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
JANUARY 22, 2019
10:30 A.M.

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

        Documents:

        DECEMBER 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

    b. Child Welfare-Juvenile Justice Screening Grant

        Documents:

        CHILD WELFARE-JUVENILE JUSTICE SCREENING GRANT.PDF

    c. 2019 HHS Per Diem Rates

        Documents:

        2019 HHS PER DIEM RATES.PDF

    d. 2019 GCHHS MN Merit System Compensation Plan

        Documents:

        2019 HHS COMPENSATION PLAN.PDF

    e. 2019 HHS Budget

        Documents:

HHS 2019 BUDGET.PDF

f. 2019 SNAP Employment And Training Agreement

Documents:

SNAP EMPLOYMENT AND TRAINING AGREEMENT.PDF

5. INTRODUCTION OF NEW & PROMOTED STAFF
6. ACTION ITEMS:
   a. Accounts Payable

      Documents:

      ACCOUNTS PAYABLE.PDF

   b. Personnel Items
      Nina Arneson

      Documents:

      PERSONNEL ITEMS.PDF
      RECLASSIFICATION REQUEST.PDF
      LIVE WELL GOODHUE COUNTY GRANT CHANGES.PDF

   c. 24/7 Child Protection On-Call Wage Adjustment
      Nina Arneson and Kris Johnson

      Documents:

      CHILD PROTECTION 24-7 ONCALL WAGE ADJUSTMENT.PDF
      CHILD PROTECTION ON CALL REPORT.PDF

7. INFORMATIONAL ITEMS:
   a. Community Health Improvement Plan (CHIP)
      Ruth Greenslade

      Documents:

      2018-2023 GOODHUE COUNTY CHIP PRESENTATION.PDF
      FULL GOODHUE CHIP WITH ALL ACTION PLANS.PDF

8. FYI-MONTHLY REPORTS:
   a. Placement Report

      Documents:

      PLACEMENT REPORT.PDF

   b. Child Protection Report

      Documents:

      CHILD PROTECTION REPORT YEAR END.PDF

   c. 2017 DHS MN Child Maltreatment Report

      Documents:

2017 DHS MN CHILD MALTREATMENT REPORT.PDF

d. 2017 DHS MN Out Of Home And Permanency Report

Documents:

2017 DHS MN OUT OF HOME AND PERMANENCY REPORT.PDF

9. ANNOUNCEMENTS/COMMENTS:
10. ADJOURN
    a. Next Meeting Will Be February 19, 2019 At 10:30 A.M.

GOODHUE COUNTY

HEALTH & HUMAN SERVICES BOARD MEETING

MINUTES OF DECEMBER 18, 2018

The Goodhue County Health and Human Services Board convened their regularly scheduled meeting at 10:30 A.M., Tuesday, December 18, 2018, in the Goodhue County Board Room located in Red Wing, Minnesota.

BOARD MEMBERS PRESENT:

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

STAFF AND OTHERS PRESENT:

Nina Arneson, Mary Heckman, Mike Zorn, Lisa Woodford, Sheila Gadient, Ruth Greenslade, Kristine Holst, Pat Thompson, and Scott Arneson.

AGENDA:

On a motion by P. Drotos and seconded by J. Majerus, the Board unanimously approved the December 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 Board Meeting on November 20, 2018.

CONSENT AGENDA:

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

ACTION ITEMS:

On a motion by J. Majerus and seconded by S. Johnson, the Board unanimously approved payment of all accounts as presented.

On a motion by P. Drotos and seconded by S. Johnson, the Board approved (6-1-0) as recommended which was not to renew the contract for Local Fraud Prevention, B. Nesseth dissenting.

FYI & REPORTS:

Placement Report
Child Protection Report
HHS Staffing Update
Live Well Goodhue County Annual Report

ANNOUNCEMENTS/COMMENTS:

Goodhue County Annual Legislative Luncheon, Tuesday December 18, 2018 at 11:30 am

ADJOURN:

On a motion by P. Drotos and seconded by J. Majerus, the Board unanimously approved adjournment of this session of the Health & Human Services Board Meeting at or around 11:20 a.m.

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (HHS)

REQUEST FOR BOARD ACTION

Requested Board Date:	January 22, 2019	**Staff Lead:**	Kris Johnson
Consent Agenda:	☒ Yes ☐ No	**Attachments:**	☐ Yes ☒ No
Action Requested:	Approve Child Care Licensure Actions		

BACKGROUND:

Child Care Relicensures:

- Tiffany Stensland Zumbrota
- Natasaporn Post Zumbrota
- Shannon Zielsdorf Zumbrota
- Carrie Cordes Red Wing
- Sarah Lexvold Goodhue
- Ronda Swenning Red Wing
- Teresa Lodermeier Zumbrota

Child Care Licensures:

Number of Licensed Family Child Care Homes: 86

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

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (GCHHS)

REQUEST FOR BOARD ACTION

Requested Board Date:	January 22, 2019	**Staff Lead:**	Mike Zorn
Consent Agenda:	☒ Yes ☐ No	**Attachments:**	☒ Yes ☐ No
Action Requested:	Approve Acceptance of CY 2019 Child Welfare/Juvenile Justice Screening Grant		

BACKGROUND: In 2011, the Department of Human Services switched from a Combined Children's Mental Health Grant to Child Welfare/Juvenile Justice Screening Grant. There are two portions to this grant. A Child Welfare portion that is connected to Health & Human Services and a Juvenile Justice portion that is connected to Court Services.

