

# Family Health- Evidence Based Family Home Visiting Update

October 2018

Brooke Hawkenson

Family Health Supervisor

# Evidence Based Model


- Reduced child maltreatment
- Improved child health including increase birth weight
- Improved parent-child interaction
- Improved school readiness and adjustment to 1st grade
- Improved family self-sufficiency
- Improved coordination of services and referrals

# Program Structure

7 County Site

- Goodhue, Wabasha, Winona, Rice, Freeborn, Dodge, Steele

- 1 regional Family Home Visiting Coordinator
  - Housed locally in Goodhue County
  - Coordinator will spend 50% of time as coordinator and 50% split between Goodhue and Wabasha completing Parent Surveys

- Goodhue County will also have 1 full time Family Home Visitor to conduct home visits. Goodhue has staff on board for this position.
- Each county can staff their program as they wish. Some may use nurses others may us para professionals to staff their model.
- Number of FTE's is determined by HFA staffing model
- All counties are in different phases of the hiring process

# Implementation Process

1. Affiliation
2. Core training for new staff
3. Enrolling/serving families
4. Accreditation

# 1. Affiliation

- Consists of submitting affiliation application
- Completion of HFA Affiliation implementation plan
- Completion of HFA Affiliation phone call with implementation specialist to discuss implementation plan and have plan approved.

- HFA affiliation phone call completed
- HFA affiliated site as of June 11, 2018

- Official program title: **Healthy Families of SE Minnesota**

# Implementation Process

**2. Completion of Core Training**

- Home Visitor Core Training (Integrated Strategies for Home Visiting)
- Parent Survey Core Training
- Growing Great Kids Curriculum
- Supervisor Core Training
- Program Coordinator is required to attend specialized implementation training just for Program Coordinators

# Implementation Process

- **3. Enrolling/Serving families**
  - Model fidelity is achieved through implementing “HFA Best Practice Standards”
  - Number of visits are based on case weights (formula for determining how often visits should occur)
  - Generally weekly for the first 6 months, then decreases thereafter
  - Visits include: Screening and assessment for risks of child maltreatment or other adverse childhood experiences, home visiting services, child growth and development screenings, education on healthy attachment and bonding, and maternal depression screens
  - Each county will have a different implementation date due to staff training.
  - Quarterly reporting and invoicing will be completed
  - PhDoc already has forms imbedded to track reporting requirements

# Implementation Process

## 4. Accreditation

- Completion of self assessment at 1 year after affiliation date (June 11, 2018)
- Completion of accreditation site visit at 2 years after affiliation date
- Reaccreditation occurs every 4 years thereafter
- Process similar to that of PH accreditation
- We must document that we meet all HFA Best Practice Standards

# Where are we now?

- Some counties began enrolling families in July. Our goal is to serve 90 families (site wide) by July of 2019 and 180 families by July of 2020. We currently have 14 families enrolled.
- 2 counties are still in hiring process and do not yet have staff on board.
- Several counties have been utilizing the HFA model informally for years and have staff on board and already trained in the model. We will have 10-14 staff that still need training before they can begin serving families (Goodhue has 3 staff needing training before serving families)
- Data collection reporting is already due to the state by the end of the month for our first quarter.

# Questions?

# HFA IMPACTS ON CHILDREN

healthy families america
a program of Prevent Child Abuse America
healthyfamiliesamerica.org

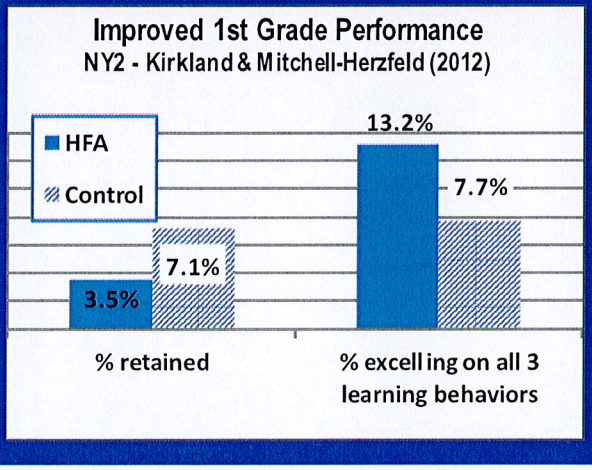
**Healthy Families America is an effective and proven model for early childhood home visiting with positive impacts in eight areas essential for children. Currently more than 75,000 families are served by more than 600 Healthy Families America sites in 38 states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the US Virgin Islands and Canada.** *Learn more about proven models of home visiting at homvee.acf.hhs.gov*

*HFA nurtures the parent-child relationship to promote child well-being and prevent* adverse childhood experiences *(**ACEs**) especially child abuse and neglect. A child's first relationships and earliest experiences lay the foundation for health and well-being across the entire lifespan, which is the core of an Infant Mental Health approach.*

## School Readiness & Adjustment

The largest long-term rigorous study of HFA to date (*NY2*)* shows impacts on academic success, with more children in gifted programs, fewer retained in first grade, and fewer receiving special education services. HFA also increased positive learning behaviors (works and plays cooperatively, follows oral directions and rules, and completes work on time).

These results are consistent with other studies reporting early indicators of children who are ready to learn, including higher scores for HFA children compared to controls on tests of cognitive development (*AK, CA*) or developmental screening (*GA, NY1*) at age 1 or 2 years, and fewer behavioral problems (*AK, CA*).




## Child Abuse & Neglect

Parents' self-reports provide a powerful measure of child maltreatment; several rigorous studies show reductions in harsh parenting, neglect, physical abuse, and psychological abuse measured from one to seven years (*AK, AZ2, CA, HI2, NY2*), and increased use of non-violent discipline (*NY2*).

Studies have also shown reduced rates of substantiated maltreatment (*HI1*, AZ3, OR, VA5), with strongest results for select subgroups, such as first-time moms who enrolled prenatally (*NY2*), moms who were not depressed (*MA2*), parents with prior CPS involvement (*NY2*), and those who received the recommended number of visits (FL4).

## Children's Health

HFA improves birth outcomes, including low birth weight, a problem with tremendous public and personal costs. When moms enroll in HFA before the third trimester, multiple studies report positive impacts on birth weight (*NY2*, FL3, DC, NJ1, VA4), and fewer birth complications (*VA2*). HFA has also been shown to increase breastfeeding (*NY1, NY2*, MA1, OR, WI).

HFA improves parents' access to health care for their child by helping them:

- ◊ obtain insurance coverage (*AK, NY2*, OR),
- ◊ complete well-baby visits (*CA, VA2*, OR, WI), and,
- ◊ establish a medical home for routine and preventive health care needs (*AK*, AZ1, *CA*, FL3, FL4, *HI2*, IA, MD1, MD2, *NY2*, OR, TN, VA1, VA3, VA4, VT).

**THE BOTTOM LINE:** Healthy Families America nurtures child development, including long-term improvements in children's school performance, and prevents *adverse childhood experiences* (ACEs) such as child abuse and neglect. These outcomes have been shown in rigorous studies in multiple states.

***Evaluation Studies:** State abbreviations refer to evaluation studies; those in *italics* indicate Randomized Control Trials (*RCTs*). For more information, see the HFA Evaluation Table at healthyfamiliesamerica.org/research/

***More Information:** Go to healthyfamiliesamerica.org to read more about HFA's positive impacts for children and communities.

# HFA IMPACTS ON COMMUNITIES

healthy families america
a program of Prevent Child Abuse America

healthyfamiliesamerica.org

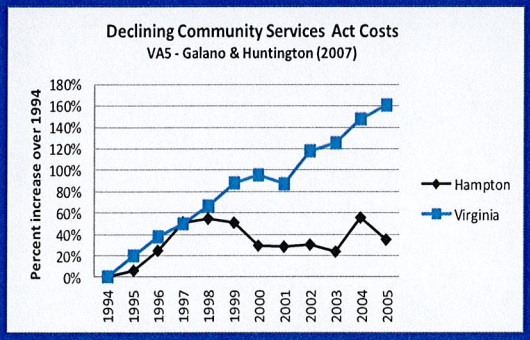
**Healthy Families America is an effective and proven model for early childhood home visiting with positive impacts in eight areas essential for children. Currently there are 590 Healthy Families America home visitation sites in 40 states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the US Virgin Islands and Canada.** *Learn more about home visiting at homvee.acf.hhs.gov*

*Expanding, or "scaling up", Healthy Families America to serve the entire community offers measurable improvements on child and family well-being. Further, Healthy Families America builds and sustains community partnerships through the creation of community advisory boards, staff training on local family resources, linkages and referrals, and more.*

## COMMUNITY-WIDE IMPACT STUDY

A ground-breaking study commissioned by Hampton Virginia city leaders found significant community benefits of HFA (VA5). *

- The study examined rates of change in several key benchmark areas, comparing Hampton to similar communities.
- The strongest results showed a greater rate of improvement for Hampton on rates of child maltreatment, child maltreatment fatalities, and infant mortality.
- Hampton's costs related to these outcomes indicate savings compared to state costs, shown in the figure below.




## IMPROVED BIRTH SPACING & OUTCOMES

Delaying subsequent pregnancies helps young families achieve greater financial security. More HFA moms waited at least two years to have another child (FL4, NC, VA2b). HFA also improves birth outcomes, including low birth weight, a problem with tremendous public and personal costs. When moms enroll in HFA before the third trimester, studies report positive impacts on birth weight (*NY2*, FL3, DC, NJ1, VA4), and fewer birth complications (*VA2*).

## LOWER EDUCATION COSTS

The largest long-term rigorous study of HFA to date (*NY2*) shows impacts on academic success, with fewer children retained in first grade or receiving special education services. Other rigorous studies show early indicators of school readiness (*AK, CA, GA, NY1*).

## IMPROVED FAMILY SELF-SUFFICIENCY

In multiple studies, HFA parents show significant gains in their education (*AZ2, CA, NY1*, DC, FL4, MA1, MD2, NJ1) that can lead to increased family income and tax base.

## REDUCED CHILD MALTREATMENT

Several rigorous studies show reductions in child maltreatment measured via parent self-report (*AK, AZ2, CA, HI2, NY2*), or substantiated reports (*HI1*, VA5). Strongest results on substantiated reports are for select subgroups (*MA2, NY2,* FL4, OR), such as first-time moms who enrolled prenatally (*NY2*).

**THE BOTTOM LINE:** At full-scale (serving an entire community), Healthy Families America has the potential to achieve community-wide benefits, including intermediate system change and long-term impacts on community health.

***Evaluation Studies:*** State abbreviations refer to evaluation studies; those in *italics* indicate Randomized Control Trials (*RCT*). For more information, see the HFA Evaluation Table at healthyfamiliesamerica.org/research/

***More Information:*** Please visit healthyfamiliesamerica.org to read more about HFA's positive impacts for children and communities.

# HFA IMPACTS ON PARENTS & FAMILIES

healthy families america
a program of Prevent Child Abuse America

healthyfamiliesamerica.org

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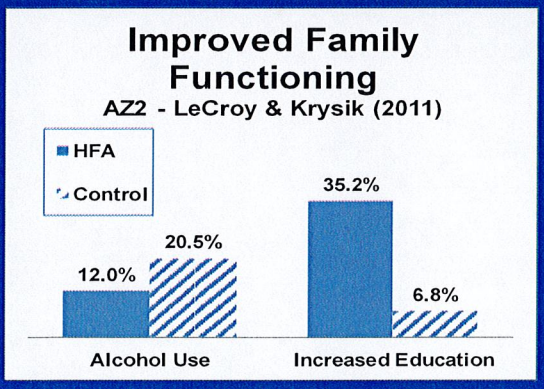
*A parent's personal resources—including knowledge, skills, and attitudes toward parenting—impact their relationship with their baby. Healthy Families America helps parents develop their personal resources to improve family functioning, strengthen the parent-child relationship, promote child well-being, and prevent adverse childhood experiences (ACEs).*

## Family Functioning and Self-Sufficiency:

HFA parents make significant gains in their education (*AZ2*, CA, NY1,* DC, MA1, MD2, NJ1) and make better use of community resources (*AZ2*).

Delaying subsequent pregnancies impacts the health of both moms and babies, as well as helping young families achieve greater financial security. More HFA waited longer to have another child (FL4, NC, VA2b).

Substance abuse is another indicator of family functioning, as well as a risk factor for child maltreatment. Mothers in HFA reported less alcohol use compared to control families (*AZ2*).




## Positive Parenting Attitudes

HFA helps parents develop more positive beliefs about their role as parents. Compared to control families, HFA parents:

* showed stronger parenting efficacy (*AK, HI2*),
* had reduced parenting stress levels (*MA2*), and,
* had more positive perspectives on their parenting roles and responsibilities (*GA, HI1, NY2*).

Even more studies support these findings (CT, MA1, NJ1, OR).