Attached please find grant award notice and acceptance of county award for 2019.

Due to the timely nature- this was signed in December 2018

RECOMMENDATION: Goodhue County HHS recommends approval as requested.

DEPARTMENT OF HUMAN SERVICES

December 7, 2018

County: **Goodhue**
County Director: Nina Arneson
County (Name of Person in Charge) Program Coordinator:
DHS (Person in Charge) Program Coordinator: Neerja Singh

On behalf of the Minnesota Department of Human Services, I am pleased to inform you that **Goodhue** County has been awarded funding for a Child Welfare/Juvenile Justice Screening Grant, which is dispersed in the Children's Mental Health Screening Grant for the next calendar year (CY 2019).

The Screening Grant provides state-appropriated funds to support children's mental health screening, assessment, and mental health services to children in the child welfare and juvenile justice systems (prioritizing funds for uninsured and underinsured youth).

Children to be screened are described in Minnesota Statutes, § 245.4874, subd.i 1(12),; § 260B.157, subd. 1; § 260B.176, subd. 2(e); and § 260B.235, subd. 6. They include a child:

- receiving protective services,
- in out-of-home placement,
- for whom parental rights have been terminated,
- found delinquent,
- detained for an alleged delinquent act, and
- found to have committed a petty juvenile offense for the third or subsequent time.

The Department has allocated $61,673.00 to Goodhue County for Child Welfare/Juvenile Justice Screening for CY 2019. Reimbursement for Child Welfare/Juvenile Justice Screening expenditures cannot exceed the annual CY allocation. There is no carry over of unused funds from one calendar year to another. Marginal use of grant funds will result in future grant reductions or cancellations.

These funds will be allocated one year at a time. This Screening Grant is not considered accepted until Neerja Singh, the representative from the State of Minnesota, receives the Acceptance of Screening Grant Letter from the Goodhue County Board.

1. TERM OF GRANT AWARD

This grant award is effective on January 1, 2019, or upon the date that the final required signature is obtained by the STATE, pursuant to Minnesota Statutes, section 16C.05, subdivision 2, whichever occurs later, and shall remain in effect through December 31, 2019, or until all obligations set forth in this grant award have been satisfactorily fulfilled, whichever occurs first. COUNTY understands that NO work should begin under this grant award until ALL required signatures have been obtained, and

GRANTEE is notified to begin work by the STATE's Authorized Representative. The COUNTY shall have a continuing obligation, after said grant period, to comply with the following provisions of grant clauses: Liability; State Audits; and Jurisdiction and Venue.

2. Amount and Period of Funding

The $61,673.00 award is for calendar year 2019 (January 1, 2019 – December 31, 2019). The breakdown of the total is as follows: Child Welfare $45,081.00 and Juvenile Justice $16,592.00. Quarterly payments will be based on actual reimbursement determined by Budget Reporting and Accounting for Social Service (BRASS) system code expenditure data. Children's mental health screening expenditures are reported under the BRASS system. Time and expenses related to children's mental health screenings will be reported using the 111x Mental Health Screening BRASS code. Children's mental health assessments and services are reported under the BRASS code specific to those services. All Child Welfare/Juvenile Justice Screening Grant award funds must be expended by Dec. 31, 2018.

3. County Duties

ALLOWABLE USES. The allowable uses of grant funding are also unchanged for CY2019. The categories below show how the funding may be spent in 2019 and should be represented in the budget (see attached sample) that counties submit to DHS.

- Administration and conducting screenings (up to 25% of the grant award – *staff time, etc.*);
- Data collection and reporting (up to 10% of the grant award – *time collecting and reporting data*);
- Clinical Services (unlimited – *Diagnostic Assessments, therapy, CTSS if not paid otherwise*);
- Clinical and/or ancillary mental health services (unlimited – *respite care, parent trainings, groups*);
- Clinical supervision (up to 10% of the grant award – *for interns, practicum students*);
- Training for child welfare and juvenile justice staff (up to 10% of the grant award – *e.g. Trauma focused care, anti-stigma training, best practices and similar trainings on mental health topics*).

4. Reporting Requirements

Fiscal reporting for this grant must follow the Social Services Expenditure and Reconciliation Report (SEAGR) and DHS Form 2895. Children's mental health screening expenditures are reported under the Budget Reporting and Accounting for Social Service (BRASS) system. Effective January 1, 2012, time and expenses related to children's mental health screenings will be reported using the 111x Mental Health Screening BRASS code. Children's mental health assessments and services are reported under the BRASS code specific to those services.