## Parent-Child Interaction

It takes time for parents to get acquainted with their new baby. Responsiveness and communication are the building blocks of attachment; the parent-child bond promotes child well-being and protects against child maltreatment. HFA shows significant impacts on parent-child interaction in numerous studies (*GA, HI1, VA2,* AZ1, FL2, IL, IN, MD1, MI, NJ1, OR, WI, VA4). In particular, researchers in a rigorous study observed significant improvements at two years on overall scores and specific areas of sensitivity, child clarity, and child responsiveness, while scores for control families declined (*VA2*).

## Support for Child Development

HFA increases parents' understanding of children's developmental milestones and needs (*NY2,* IA, MD1); and helps parents create a more responsive and developmentally stimulating home environment (*AK, GA, HI1, VA2,* AZ1, DC, FL4, IL, IN, MD1, MI, NJ1, OR, VA4, WI).

**THE BOTTOM LINE:** HFA benefits parents in many ways that help them be the best parents they can be, and reach personal goals (such as furthering their education and gaining employment). These outcomes have been shown in rigorous studies in multiple states.

**** Evaluation Studies:*** State abbreviations refer to evaluation studies; those in *italics* indicate Randomized Control Trials (*RCTs*). For more information, see the HFA Evaluation Table at healthyfamiliesamerica.org/research/

***More Information:*** Please visit healthyfamiliesamerica.org to read more about HFA's positive impacts for children and communities.

# Local Public Health Act Performance Measures in 2017

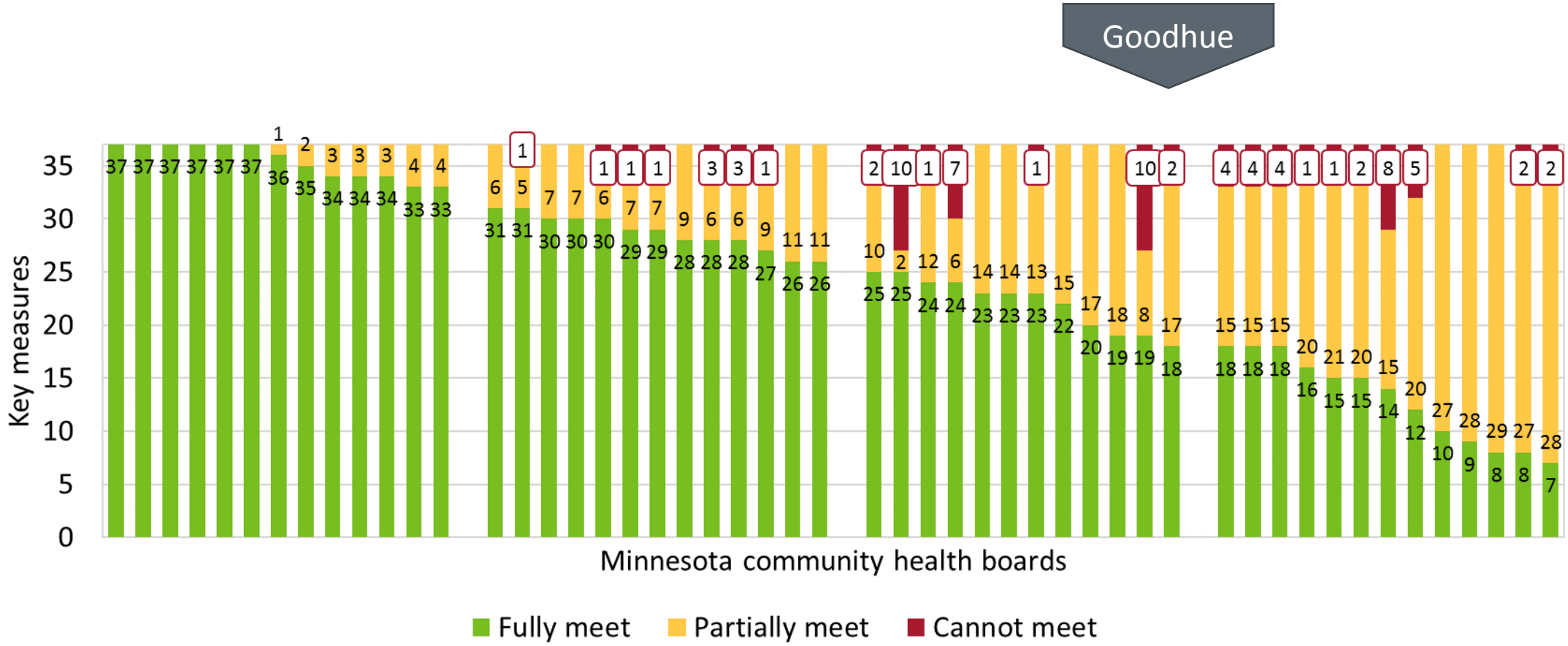
An Overview of 2017 Local Public Health Annual Reporting Data for
**Goodhue County Health and Human Services Board**

**October 16, 2018**

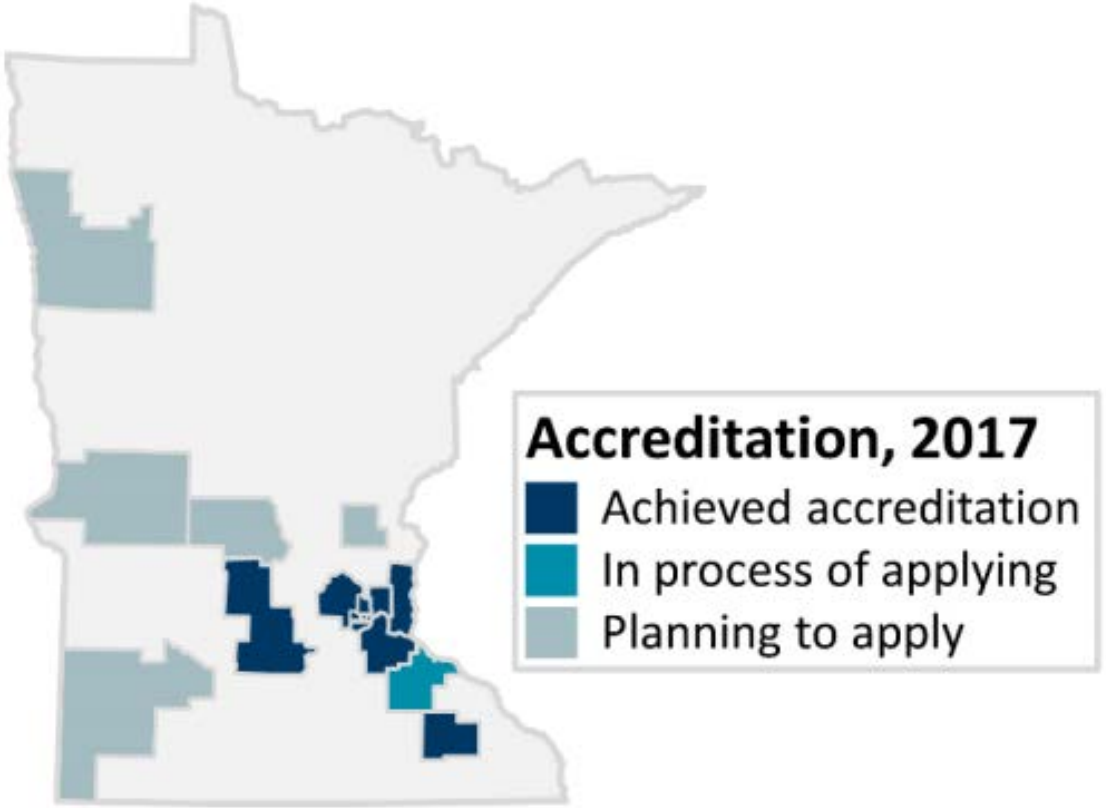
# Overview of Annual Reporting

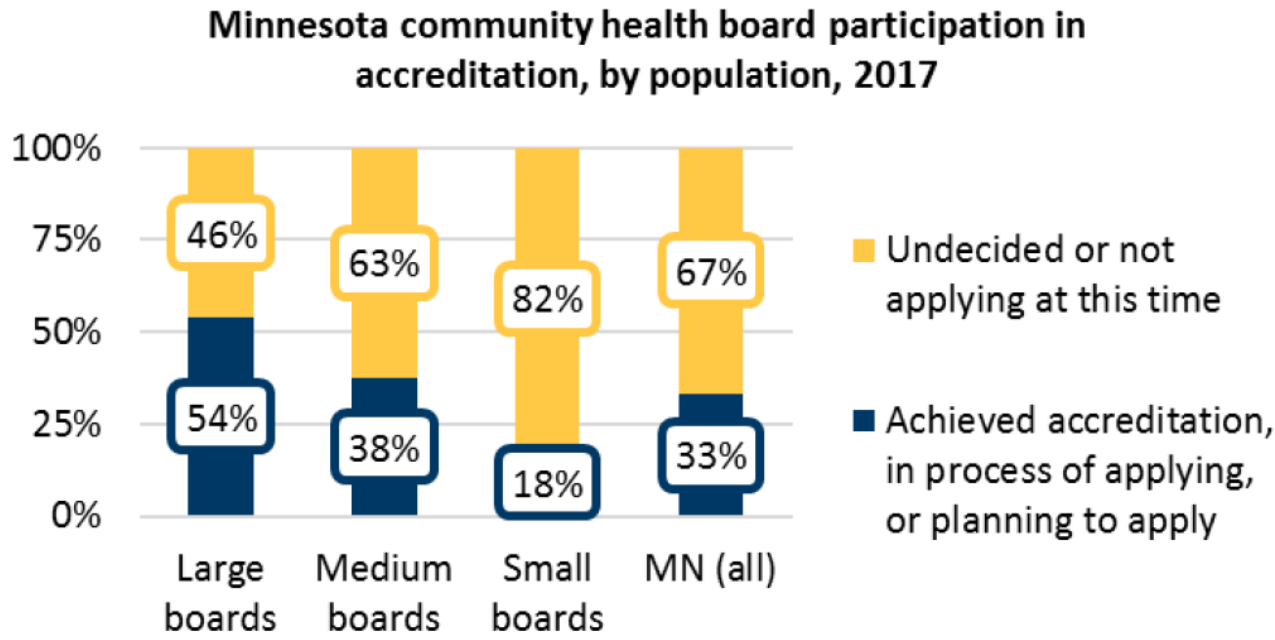
- All community health boards report annually to MDH on a set of performance measures (51 boards in 2017)
- Data reported in 2018 on capacity and services for 2017 calendar year
- Measures relate to the six areas of public health responsibility in the Local Public Health Act
- Reports facilitate comparisons with other community health boards and with community health board's own historical data

# At a Glance: Minn. Community Health Board Capacity to Meet National Measures, 2017

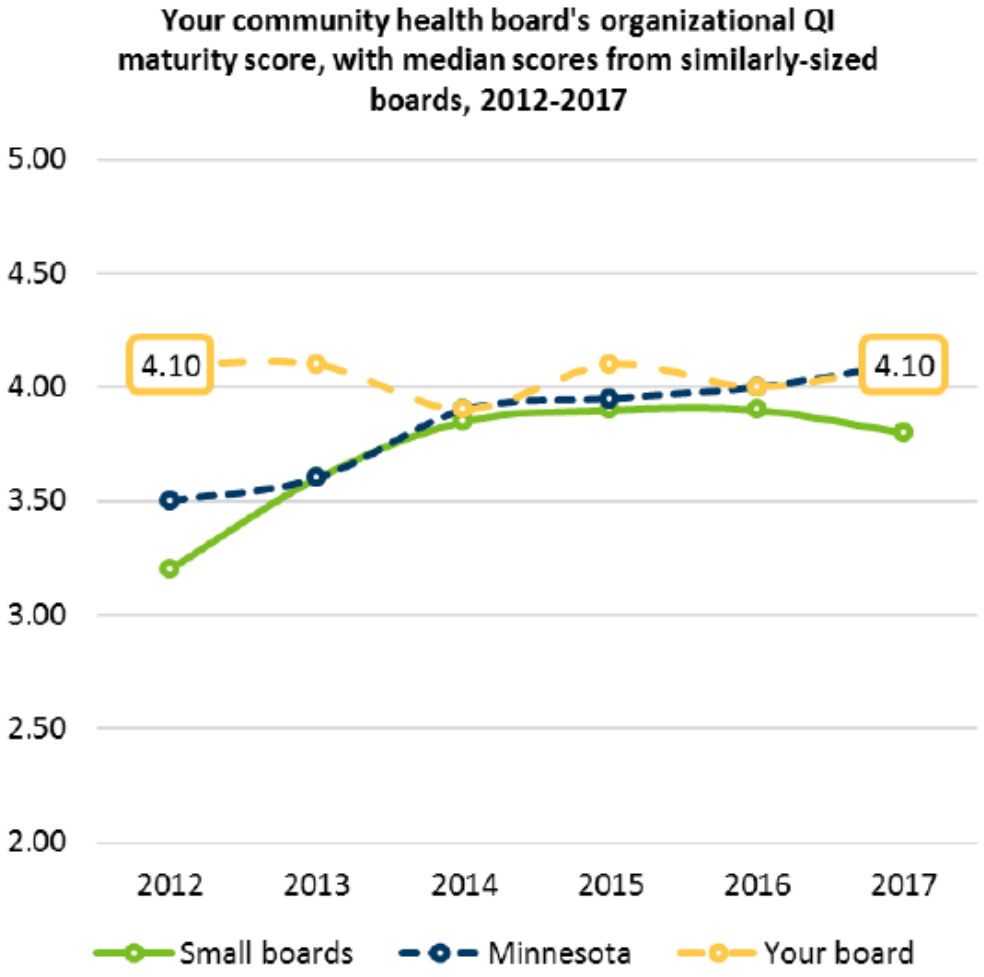


# Highlights


Accreditation, 2017
Achieved accreditation
In process of applying
Planning to apply