5. CONDITIONS OF PAYMENT

All services provided by COUNTY pursuant to this grant contract shall be performed to the satisfaction of the STATE, as determined at the sole discretion of Neerja Singh, 651-431-2246,

neerja.singh@state.mn.us as the authorized representative, and in accord with all applicable federal, state, and local laws, ordinances, rules and regulations. The COUNTY shall not receive payment for work found by the STATE to be unsatisfactory, or performed in violation of federal, state or local law, ordinance, rule or regulation.

6. PAYMENT RECOUPMENT

The COUNTY must reimburse the STATE upon demand or the STATE may deduct from future payments under this grant any amounts paid by the STATE, under this or any previous grant, for which invoices and progress reports have not been received, or for which the COUNTY's books, records or other documents are not sufficient to clearly substantiate that those amounts were used by the COUNTY to perform grant services.

7. Insufficient Funds

The STATE may immediately terminate this grant award if it does not obtain funding from the Minnesota Legislature, or other funding source; or if funding cannot be continued at a level sufficient to allow for the payment of the services covered here. Termination will be by written or fax notice to the County. The STATE is not obligated to pay for any services that are provided after notice and effective date of termination. However, the COUNTY will be entitled to payment, determined on a pro rata basis, for services satisfactorily performed to the extent that funds are available. The STATE will not be assessed any penalty if the grant contract is terminated because of the decision of the Minnesota Legislature, or other funding source, not to appropriate funds. The STATE must provide the COUNTY notice of the lack of funding within a reasonable time of the STATE's receiving that notice.

8. Breach

Upon STATE's knowledge of a curable material breach of the grant contract by COUNTY, STATE shall provide COUNTY written notice of the breach and ten (10) days to cure the breach. If COUNTY does not cure the breach within the time allowed, COUNTY will be in default of this grant contract and STATE may cancel the grant contract immediately thereafter. If COUNTY has breached a material term of this grant contract and cure is not possible, STATE may immediately terminate this grant contract.

9. LIABILITY

To the extent provided for in Minnesota Statutes, section 466.01 to 466.15, the COUNTY agrees to be responsible for any and all claims or causes of action arising from the performance of this grant by COUNTY or COUNTY's agents or employees. STATE's liability and that of its agents or employees, if any, for any and all claims or causes of action arising from the performance of this grant shall be governed by Minnesota Statutes, section 3.736. This clause shall not be construed to bar any legal remedies COUNTY may have for the STATE's failure to fulfill its obligations pursuant to this grant.

10. STATE AUDITS

Minnesota Statutes, section 16C.05, subdivision 5, the books, records, documents, and accounting procedures and practices of the COUNTY and its employees, agents, or subcontractors relevant to this grant contract shall be made available and subject to examination by the STATE, including the contracting Agency/Division, Legislative Auditor, and State Auditor for a minimum of six years from the end of this grant contract.

11. AMENDMENTS

Any amendments to this award letter shall be in writing, and shall be executed by the same parties who executed the original award letter, or their successors in office.

12. JURISDICTION AND VENUE

This award letter, and amendments and supplements thereto, shall be governed by the laws of the State of Minnesota. Venue for all legal proceedings arising out of this grant contract, or breach thereof, shall be in the state or federal court with competent jurisdiction in Ramsey County, Minnesota.

13. WAIVER

If the STATE fails to enforce any provision of this award letter, that failure does not waive the provision or the STATE's right to enforce it.

14. AWARD LETTER COMPLETE

This award letter contains all negotiations and agreements between the STATE and the COUNTY. No other understanding regarding this award letter, whether written or oral may be used to bind either party.

15. Affirmative Action

COUNTY is encouraged to prepare and implement an Affirmative Action plan for the employment of qualified minority persons, women and persons with disabilities, and to submit the plan to the Commissioner of Human Rights, in accordance with Minnesota Statutes, section 363A.36.

16. Non-Discrimination

The COUNTY agrees not to discriminate against any employee or applicant for employment because of race, color, creed, religion, national origin, sex, marital status, status in regard to public assistance, membership or activity in a local commission, disability, sexual orientation, or age in regard to any position for which the employee or applicant for employment is qualified. Minnesota Statutes, section 363A.02. COUNTY agrees to take affirmative steps to employ, advance in employment, upgrade, train, and recruit minority persons, women, and persons with disabilities.

The COUNTY must not discriminate against any employee or applicant for employment because of physical or mental disability in regard to any position for which the employee or applicant for employment is qualified. The COUNTY agrees to take affirmative action to employ, advance in employment, and otherwise treat qualified disabled persons without discrimination based upon their physical or mental disability in all employment practices such as the following: employment, upgrading, demotion or transfer, recruitment, advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. Minnesota Rules, part 5000.3550.

COUNTY agrees to comply with the rules and relevant orders of the Minnesota Department of Human Rights issued pursuant to the Minnesota Human Rights Act. Notification to employees and other affected parties. The COUNTY agrees to post in conspicuous places, available to employees and applicants for employment, notices in a form to be prescribed by the commissioner of the Minnesota Department of Human Rights. Such notices will state the rights of applicants and employees, and COUNTY's obligation under the law to take affirmative action to employ and advance in employment qualified minority persons, women, and persons with disabilities.

17. WORKERS' COMPENSATION

The COUNTY certifies that it is in compliance with Minnesota Statutes, section 176.181, subd. 2, pertaining to workers' compensation insurance coverage. The COUNTY'S employees and agents will not be considered employees of the STATE. Any claims that may arise under the Minnesota Workers' Compensation Act on behalf of these employees or agents and any claims made by any third party as a consequence of any act or omission on the part of these employees or agents are in no way the STATE'S obligation or responsibility.

18. VOTER REGISTRATION CERTIFICATION

COUNTY certifies that it will comply with Minnesota Statutes, section 201.162 by providing voter registration services for its employees and for the public served by the GRANTEE.

19. OWNERSHIP OF EQUIPMENT

The STATE shall have the right to require transfer of all equipment purchased with grant funds (including title) to the STATE or to an eligible non-STATE party named by the STATE. This right will normally be exercised by the STATE only if the project or program for which the equipment was acquired is transferred from one grantee to another.

20. FEDERAL AUDIT REQUIREMENTS AND GRANTEE DEBARMENT INFORMATION.

COUNTY certifies it will comply with the Single Audit Act, and Code of Federal Regulations, title 2, subtitle A, chapter II, part 200, as applicable. All sub-recipients receiving $750,000 or more of federal assistance in a fiscal year will obtain a financial and compliance audit made in accordance with the

Single Audit Act, or Code of Federal Regulations, title 2, subtitle A, chapter II, part 200, as applicable. Failure to comply with these requirements could result in forfeiture of federal funds.

DEBARMENT BY STATE, ITS DEPARTMENTS, COMMISSIONS, AGENCIES OR POLITICAL SUBDIVISIONS

COUNTY certifies that neither it nor its principles is presently debarred or suspended by the STATE, or any of its departments, commissions, agencies, or political subdivisions. COUNTY'S certification is a material representation upon which the grant contract award was based. The COUNTY shall provide immediate written notice to the STATE'S authorized representative if at any time it learns that this certification was erroneous when submitted or becomes erroneous by reason of changed circumstances.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY, AND VOLUNTARY EXCLUSION

Federal money will be used or may potentially be used to pay for all or part of the work under the grant contract, therefore COUNTY certifies that it is in compliance with federal requirements on debarment, suspension, ineligibility and voluntary exclusion specified in the solicitation document implementing Executive Order 12549. COUNTY'S certification is a material representation upon which the grant contract award was based.

21. STATE AUTHORIZED REPRESENTATIVES

The STATE'S authorized representative for the purposes of administration of this grant award is **Neerja Singh**, neerja.singh@state.mn.us or her successor. Such representative, acting on behalf of the STATE, shall have final authority for acceptance of COUNTY'S services and if such services are accepted as satisfactory, shall so certify on each invoice submitted pursuant to Clause 2.2. All notices required under this grant award shall be made to the Authorized Representative. If the STATE's Authorized Representative changes at any time during this grant contract, STATE will notify COUNTY in a reasonable amount of time.

State's Authorized Representative contact information:

Neerja Singh, LICSW, LADC
P.O. Box 64981
St. Paul, MN 55164-0981
Phone: 651-431-2246
neerja.singh@state.mn.us

All reports, except fiscal, must be sent to the grant manager via e-mail or direct mail.

Please submit a budget to Neerja Singh (neerja.singh@state.mn.us) for how your County will be spending grant funds by December 31, 2018,

For questions on financial matters or SEAGR reporting, contact: Craig Beske, Program Accountant, 651-431-3780, Craig.Beske@state.mn.us.

Sincerely,

Maisha Giles, MA, LMFT, LICSW, LADC
Director, Community Supports Administration

Enclosures

cc: County Social Services Director
County Social Services Fiscal Supervisor

Screening Grant Budget

Cal. Year: 2019 County: Goodhue Grant Award: $61,673

Administration and Operating Expenses (up to 25% of the grant award) (*staff time in administering screens, screening tools/supplies, clerical support of data entry, and computers and/or software*)	**TOTAL**	**Grant Funds**
Juvenile Justice Mental Health Screenings	$2,120	
Child Welfare Screenings	$5,000	
		$7,120
Data Collection and Reporting (up to 10% of the grant award) (*time spent collecting and reporting data to DHS*)		
Clinical Services (Unlimited) (*Diagnostic Assessments, psychotherapy, CTSS and similar documented treatment related costs*)		
Contract with Fernbrook and Mental Health Center for Mental Health		
Services for children who are uninsured or underinsured		
		$54,553
Ancillary or Supportive Services (Unlimited) *(respite care, skills and support groups, parent training, and other similar costs.)*		
Clinical Supervision (up to 10% of the grant award) (*clinical supervision for interns, practicum students, and those who are pursuing licensure*)		
Training for Child Welfare and Probation Officers (up to 10% of the grant award) (*trainings on screening, trauma focused care, anti-stigma, best practices and other similar trainings)*		
	Total:	**$61,673**