Minnesota community health board participation in accreditation, by population, 2017
100%
75%
50%
25%
0%
46%
54%
63%
38%
82%
18%
67%
33%
Large boards
Medium boards
Small boards
MN (all)
Undecided or not applying at this time
Achieved accreditation, in process of applying, or planning to apply

# Strengths



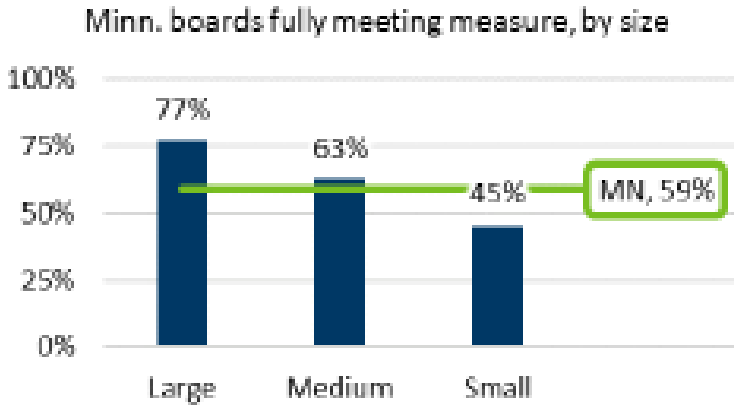

- Quality Improvement Maturity Score based on responses to 10 questions
- 2012-2013: supervisors/ directors responses
- 2014-2017: responses from survey of all GCHHS staff
- Our agency is above average for our size.

# Opportunities

6.3.4. Patterns or trends identified in compliance from enforcement activities and complaints.

A community health board has a role in ensuring that public health laws are enforced—either by using its authority to enforce, or working with those who have the legal authority to enforce.

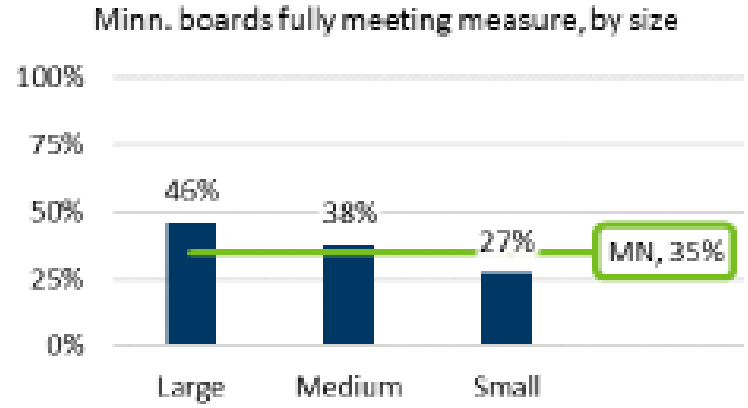
Your community health board in 2017: Cannot Meet




11.1.2. Ethical issues identified and ethical decisions made.

Efforts to achieve the goal of protecting and promoting the public's health have inherent ethical challenges. Employer/employees relations may also raise ethical issues. Understanding the ethical dimensions of policies and decisions is important for the provision of effective public health and public health management.

Your community health board in 2017: Cannot Meet



# Next Steps

- 6.3.4 Patterns or trends identified in compliance from enforcement activities and complaints
  - Environmental Health Continuous Improvement Board membership
  - MDH revising inspection protocols to clarify communication of trends
  - Regular updates from MDH about Goodhue County

- 11.1.2 Ethical issues identified and ethical decisions made
  - Ethics policy written
  - Public Health Ethics training completed
  - Public Health Ethics committee formed

# Next Steps: State-Level Activities to Strengthen Public Health in Minnesota

- SCHSAC sees wide variability among community health boards related to performance and resources
- Response: SCHSAC Strengthening Public Health Workgroup
- Workgroup identified three priorities:
  - Clarify basic public health responsibilities; identify new ways to carry them out
  - Align public health funding and resources with local needs
  - Take comprehensive, multi-sectoral approach to workforce development
- More information: SCHSAC Workgroups

# Local Public Health Act Performance Measures for 2017

GOODHUE | JULY 2018

DEPARTMENT OF HEALTH

This report was produced by:

Minnesota Dept. of Health
Center for Public Health Practice
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www.health.state.mn.us

If you would like help interpreting this data or would like to discuss ideas on using your data to communicate progress or improve quality, please contact the MDH Center for Public Health Practice (above), or your public health nurse consultant: Who Is My Public Health Nurse Consultant?

Introduction

# About this report

Each spring, Minnesota community health boards report data from the previous year on programs, activities, and resources, to help monitor the health of the state-local public health partnership in three key areas: Finance and Staffing, Title V MCH Block Grant, and Local Public Health Act (LPH Act) performance measures. This report shares state-level information on Local Public Health Act (LPH Act) performance measures, next to your community health board's own responses. For more information, visit: Annual Reporting for Local Public Health.

## What are LPH Act performance measures?

The LPH Act performance measures correspond with Minnesota's six areas of public health responsibility found in statute: assure an adequate local public health infrastructure (this area includes capacity measures based on national standards and Minnesota-specific measures), promote healthy communities and healthy behavior, prevent the spread of communicable diseases, protect against environmental health hazards, prepare and respond to emergencies, assure health services. This report addresses only the infrastructure area.

## How do community health boards respond?

For a majority of measures, a community health board responds based on services provided in one or more of its individual health departments. For capacity measures aligning with national standards, a community health board responds based on the lowest level of capacity of its individual health departments. If you have questions about how community health boards were instructed to respond, please refer to this year's instructions at: Module: LPH Act Performance Measures.

Findings in this data book are noted by year and community health board population. In 2017, Minnesota had 51 community health boards; 13 "large" community health boards had a population of 100,000 residents or more, 16 "medium" boards had a population between 50,000 and 99,999 residents, and 22 "small" boards had a population 49,999 or fewer residents.

**Your community health board is classified as**: Small

## What does MDH do with the data?

MDH and the SCHSAC Performance Improvement Steering Committee use the data submitted by community health boards to monitor the performance of the state's public health system, identify strengths and gaps, and recommend opportunities for improvement.


Minnesota Public Health System Performance Management Cycle

## Taking action

A number of community health boards use this data to identify and make improvements in their organizations. To learn about those efforts, view presentation slides online for *Using Data to Tell Your Story* and *Data In, Data Out, Now What?*

Along with this report, you will also have received a set of presentation slides with ideas for sharing your data with stakeholders. Community health boards have used these slides as a starting point to explain some of their activities and the importance of public health to local elected officials, local government, community organizations, and other partners.

## Questions and assistance

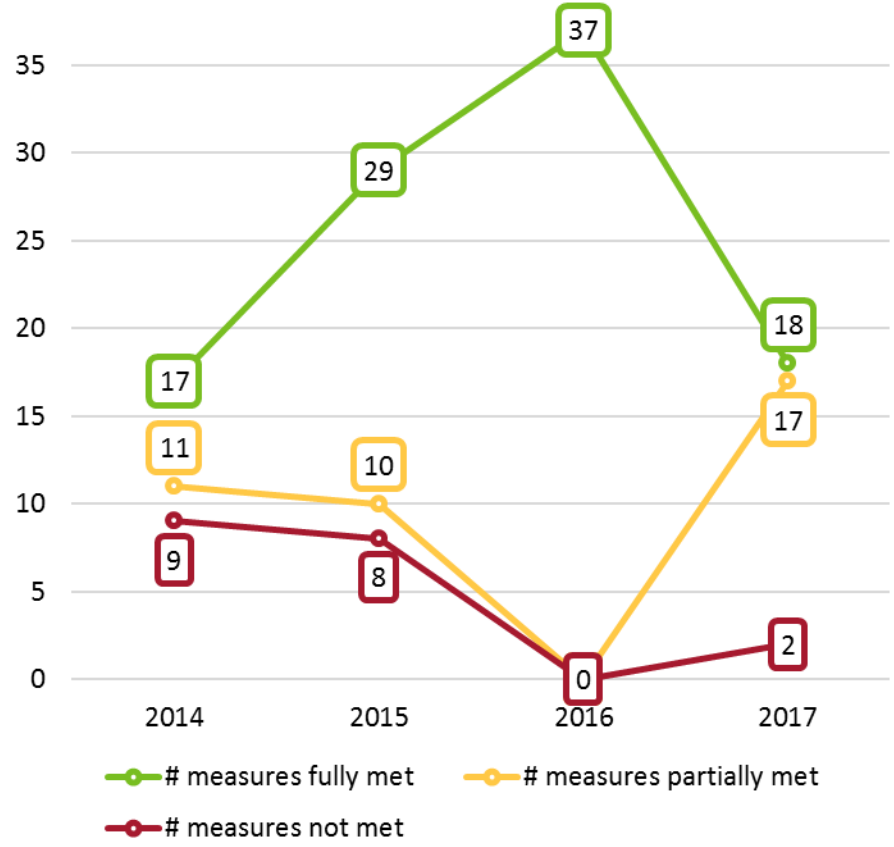
If you would like help interpreting this data or would like to discuss ideas on using your data to communicate progress or improve quality, please contact your public health nurse consultant: Who Is My Public Health Nurse Consultant?

Assure an adequate local public health infrastructure: Capacity measures from national standards

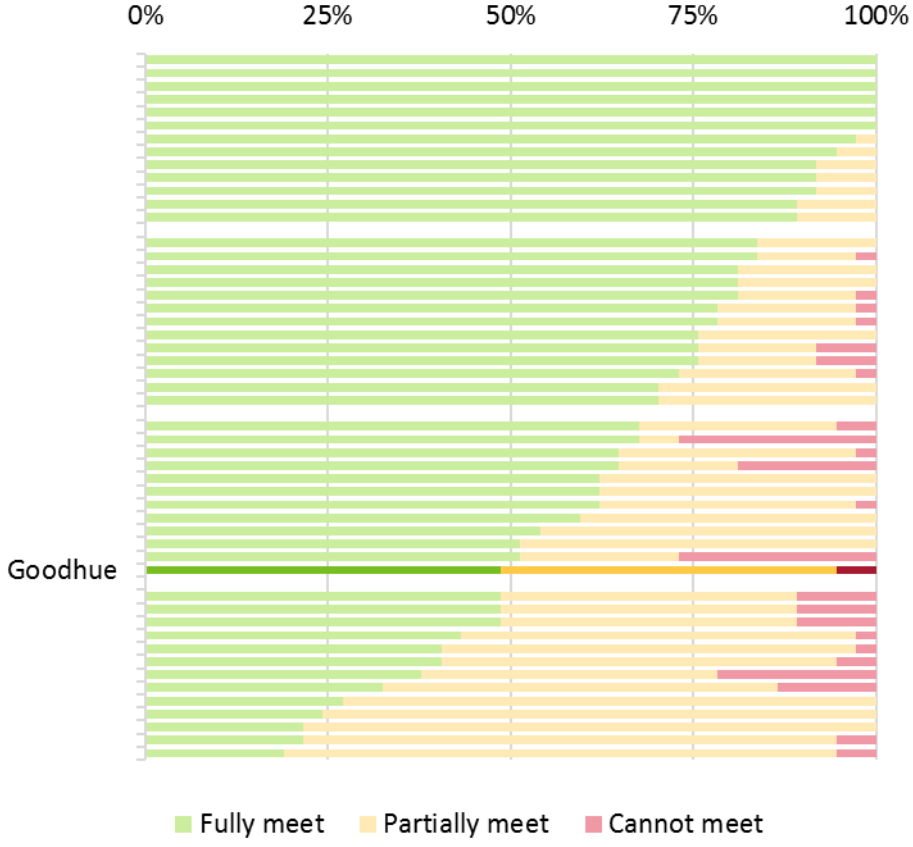
# Progress on key national public health measures

At left, each bar represents a community health board's current ability (in 2017) to meet 37 key national public health measures. At right, you will see your community health board's individual progress meeting these same key national measures from 2014 to 2017 (excluding those community health boards not in place during that time).