*Electronic copies of this form available upon request. Contact: neerja.singh@state.mn.us

ACCEPTANCE OF GOODHUE COUNTY AWARD

ACCEPTANCE OF Child Welfare/Juvenile Justice Screening Grant 2019 Grant award for *the January 1, 2019 through December 31, 2019 Child Welfare/Juvenile Justice Screening Grant award* available through Minnesota Statutes, § 245.4874, subd. 1(12); § 260B.157, subd. 1; § 260B.176, subd. 2(e); and § 260B.235, subd. 6.

Name of County: Goodhue

County Project Coordinator: Kristin Johnson

It is understood and agreed by the county board that any funds granted pursuant to this grant award extension for the Child Welfare/Juvenile Justice Screening grant award funded through Children's Mental Health Screening Grant, are to be expended for the purposes set forth in the county award letter dated December 7, 2018 as approved by the Minnesota Commissioner of the Department of Human Services and in accordance with applicable laws and rules. The application and grant award letter are both incorporated into this award by reference. Further it is understood that the budgets, expenditures, and program will be subject to periodic review by the Commissioner. If funds are not being used to implement the approved plan and according to the grant award letter, they may be subject to return or future payment deductions in accordance with Minnesota Statutes, section 256.01, subdivision 2. All payment information is included in the incorporated grant award letter. An amended grant award letter will be issued and must be signed in the event any changes are made to the terms of the grant award.

The receipt of grant funds by the county board assures acceptance by the board of the following responsibilities:

1. Utilization of written personnel policies in assigning and compensating project employees.
2. Compliance with Titles VI and VII of the United States Civil Rights Act of 1964, Americans with Disabilities Act, Minnesota Statutes, chapter 363 and the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13.
3. Compliance with Workers Compensation insurance coverage requirements of Minnesota Statues, section 176.181, subdivision 2.
4. Responsibility for any and all claims or causes of action arising from the performance of this grant to the extent provided for in Minnesota Statutes, section 466.01- 466.15.
5. Compliance with all applicable federal and state regulations, including, but not limited to, the Single Audit Act (OMB Circular A-133), Debarment and Suspension certifications (45 CFR 92.35) and Federal Cost Principles and Administrative Requirement (OMB Circulars A-87 and A-102.

Signature: _____

Chairperson: Brad Anderson

Date: _____

Goodhue County
Health and Human Services

DATE: January 18, 2019

TO: Goodhue County Health and Human Services Board

FROM: Nina Arneson, HHS Director

RE: 2019 Per Diem Rates

On December 18, 2018, the County Goodhue County Board set 2019 County per diem payment at $50.00 per day. This will be also utilized for the HHS Board Members meetings as allowable under MS 375.055.

This is to request the HHS Board adopt the rate set by Goodhue County Board.

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (GCHHS)

REQUEST FOR BOARD ACTION

Requested Board Date:	January 22, 2019	**Staff Lead:**	Nina Arneson
Consent Agenda:	☒ Yes ☐ No	**Attachments:**	☒ Yes ☐ No
Action Requested:	Approve CY 2019 Minnesota Merit System Compensation Plan for Goodhue County HHS Department		

BACKGROUND:

The Minnesota Merit System has presented all Merit System Counties with its recommended Compensation Plan for CY 2019. Goodhue County Health & Human Services will be adopting within the minimums and maximums of the Minnesota Merit System Plan as recommended by the Minnesota Merit System.

For CY 2019, Goodhue County has adopted 3.0% COLA for all non-union employees. Attached is the GCHHS Compensation plan as of January 1, 2019 with Goodhue County's 3.0% COLA increase as approved by the Goodhue County Board.

RECOMMENDATION: The HHS Department recommends approving the CY 2019 HHS Minnesota Merit System Compensation Plan based on the action of the Goodhue County Board meeting on December 18, 2018 for all non-union employees.

December 29 2018
3.00% COLA For 2019

GOODHUE COUNTY HEALTH & HUMAN SERVICES COMPENSATION PLAN
December 29 2018

	1	2	3	4	5	6	7	8	9	10	
Office Support Specialist 78 COUNTY	2683	2803	2926	3067	3201	3352	3503	3645	3808	3856	
Bi-Weekly	1238.38	1293.52	1350.57	1415.70	1477.50	1546.90	1616.78	1682.39	1757.50	1779.60	22.25 Top
Hourly	15.48	16.17	16.88	17.70	18.47	19.34	20.21	21.03	21.97	22.25	0.38 HHS Adjust
Merit 6	2543	2657	2774	2904	3032	3174	3318	3468	3633	3791	21.87 Merit Max