**Your community health board's progress toward meeting 37 key national public health measures, 2014-2017**




**Your community health board's ability to meet 37 key national public health measures, 2017**

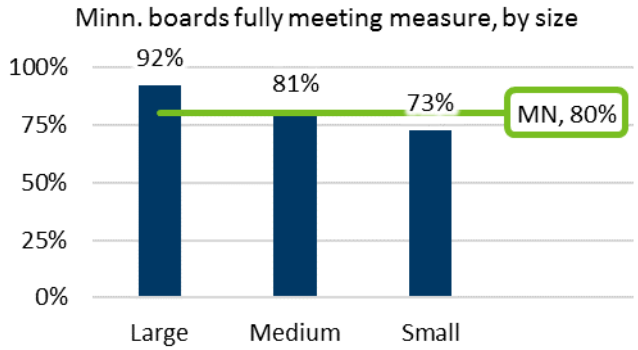


Community health boards report on a subset of 37 measures used by the Public Health Accreditation Board (PHAB), on the following pages. If your community health board is preparing for national public health accreditation, MDH encourages you to rely on official PHAB guidance, rather than solely on the measures below.

### 1.1.2. A local community health assessment.

A thorough and valid community health assessment is a customary practice and core function of public health, and also is a national standard for all public health departments. Since the passage of the Local Public Health Act in 1976, Minnesota community health boards have been required to engage in a community health improvement process, beginning with a community health assessment.

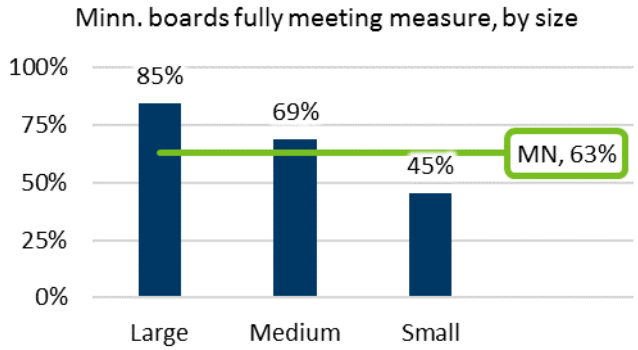
Your community health board in 2017: Partially Meet




### 1.2.2. Communication with surveillance sites.

Communicating with surveillance sites about their responsibilities ensures sites are providing timely, accurate, and comprehensive data.

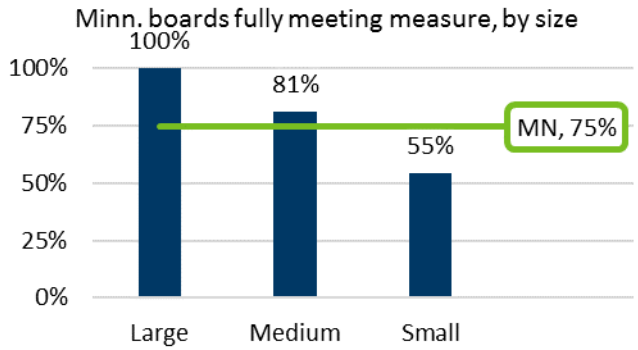
Your community health board in 2017: Fully Meet



1.3.1. Data analyzed and public health conclusions drawn.

Valid analysis of data is important for assessing a health problem's contributing factors, magnitude, geographic location(s), changing characteristics, and potential interventions, and for designing and evaluating programs for continuous quality improvement.

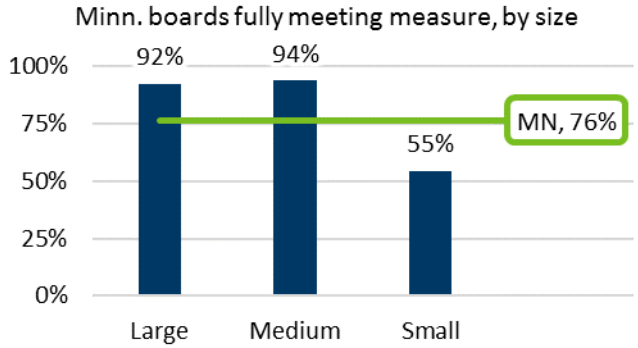
Your community health board in 2017: Partially Meet




1.4.2. Community summaries or fact sheets of data to support public health improvement planning processes at the local level.

Public health data must inform the development of public health policies, processes, programs, and interventions. Community health boards must share data with other organizations to inform and support others' health improvement efforts.

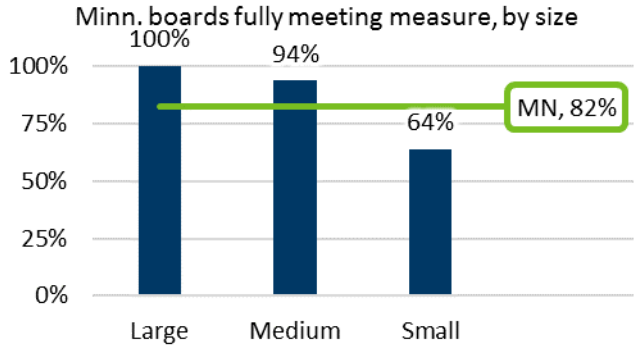
Your community health board in 2017: Partially Meet




2.1.4. Collaborative work through established governmental and community partnerships on investigations of reportable diseases, disease outbreaks, and environmental public health issues.

The ability to conduct timely investigations of suspected or identified health problems is necessary for the detection of the source of the problem, the description of those affected, and the prevention of the further spread of the problem.

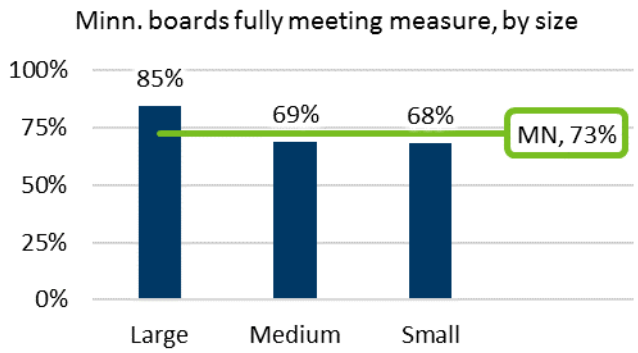
Your community health board in 2017: Partially Meet



2.2.3. Complete After Action Reports (AARs).

Community health boards must be able to act on information concerning health problems and environmental public health hazards that was obtained through public health investigations, and contain or mitigate those problems and hazards in coordination with other stakeholders. After Action Reports (AARs) can demonstrate a community health board's ability to do this.

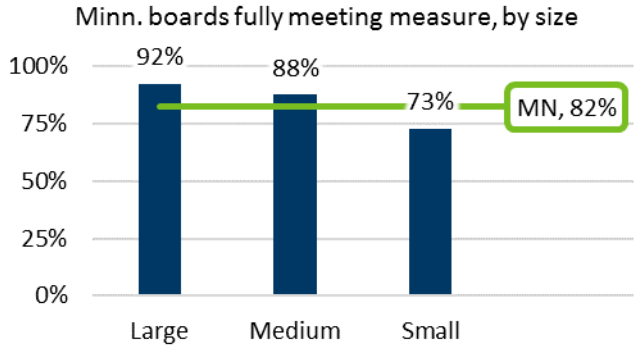
Your community health board in 2017: Partially Meet




3.1.2. Health promotion strategies to mitigate preventable health conditions.

Health promotion aims to enable individuals and communities to protect and improve their own health. Community health boards must establish strategies to promote health and address preventable health conditions.

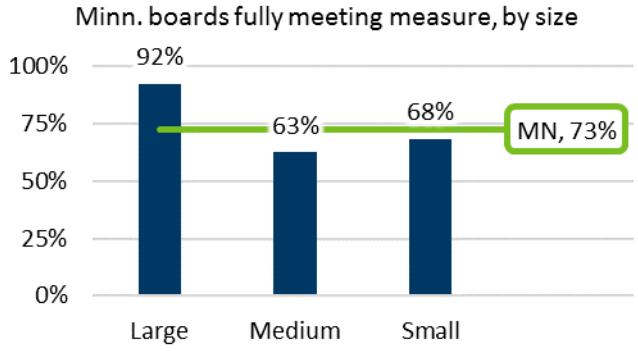
Your community health board in 2017: Partially Meet




3.1.3. Efforts to specifically address factors that contribute to specific populations' higher health risks and poorer health outcomes.

Differences in population health outcomes are well documented. Factors that contribute to these differences are many and varied and include the lack of opportunities and resources, economic and political policies, discrimination, and other aspects of a community that impact on individuals' and populations' resilience.

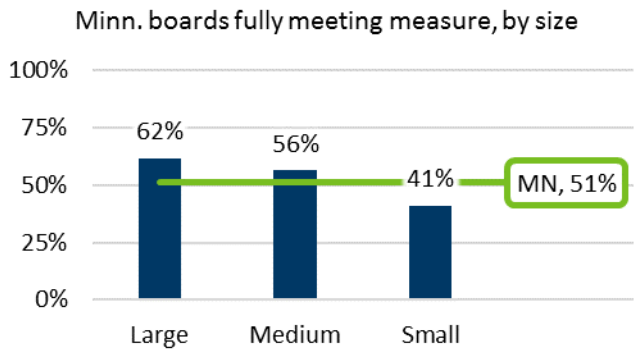
Your community health board in 2017: Partially Meet



3.2.2. Organizational branding strategy.

Branding can help to position a community health board as a valued, effective, trusted leader in the community, by communicating what a community health board stands for and what it provides that is unique and differentiated from other agencies and organizations.

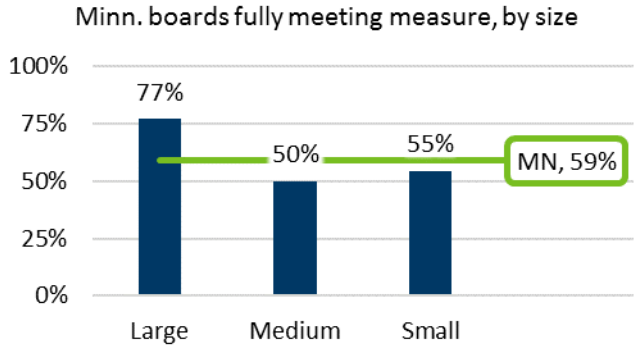
Your community health board in 2017: Partially Meet




3.2.3. Communication procedures to provide information outside the health department.

Consistent communication procedures and protocols ensure reliability in the management of communications on public health issues, and that information is in an appropriate format to reach target sectors or audiences.

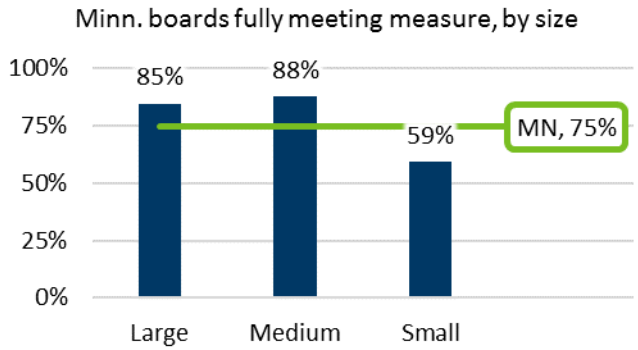
Your community health board in 2017: Partially Meet




3.2.5. Information available to the public through a variety of methods.

Community health boards need to be able to present information to different audiences through a variety of methods.

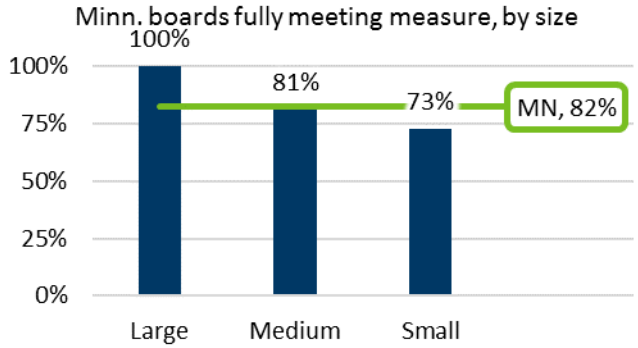
Your community health board in 2017: Fully Meet



5.1.3. Inform governing entities, elected officials, and/or the public of potential intended or unintended public health impacts from current and/or proposed policies.

Community health boards must provide policy makers and the public with sound, science-based, current public health information that must be considered in setting or supporting policies.

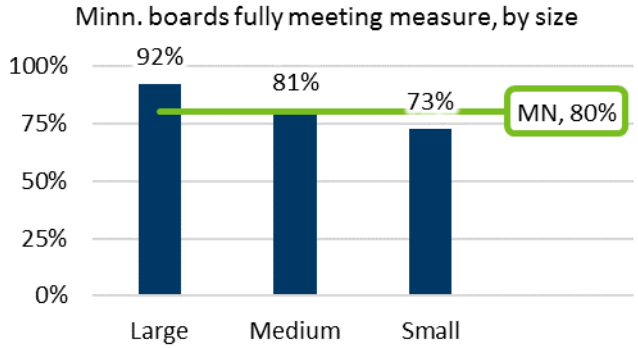
Your community health board in 2017: Fully Meet




5.2.3. Elements and strategies of the health improvement plan implemented in partnership with others.

The community health improvement plan is only useful when implemented, and provides guidance for priorities, activities, and resource allocation. A community health board must implement its community health improvement plan in partnership with others.