	1	2	3	4	5	6	7	8		
Office Support Specialist SR 80 COUNTY	3276	3429	3590	3748	3921	4071	4252	4302		
Bi-Weekly	1512.20	1582.56	1656.72	1729.92	1809.79	1878.72	1962.39	1985.68	24.82 Top	
Hourly	18.90	19.78	20.71	21.62	22.62	23.48	24.53	24.82	0.36 HHS Adjust	
Merit 6	3104	3247	3400	3549	3715	3876	4053	4240	24.46 Merit Max	

	1	2	3	4	5	6	7	8	9		
Accounting Technician 80 COUNTY	3280	3433	3584	3752	3915	4093	4282	4492	4683		
Bi-Weekly	1513.62	1584.46	1654.34	1731.59	1806.94	1889.18	1976.41	2073.15	2161.57	27.02 Top	
Hourly	18.92	19.81	20.68	21.64	22.59	23.61	24.71	25.91	27.02	0.26 HHS Adjust	
Merit 7 2016 Merit Evaluation	3247	3400	3549	3715	3876	4053	4240	4449	4638	26.76 Merit Max	

	1	2	3	4	5	6	7	8	9	10	
Case Aide 81 COUNTY	3579	3743	3922	4092	4270	4481	4682	4823	4984	5031	
Bi-Weekly	1651.96	1727.55	1810.26	1888.70	1970.94	2067.92	2161.10	2226.23	2300.39	2322.02	29.03 Top
Hourly	20.65	21.59	22.63	23.61	24.64	25.85	27.01	27.83	28.75	29.03	0.43 HHS Adjust
Merit 5	3318	3468	3633	3791	3957	4142	4337	4535	4738	4957	28.60 Merit Max

	1	2	3	4	5	6	7	8	9	10	
Information Systems Specialist SR 81 COUNTY	3579	3743	3922	4092	4270	4481	4682	4823	4984	5031	
Bi-Weekly	1651.96	1727.55	1810.26	1888.70	1970.94	2067.92	2161.10	2226.23	2300.39	2322.02	29.03 Top
Hourly	20.65	21.59	22.63	23.61	24.64	25.85	27.01	27.83	28.75	29.03	0.43 HHS Adjust
Merit 5	3318	3468	3633	3791	3957	4142	4337	4535	4738	4957	28.60 Merit Max

	1	2	3	4	5	6	7	8		
Support Enforcement Aide 81 COUNTY	3563	3718	3895	4059	4249	4448	4664	4705		
Bi-Weekly	1644.36	1716.14	1797.90	1873.49	1961.20	2052.71	2152.54	2171.68	27.15 Top	
Hourly	20.55	21.45	22.47	23.42	24.51	25.66	26.91	27.15	0.39 HHS Adjust	
Merit 8	3400	3549	3715	3876	4053	4240	4449	4638	26.76 Merit Max	

	1	2	3	4	5	6	7	8	9		
HHS Administrative Aide COUNTY	3915	4073	4261	4470	4661	4878	5094	5318	5590		
Bi-Weekly	1806.94	1879.67	1966.67	2063.17	2151.12	2251.42	2351.25	2454.41	2579.91	32.25 Top	
Hourly	22.59	23.50	24.58	25.79	26.89	28.14	29.39	30.68	32.25	0.31 HHS Adjust	
Merit 7 Adopted 11/2015	3876	4053	4240	4449	4638	4853	5069	5292	5536	31.94 Merit Max	

	1	2	3	4	5	6	7	8	9		
Eligibility Worker 82 COUNTY	4015	4190	4374	4569	4767	4965	5156	5385	5618		
Bi-Weekly	1853.17	1933.86	2018.84	2108.81	2200.32	2291.59	2379.78	2485.31	2592.75	32.41 Top	
Hourly	23.16	24.17	25.24	26.36	27.50	28.64	29.75	31.07	32.41	0.47 HHS Adjust	
Merit 7	3876	4053	4240	4449	4638	4853	5069	5292	5536	31.94 Merit Max	

	1	2	3	4	5	6	7	8	9	10	
Child Support Officer 82 COUNTY	3988	4162	4352	4554	4776	4979	5200	5325	5547	5618	
Bi-Weekly	1840.69	1921.03	2008.50	2101.68	2204.36	2298.01	2400.22	2457.74	2559.95	2592.75	32.41 Top
Hourly	23.01	24.01	25.11	26.27	27.55	28.73	30.00	30.72	32.00	32.41	0.47 HHS Adjust
Merit 6	3715	3876	4053	4240	4449	4638	4853	5069	5292	5536	31.94 Merit Max

	1	2	3	4	5	6	7	8		
Community Support Technician 82 COUNTY	3932	4102	4279	4481	4683	4825	4969	5031		
Bi-Weekly	1814.54	1893.46	1974.75	2067.92	2161.57	2226.70	2293.26	2322.02	29.03 Top	
Hourly	22.68	23.67	24.68	25.85	27.02	27.83	28.67	29.03	0.43 HHS Adjust	
Merit 7	3633	3791	3957	4142	4337	4535	4738	4957	28.60 Merit Max	

December 29 2018
3.00% COLA For 2019

GOODHUE COUNTY HEALTH & HUMAN SERVICES COMPENSATION PLAN
December 29 2018

	1	2	3	4	5	6	7	8	9		
Child Support Lead Worker 83 COUNTY	4261	4471	4661	4877	5093	5317	5563	5822	6080		
Bi-Weekly	1966.67	2063.64	2151.12	2250.95	2350.78	2453.94	2567.55	2686.87	2806.20	35.08	Top
Hourly	24.58	25.80	26.89	28.14	29.38	30.67	32.09	33.59	35.08	0.17	HHS Adjust
Merit 8 Adopted 1/2018	4240	4449	4638	4853	5069	5292	5536	5794	6051	34.91	Merit Max

	1	2	3	4	5	6	7	8	9		
Lead Eligibility Worker 83 COUNTY	4316	4527	4722	4937	5157	5385	5633	5897	6143		
Bi-Weekly	1991.86	2089.32	2179.16	2278.52	2380.25	2485.31	2599.88	2721.58	2835.19	35.44	Top
Hourly	24.90	26.12	27.24	28.48	29.75	31.07	32.50	34.02	35.44	0.53	HHS Adjust
Merit 8 Adopted 9/4/2007	4240	4449	4638	4853	5069	5292	5536	5794	6051	34.91	Merit Max

	1	2	3	4	5	6	7	8	9	10	11	12		
Information Technology Specialist, Sr 83 MERIT	4316	4527	4722	4937	5157	5385	5633	5897	6143	6443	6557	7033		
Bi-Weekly	1991.86	2089.32	2179.16	2278.52	2380.25	2485.31	2599.88	2721.58	2835.19	2973.53	3026.30	3245.93	40.57	Top
Hourly	24.90	26.12	27.24	28.48	29.75	31.07	32.50	34.02	35.44	37.17	37.83	40.57	0.60	HHS Adjust
Merit 7	4240	4449	4638	4853	5069	5292	5536	5794	6051	6331	6613	6928	39.97	Merit Max

	1	2	3	4	5	6	7	8	9	10	11	12	13		
Registered Nurse 83 MERIT	4316	4527	4722	4937	5158	5385	5633	5897	6143	6443	6557	7033	7352		
Bi-Weekly	1991.86	2089.32	2179.16	2278.52	2380.49	2485.31	2599.88	2721.58	2835.19	2973.53	3026.30	3245.93	3393.30	42.42	Top
Hourly	24.90	26.12	27.24	28.48	29.76	31.07	32.50	34.02	35.44	37.17	37.83	40.57	42.42	0.62	HHS Adjust
Merit 4	4240	4449	4638	4853	5069	5292	5536	5794	6051	6331	6613	6928	7246	41.80	Merit Max

	1	2	3	4	5	6	7	8		
Fiscal Officer 83 COUNTY	4492	4582	4795	5007	5229	5470	5824	6143		
Bi-Weekly	2073.15	2114.99	2212.92	2310.84	2413.53	2524.77	2687.82	2835.19	35.44	Top
Hourly	25.91	26.44	27.66	28.89	30.17	31.56	33.60	35.44	0.53	HHS Adjust
Merit 9 Adopted 1/2012	4449	4638	4853	5069	5292	5536	5794	6051	34.91	Merit Max

	1	2	3	4	5	6	7	8	9	10	11	12	13		
Financial Assistance Supervisor I 84 MERIT	4555	4777	4979	5213	5443	5678	5942	6221	6496	6730	6945	7262	7352		
Bi-Weekly	2102.15	2204.83	2298.01	2405.92	2511.93	2620.80	2742.49	2871.32	2998.25	3106.16	3205.52	3351.46	3393.30	42.42	Top
Hourly	26.28	27.56	28.73	30.07	31.40	32.76	34.28	35.89	37.48	38.83	40.07	41.89	42.42	0.62	HHS Adjust
Merit 5	4240	4449	4638	4853	5069	5292	5536	5794	6051	6331	6613	6928	7246	41.80	Merit Max

	1	2	3	4	5	6	7	8	9	10	11		
Public Health Educator 84 MERIT	4526	4724	4938	5157	5383	5633	5894	6155	6443	6728	7034		
Bi-Weekly	2088.84	2180.11	2278.99	2380.25	2484.36	2599.88	2720.15	2840.90	2973.53	3105.21	3246.40	40.58	Top
Hourly	26.11	27.25	28.49	29.75	31.05	32.50	34.00	35.51	37.17	38.82	40.58	0.61	HHS Adjust
Merit 8	4449	4638	4853	5069	5292	5536	5794	6051	6331	6613	6928	39.97	Merit Max