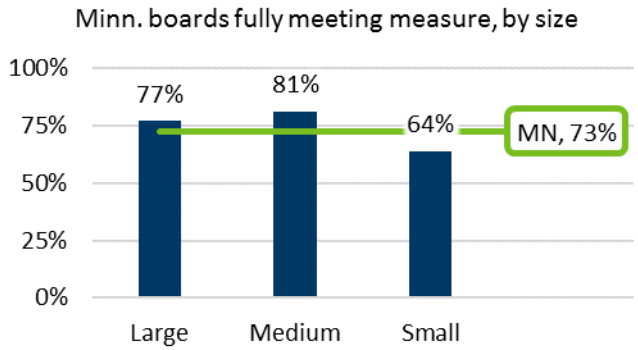
Your community health board in 2017: Fully Meet




5.2.4. Monitor the strategies in the community health improvement plan and revise as needed, in collaboration and with broad participation from stakeholders and partners.

The 2017 and 2018 performance-related accountability measure is 5.2.4. Community health boards work to meet the measure over the course of the year, and report back to MDH in the following year. More information: Accountability Requirements for the Local Public Health Act.

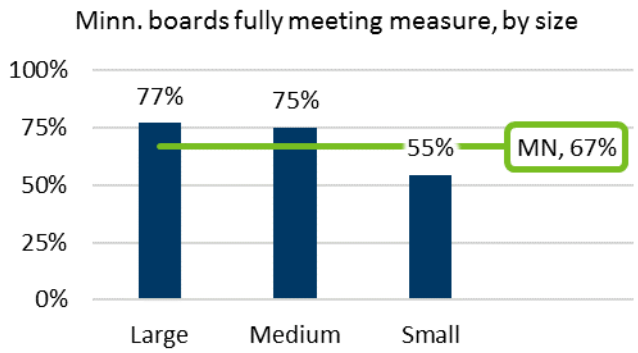
Your community health board in 2017: Fully Meet



5.3.3. Implemented community health board strategic plan.

A strategic plan sets forth what a community health board plans to achieve, how a community health board will achieve those plans, and how a community health board will monitor progress (e.g., annual reports of progress toward goals and objectives in the strategic plan). It provides a guide for making decisions on resource and policy priorities.

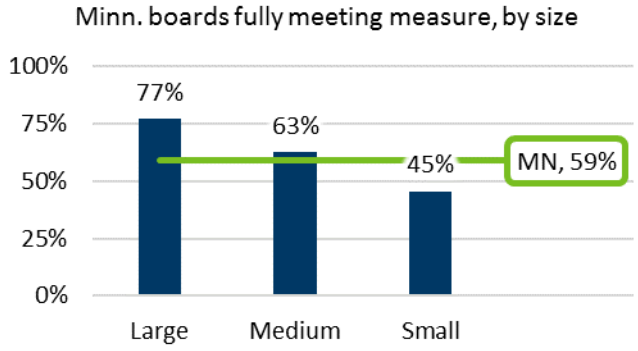
Your community health board in 2017: Fully Meet




6.3.4. Patterns or trends identified in compliance from enforcement activities and complaints.

A community health board has a role in ensuring that public health laws are enforced—either by using its authority to enforce, or working with those who have the legal authority to enforce.

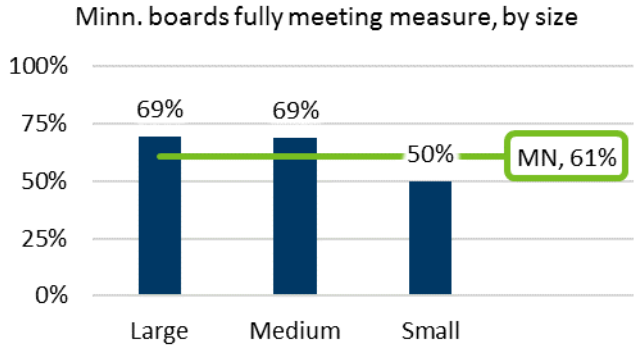
Your community health board in 2017: Cannot Meet




7.1.1. Process to assess the availability of health care services.

Collaborative efforts are required to assess the health care needs of the population of a tribe, state, or community.

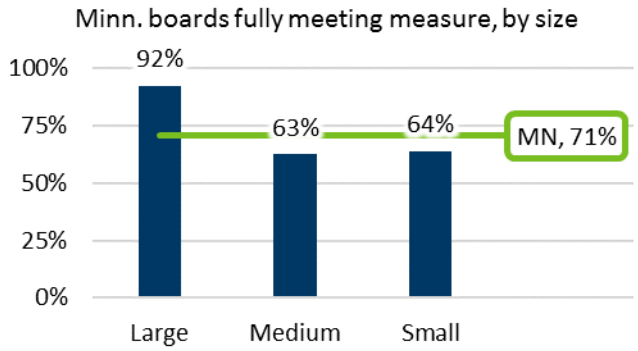
Your community health board in 2017: Partially Meet



7.1.2. Identification of populations who experience barriers to health care services.

It is important for a community health board to identify populations in its jurisdiction that experience perceived or real barriers to health care. Assessing capacity and access to health care includes the identification of those who are not receiving services, and understanding the reasons that they are not receiving needed care or experiencing barriers to care.

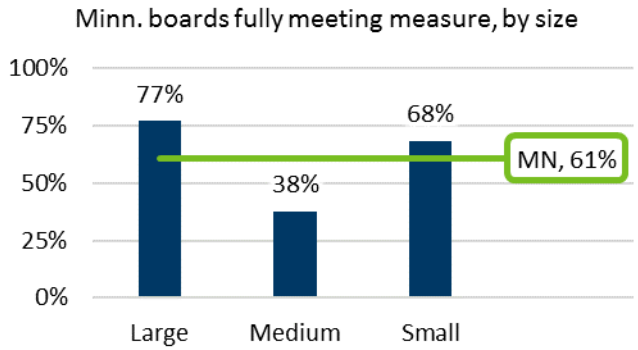
Your community health board in 2017: Fully Meet




7.1.3. Identification of gaps in access to health care services, and barriers to the receipt of health care services.

It is important for community health boards to understand the gaps in access to health care, so that effective strategies can be put into place. Community health boards must have reports of data analysis from across the public health system, which identify gaps in access to health care services and causes of access gaps.

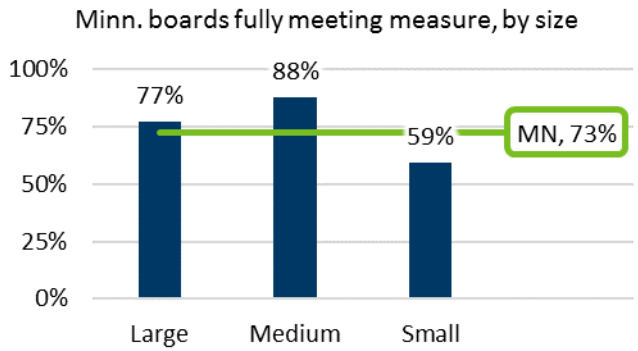
Your community health board in 2017: Fully Meet




7.2.1. Process to develop strategies to improve access to health care services.

Partnering with other organizations and agencies allows community health boards to address the multiple factors that contribute to poor access, and to coordinate strategies. A community health board does not need to have convened or led the collaborative process, but must have participated in the process.

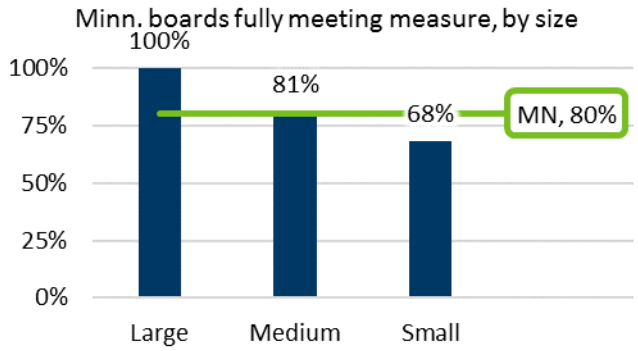
Your community health board in 2017: Partially Meet



7.2.2. Implemented strategies to increase access to health care services.

Many factors influence health care access. Community health boards can use their local knowledge of these factors to act collaboratively and implement strategies to increase access.

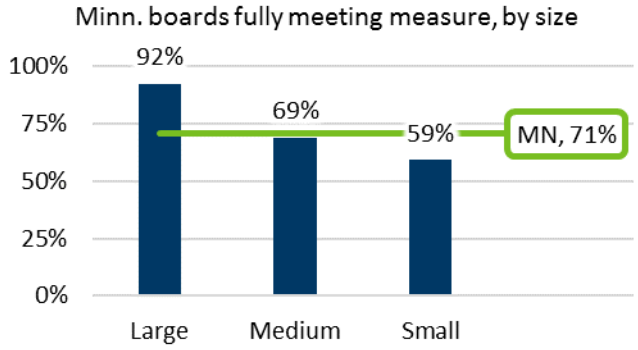
Your community health board in 2017: Fully Meet




7.2.3. Implemented culturally competent initiatives to increase access to health care services for those who may experience barriers to care due to cultural, language, or literacy differences.

Cultural differences can present serious barriers to receipt of health care services, and must be addressed in strategies if those strategies are going to be successful.

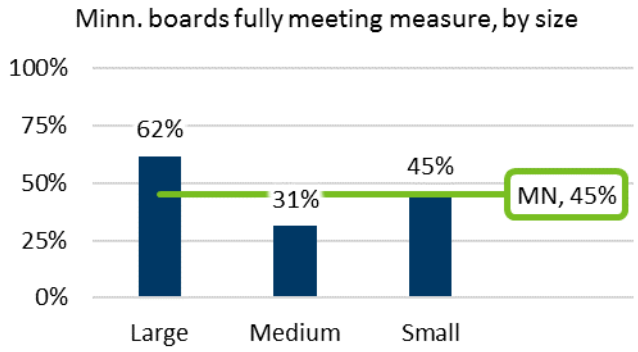
Your community health board in 2017: Partially Meet




8.2.1. Workforce development strategies.

Workforce development strategies can ensure that staff development is addressed, coordinated, and appropriate for a community health board's needs.

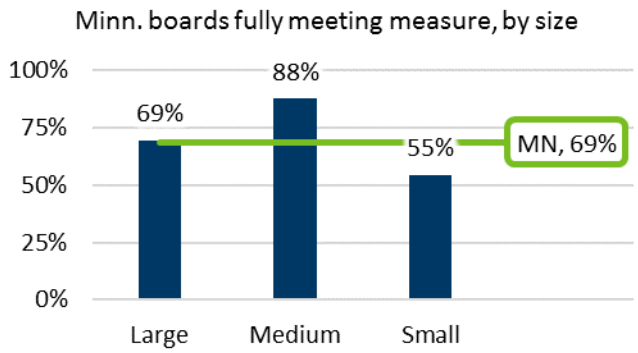
Your community health board in 2017: Partially Meet



8.2.2. A competent community health board workforce.

As in all organizations, a community health board's success depends on the capabilities and performance of its staff. In order for a community health board to function at a high level, it must take action to maximize staff capabilities and performance.

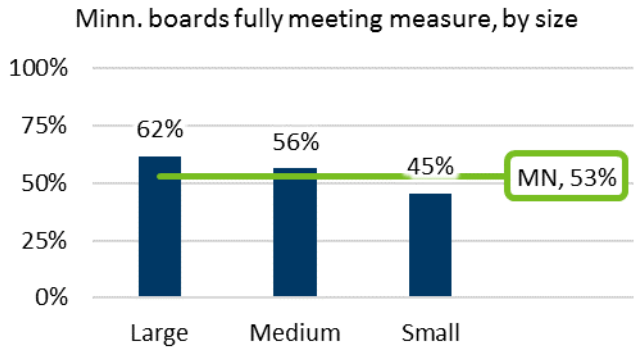
Your community health board in 2017: Fully Meet




9.1.1. Staff at all organizational levels engaged in establishing and/or updating a performance management system.

An effective performance management system engages leadership, management, and staff in its development and implementation.

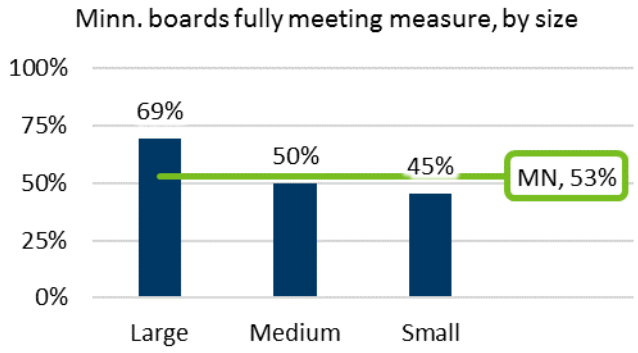
Your community health board in 2017: Partially Meet




9.1.2. Performance management policy/system.

A performance management system encompasses all aspects of using objectives and measurement to evaluate programs, policies, and processes; identify and manage opportunities for improvement; and achieve outcome targets.

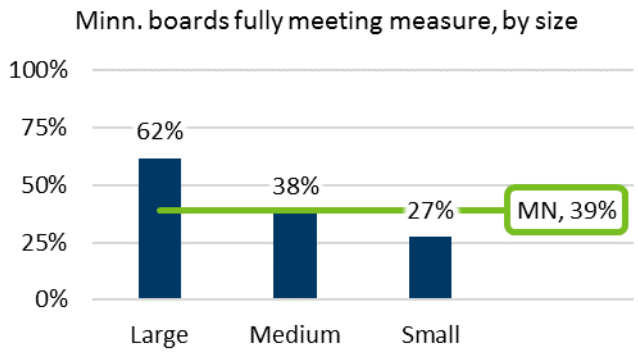
Your community health board in 2017: Fully Meet



9.1.3. Implemented performance management system.

Use of a process to evaluate and report on achievement of goals, objectives, and measures set by the performance management system is critical to improving effectiveness and efficiency.

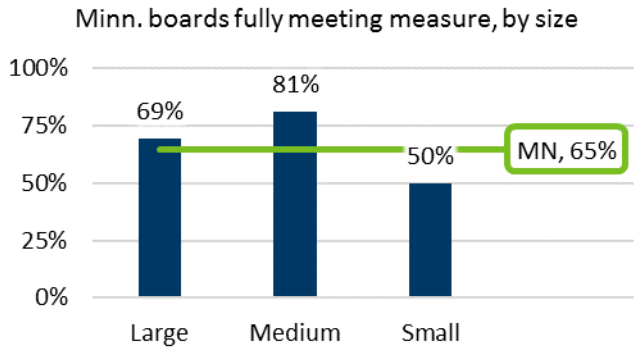
Your community health board in 2017: Fully Meet




9.1.4. Implemented systematic process for assessing customer satisfaction with community health board services.

Customer focus is a key part of a community health board's performance management system. A community health board must have the capacity to assess its process to measure the quality of customer relationships and service.

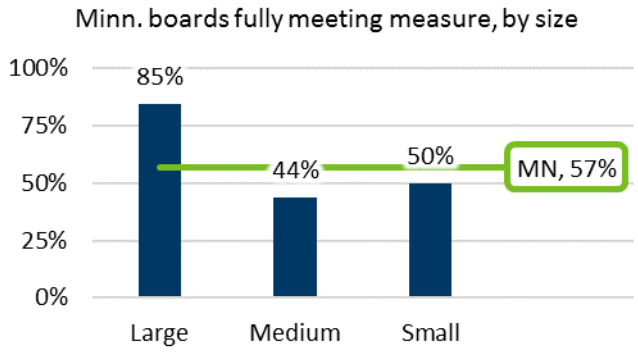
Your community health board in 2017: Partially Meet




9.1.5. Opportunities provided to staff for involvement in a community health board's performance management.

Staff must understand what a performance management system is, and how evaluation integrates with performance management. Community health boards must provide staff with development opportunities help to assure broad engagement in the performance management system.

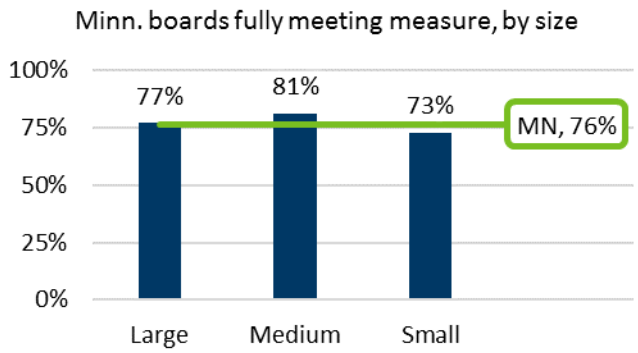
Your community health board in 2017: Fully Meet



9.2.1. Established quality improvement program based on organizational policies and direction.

Implementing a quality improvement program is an important requirement of a performance management system, and a quality improvement plan helps create the infrastructure required to make and sustain quality improvement gains.

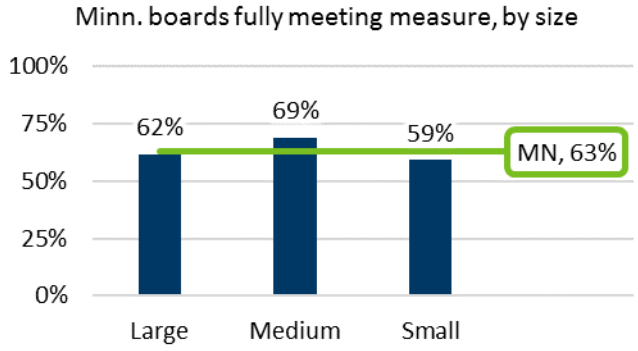
Your community health board in 2017: Fully Meet




9.2.2. Implemented quality improvement activities.

Performance management system concepts and practices serve as the framework to set targets, measure progress, report on progress, and make improvements. Community health boards must use QI activities to improve processes, programs, and interventions.

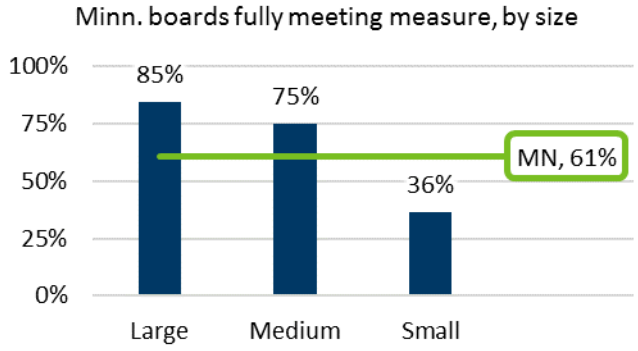
Your community health board in 2017: Fully Meet




10.2.3. Communicated research findings, including public health implications.

Public health research provides the knowledge and tools that people and communities need to protect their health. However, research findings can be confusing and difficult to translate into knowledge that steers action toward improved public health.

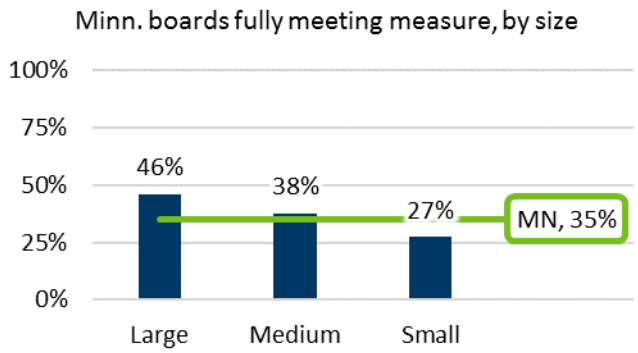
Your community health board in 2017: Partially Meet



11.1.2. Ethical issues identified and ethical decisions made.

Efforts to achieve the goal of protecting and promoting the public's health have inherent ethical challenges. Employer/employees relations may also raise ethical issues. Understanding the ethical dimensions of policies and decisions is important for the provision of effective public health and public health management.

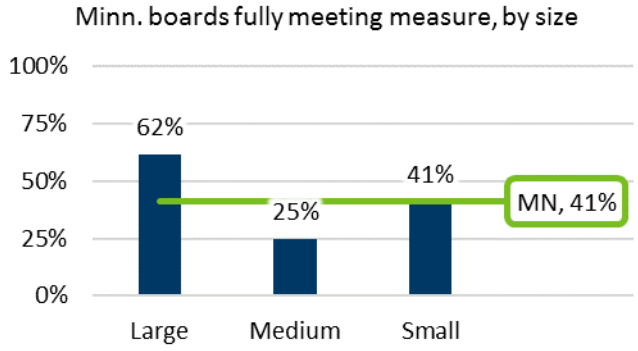
Your community health board in 2017: Cannot Meet




11.1.4. Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes.

A community health board needs to cultivate social, cultural, and linguistic competence in working with its own employees, and in providing public health programs to populations in its jurisdiction.

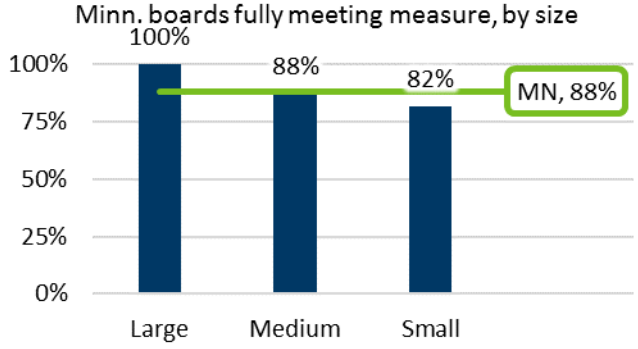
Your community health board in 2017: Fully Meet




12.2.1. Communication with the governing entity regarding the responsibilities of a community health board and of the responsibilities of the governing entity.

The governing entity is accountable for a community health board achieving its mission, goals, and objectives, to protect and preserve the health of the population within its jurisdiction.

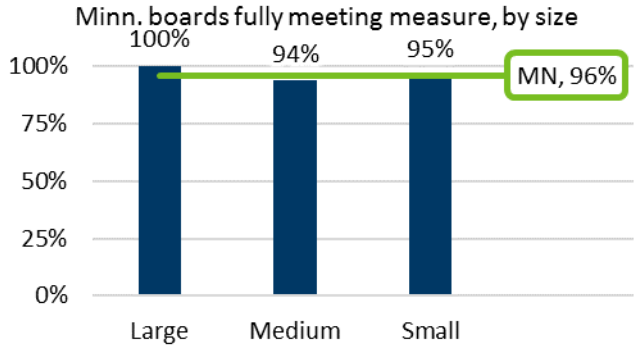
Your community health board in 2017: Fully Meet



12.3.1. Information provided to the governing entity about important public health issues facing the community, a community health board, and/or the recent actions of a community health board.

Public health governing entities exercise a wide range of responsibilities, which demand that the governing entity is well-versed in public health and in the work of a community health board.

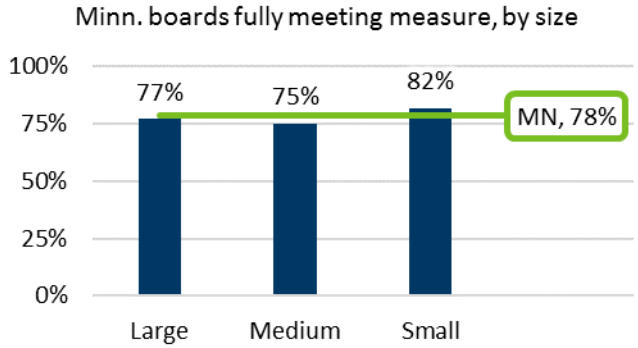
Your community health board in 2017: Fully Meet




12.3.3. Communication with the governing entity about community health board performance assessment and improvement.

Public health governing agencies exercise a wide range of responsibilities, which demand that the governing entity is well-versed in public health and in the work of a community health board. A community health board must communicate with the governing entity on assessing and improving the overall performance of a community health board.

Your community health board in 2017: Partially Meet



Assure an adequate local public health infrastructure: Minnesota-specific measures

# Workforce competency

Community health boards need a trained and competent workforce. The Core Competencies for Public Health Professionals, developed by the Council on Linkages between Academia and Public Health Practice, offer a starting point to identify professional development needs and develop a training plan. These response options are based on the Core Competencies for Public Health Professionals' eight domains, with the addition of *Informatics*.

The MDH Center for Public Health Practice provides technical assistance to community health boards that wish to assess their workforce competency or implement the Public Health Foundation's 3-Step Competency Prioritization Sequence. For more information, contact your public health nurse consultant: Who Is My Public Health Nurse Consultant?

**Your community health board's strengths**

- Cultural competency
- Financial planning and management

**Your community health board's gaps**

- Analysis/assessment
- Policy development/ program planning

| | Strengths | | | Gaps | | |
|---|---|---|---|---|---|---|
| | Large boards | Medium boards | Small boards | Large boards | Medium boards | Small boards |
| Analysis, assessment | 8% | 13% | 14% | 15% | 13% | 23% |
| Policy development, program planning | 23% | 25% | 18% | 0% | 31% | 23% |
| Communication | 8% | 38% | **36%** | 23% | 0% | 5% |
| Cultural competency | 31% | 19% | 23% | 23% | 0% | 23% |
| Community dimensions of practice | 23% | 31% | **36%** | 8% | 25% | 14% |
| Public health sciences | 15% | 0% | 5% | **46%** | **56%** | 23% |
| Financial planning and management | 31% | 13% | 27% | 31% | 25% | 14% |
| Leadership and systems thinking | **62%** | **63%** | **36%** | 8% | 6% | 23% |
| Informatics | 0% | 0% | 5% | 31% | 44% | **55%** |

Assure an adequate local public health infrastructure: Minnesota-specific measures

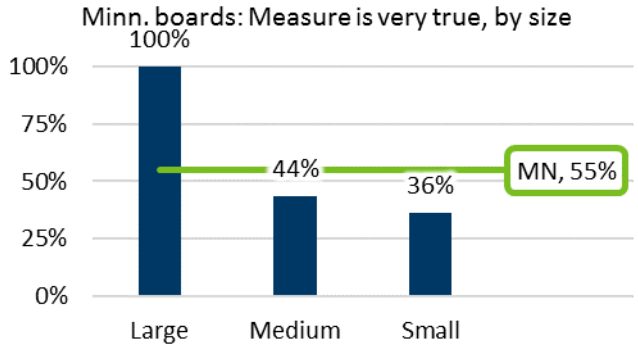
# Health equity

These questions recognize that health disparities are primarily the result of longstanding, systemic social and economic factors (e.g., social determinants of health) that have unfairly advantaged and disadvantaged some groups of people. Addressing social and economic factors that influence health is a vital part of efforts to achieve health equity.

If you would like to learn more about how to address these social and economic factors in your community health board, contact your public health nurse consultant: Who Is My Public Health Nurse Consultant?

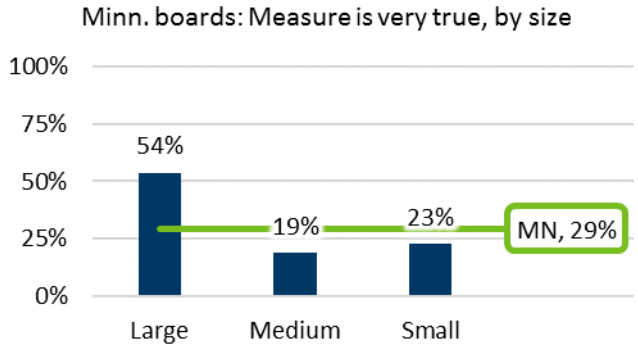
My community health board has identified health equity as a priority, with specific intent to address social determinants of health.

Your community health board in 2017: Very true



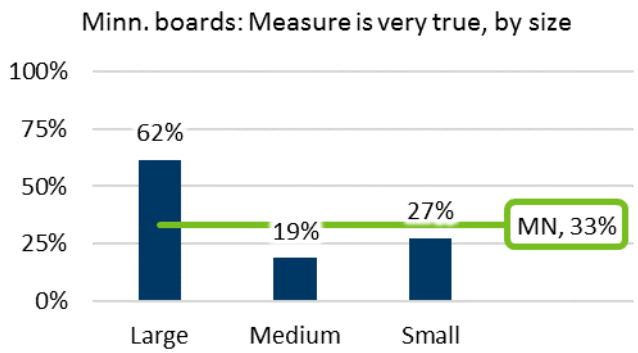

My community health board has built capacity to achieve health equity (e.g., human resources, funding, training staff) by addressing social determinants of health.

Your community health board in 2017: Somewhat true



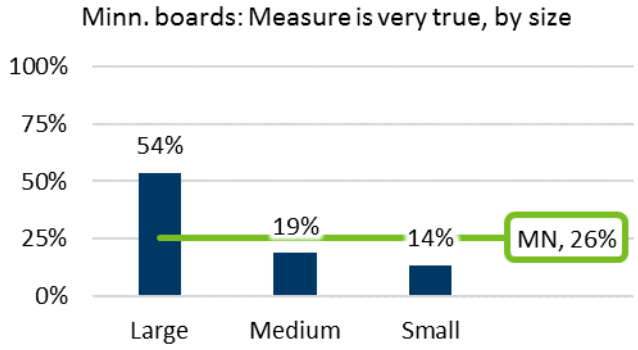
My community health board has established a core contingency of staff who are poised to advance a health equity agenda.

Your community health board in 2017: Very true



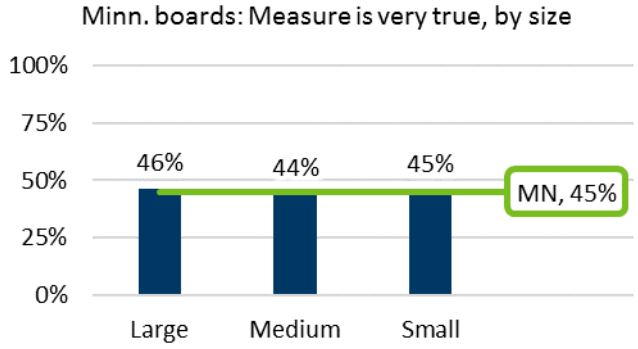

My community health board has increased the amount of internal resources directed to addressing social determinants of health.

Your community health board in 2017: Very true



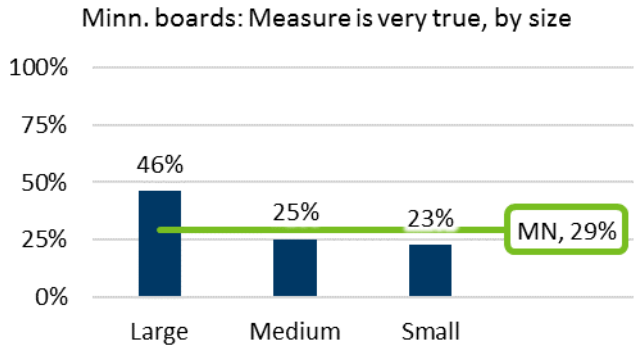

My community health board has engaged with local government agencies or other external organizations to support policies and programs to achieve health equity.

Your community health board in 2017: Very true



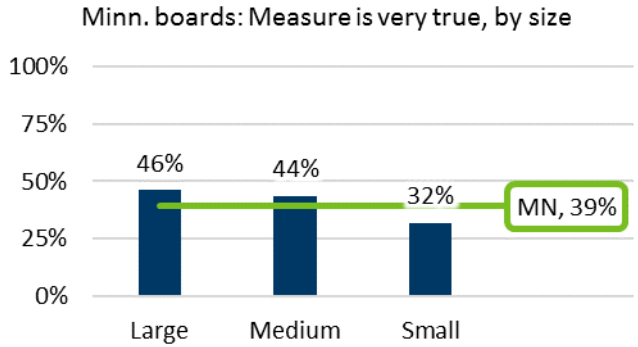
My community health board has made deliberate efforts to build the leadership capacity of community members to advocate on issues affecting social determinants of health.

Your community health board in 2017: Not true




My community health board has provided resources to community groups to support their self-identified concerns for achieving health equity in their communities.

Your community health board in 2017: Somewhat true



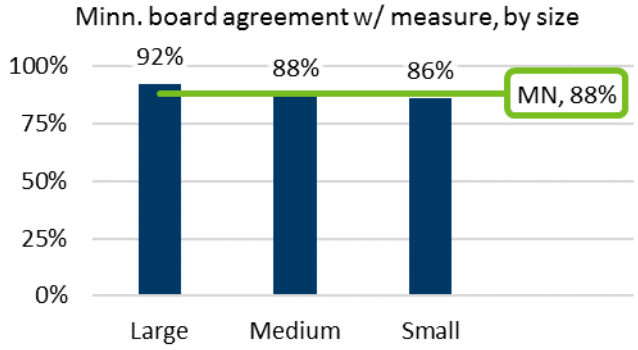
Assure an adequate local public health infrastructure: Minnesota-specific measures

# Organizational quality improvement maturity

Assessing organizational QI maturity can help a community health board identify key areas for quality improvement, and determine additional education or training needed for staff and leadership. If you would like assistance surveying your community health board's staff to assess organizational QI maturity, please contact your public health nurse consultant: Who Is My Public Health Nurse Consultant?

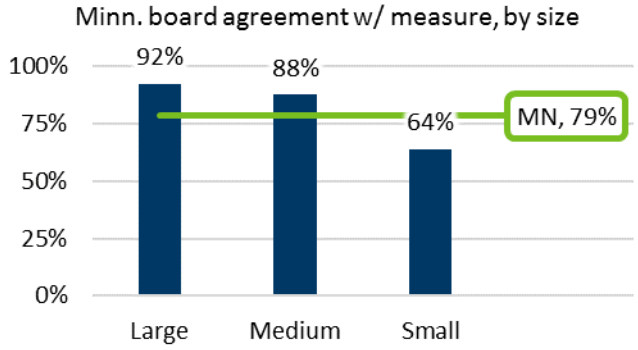
Staff members are routinely asked to contribute to decisions at my community health board.

Your community health board in 2017: Agree



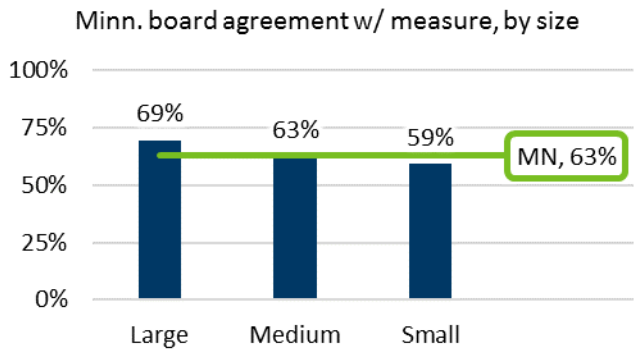

The leaders of my community health board are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.

Your community health board in 2017: Agree



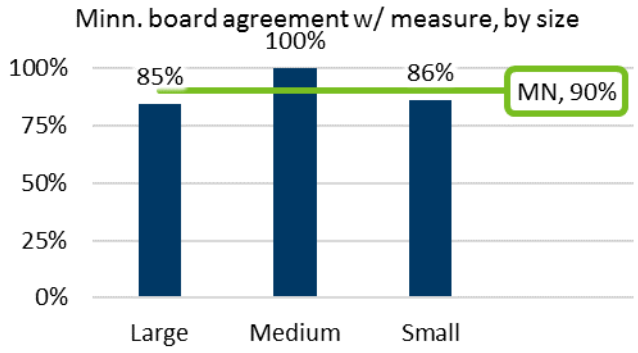
For many individuals responsible for programs and services in my community health board, job descriptions include specific responsibilities related to measuring and improving quality.

Your community health board in 2017: Agree



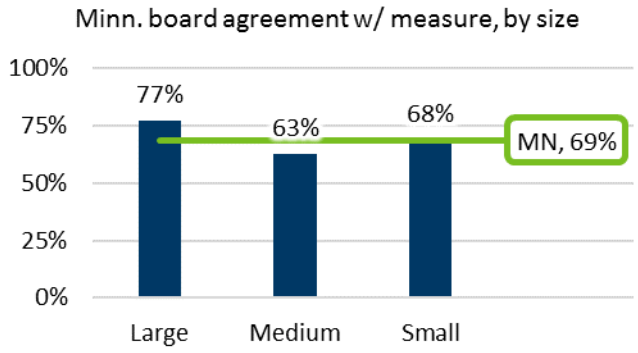

My community health board has a quality improvement (QI) plan.

Your community health board in 2017: Agree



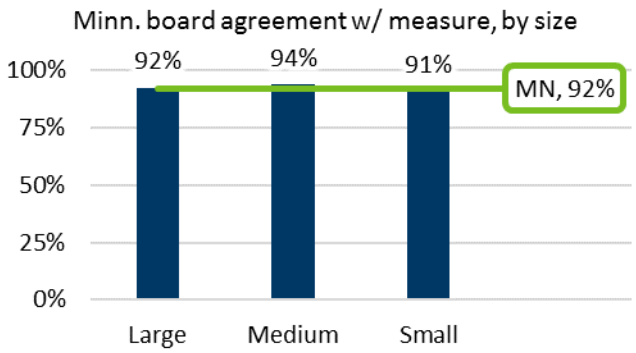

Customer satisfaction information is routinely used by many individuals responsible for programs and services in my community health board.

Your community health board in 2017: Agree



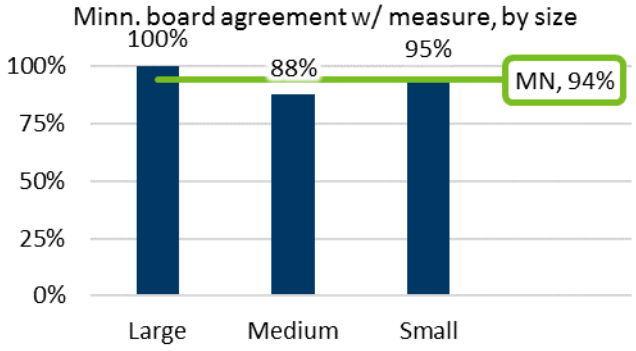
When trying to facilitate change, community health board staff has the authority to work within and across program boundaries.

Your community health board in 2017: Agree



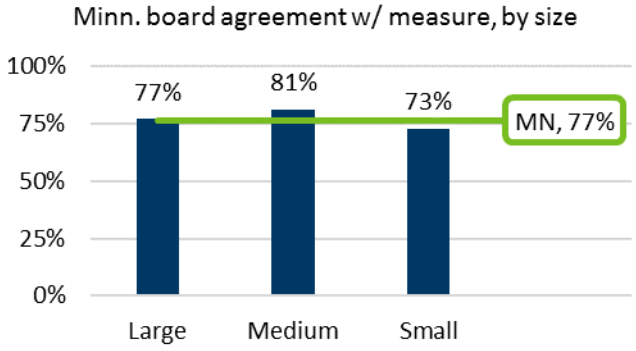

The key decision makers in my community health board believe QI is very important.

Your community health board in 2017: Strongly agree



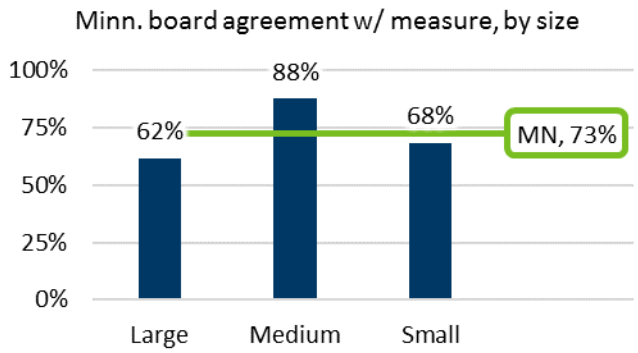

My community health board currently has a pervasive culture that focuses on continuous QI.

Your community health board in 2017: Agree



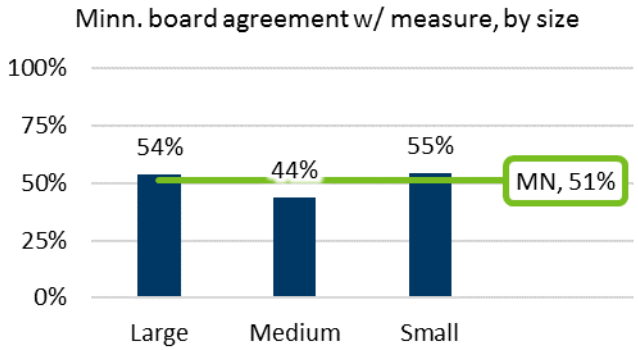
My community health board currently has aligned its commitment to quality with most of its efforts, policies, and plans.

Your community health board in 2017: Agree

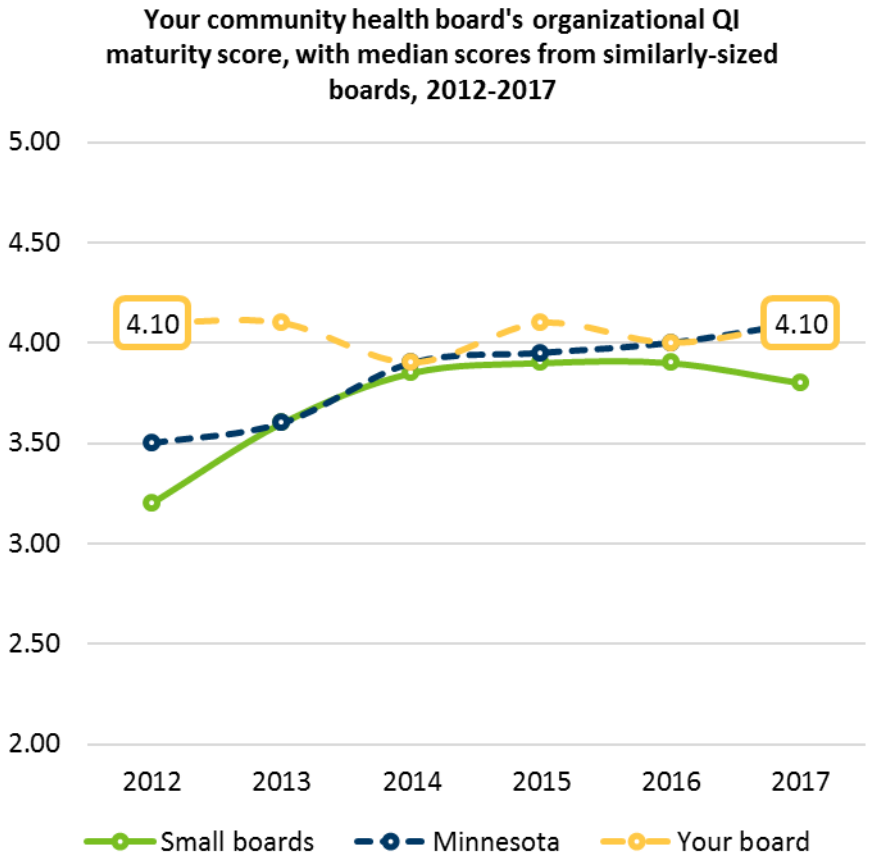



My community health board currently has a high level of capacity to engage in QI efforts.

Your community health board in 2017: Agree



To monitor system-level changes in QI maturity, the Minnesota Public Health Research to Action Network developed the organizational QI maturity score, which corresponds to the NACCHO Roadmap for a Culture of Quality Improvement. You may see your community health board's QI maturity score fluctuate as your community health board becomes more immersed in quality improvement activities and gains a better understanding of what quality improvement looks like to you. If you would like assistance surveying your community health board's staff to assess organizational QI maturity, please contact your public health nurse consultant: Who Is My Public Health Nurse Consultant?




A community health board's organizational QI maturity score is based on its responses to the 10 questions from the previous pages:

1. Staff members are routinely asked to contribute to decisions at my community health board.
2. The leaders of my community health board are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.
3. For many individuals responsible for programs and services in my community health board, job descriptions include specific responsibilities related to measuring and improving quality.
4. My community health board has a quality improvement (QI) plan.
5. Customer satisfaction information is routinely used by many individuals responsible for programs and services in my community health board.
6. When trying to facilitate change, community health board staff has the authority to work within and across program boundaries.
7. The key decision makers in my community health board believe QI is very important.
8. My community health board currently has a pervasive culture that focuses on continuous QI.
9. My community health board currently has aligned its commitment to quality with most of its efforts, policies, and plans.
10. My community health board currently has a high level of capacity to engage in QI efforts.

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Your community health board's organizational QI maturity score | 4.1 | 4.1 | 3.9 | 4.1 | 4.0 | 4.1 |

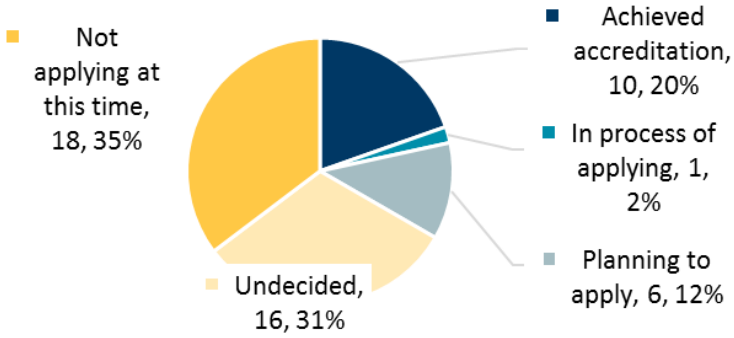
Assure an adequate local public health infrastructure: Minnesota-specific measures

# Voluntary public health accreditation

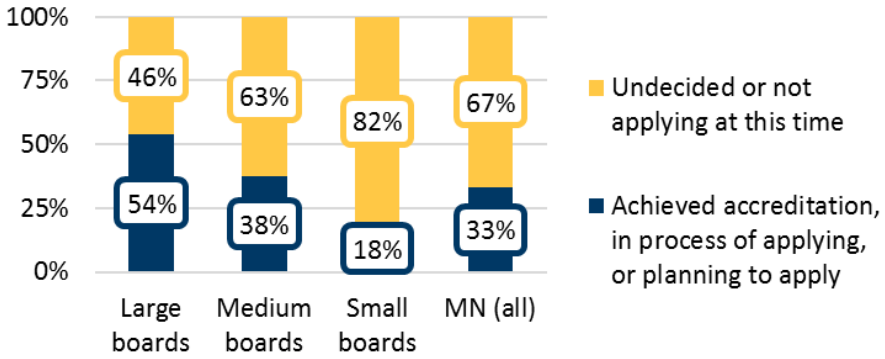
Systematic information on accreditation preparation is useful for networking, mentoring, and sharing among community health boards, and enables monitoring system-level progress to implement the SCHSAC recommendation that all community health boards are prepared to apply for voluntary national accreditation by 2020 (as well as a national goal to increase percentage of population served by an accredited health department).

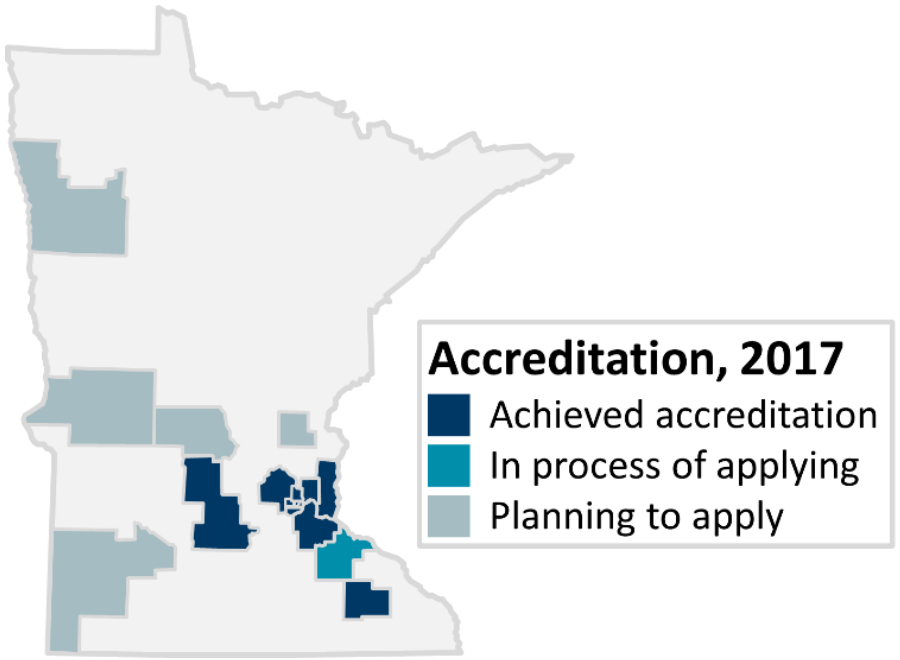
**You reported that your community health board is**: My community health board is in the process of accreditation (e.g., has submitted a statement of intent)

**Minnesota community health board participation in national voluntary public health accreditation, 2017**




**Minnesota community health board participation in accreditation, by population, 2017**



**GOODHUE COUNTY**
**HEALTH & HUMAN SERVICES (HHS)**

## Monthly Report

## CD Placements

CONSOLIDATED FUNDING LIST FOR OCTOBER 2018

**In-Patient Approval:**

#02681462R – 16 year old male – two previous treatments – Maple Lake Recovery Center, Maple Lake

#03726177R – 46 year old male – two previous treatments – Oakridge, Rochester

#02465943R – 34 year old male – five previous treatments – Twin Town Treatment Center, St. Paul

#05530507R – 44 year old male – one previous treatment – MN Adult & Teen Challenge, Rochester

**Outpatient Approvals:**

#01639490R – 40 year old male – two previous treatments – Common Ground, Red Wing

#01697824R – 40 year old female – one previous treatment – Recovery Is Happening, Rochester

#01789456R – 26 year old male – numerous previous treatments – Northstar Behavioral Health, St. Paul

**Halfway House Approvals:** None

**GOODHUE COUNTY**
**HEALTH & HUMAN SERVICES (GCHHS)**

**Monthly Update**
**Child Protection Assessments/Investigations**

| | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| **January** | 18 | 18 | 21 | 25 |
| **February** | 11 | 26 | 22 | 21 |
| **March** | 23 | 16 | 17 | 27 |
| **April** | 24 | 32 | 17 | 22 |
| **May** | 24 | 21 | 31 | 19 |
| **June** | 7 | 17 | 28 | 23 |
| **July** | 14 | 18 | 21 | 22 |
| **August** | 17 | 19 | 33 | 11 |
| **September** | 31 | 25 | 20 | 18 |
| **October** | 30 | 18 | 28 | |
| **November** | 20 | 22 | 19 | |
| **December** | 17 | 15 | 16 | |
| **Total** | **236** | **247** | **273** | **188** |