	1	2	3	4	5	6	7	8	9	10	11	12		
Planner (Human Services) 84 MERIT	4471	4663	4878	5095	5319	5562	5824	6082	6363	6646	6964	7352		
Bi-Weekly	2063.64	2152.07	2251.42	2351.73	2454.77	2567.08	2687.82	2807.15	2936.93	3067.18	3214.08	3393.30	42.42	Top
Hourly	25.80	26.90	28.14	29.40	30.68	32.09	33.60	35.09	36.71	38.34	40.18	42.42	0.62	HHS Adjust
Merit 6 Adopted 12/2013	4449	4638	4853	5069	5292	5536	5794	6051	6331	6613	6928	7246	41.80	Merit Max

December 29 2018
3.00% COLA For 2019

GOODHUE COUNTY HEALTH & HUMAN SERVICES COMPENSATION PLAN
December 29 2018

	1	2	3	4	5	6	7	8	9	10	11	12	13	
Public Health Nurse 84 MERIT	4526	4720	4938	5156	5383	5688	5950	6215	6507	6796	7122	7373	7688	
Bi-Weekly	2088.84	2178.69	2278.99	2379.78	2484.36	2625.07	2746.30	2868.47	3003.00	3136.59	3287.28	3402.80	3548.27	44.35 Top
Hourly	26.11	27.23	28.49	29.75	31.05	32.81	34.33	35.86	37.54	39.21	41.09	42.54	44.35	0.65 HHS Adjust
Merit 4	4449	4638	4853	5069	5292	5536	5794	6051	6331	6613	6928	7246	7574	43.70 Merit Max

	1	2	3	4	5	6	7	8	9	10	11	12		
Social Worker 84 MERIT	4483	4689	4922	5131	5367	5607	5853	6129	6399	6653	6932	7033		
Bi-Weekly	2069.11	2163.95	2271.86	2368.37	2477.11	2587.99	2701.61	2828.54	2953.56	3070.51	3199.34	3245.93	40.57	Top
Hourly	25.86	27.05	28.40	29.60	30.96	32.35	33.77	35.36	36.92	38.38	39.99	40.57	0.60	HHS Adjust
Merit 6	4240	4449	4638	4853	5069	5292	5536	5794	6051	6331	6613	6928	39.97	Merit Max

	1	2	3	4	5	6	7	8	9	10	11	12		
Care Coordinator 84 MERIT	4483	4689	4922	5131	5367	5607	5853	6129	6399	6653	6932	7033		
Bi-Weekly	2069.11	2163.95	2271.86	2368.37	2477.11	2587.99	2701.61	2828.54	2953.56	3070.51	3199.34	3245.93	40.57	Top
Hourly	25.86	27.05	28.40	29.60	30.96	32.35	33.77	35.36	36.92	38.38	39.99	40.57	0.60	HHS Adjust
Merit 6	4240	4449	4638	4853	5069	5292	5536	5794	6051	6331	6613	6928	39.97	Merit Max

	1	2	3	4	5	6	7	8	9	10	11	12		
Social Services/Waiver HHS Team Leader MERIT	4877	5093	5317	5563	5822	6080	6362	6646	6962	7282	7611	7947		
Bi-Weekly	2250.95	2350.78	2453.94	2567.55	2686.87	2806.20	2936.45	3067.18	3213.12	3360.97	3512.62	3667.71	45.85	Top
Hourly	28.14	29.38	30.67	32.09	33.59	35.08	36.71	38.34	40.16	42.01	43.91	45.85	0.23	HHS Adjust
Merit 5 Adopted 1/2018	4853	5069	5292	5536	5794	6051	6331	6613	6928	7246	7574	7907	45.62	Merit Max

	1	2	3	4	5	6	7	8	9	10	11	12	13	
Financial Assistance Supervisor II MERIT	4683	4878	5094	5318	5562	5822	6081	6362	6645	6963	7281	7611	7986	
Bi-Weekly	2161.57	2251.42	2351.25	2454.41	2567.08	2686.87	2806.67	2936.45	3066.71	3213.60	3360.49	3512.62	3685.66	46.07 Top
Hourly	27.02	28.14	29.39	30.68	32.09	33.59	35.08	36.71	38.33	40.17	42.01	43.91	46.07	0.45 HHS Adjust
Merit 5 Adopted 12/2015	4638	4853	5069	5292	5536	5794	6051	6331	6613	6928	7246	7574	7907	45.62 Merit Max

	1	2	3	4	5	6	7	8	9	10	11			
Public Health Nursing/Community Health Supervisor 86 MERIT	5385	5633	5894	6174	6460	6747	7071	7392	7729	8045	8374			
Bi-Weekly	2485.31	2599.64	2720.15	2849.46	2981.61	3113.77	3263.52	3411.84	3567.29	3713.23	3864.88	48.31	Top	
Hourly	31.07	32.50	34.00	35.62	37.27	38.92	40.79	42.65	44.59	46.42	48.31	0.70	HHS Adjust	
Merit 6	5292	5536	5794	6051	6331	6613	6928	7246	7574	7907	8252	47.61	Merit Max	

	1	2	3	4	5	6	7	8	9	10	11	12		
Social Service Supervisor 87 MERIT	6070	6336	6631	6922	7258	7590	7937	8281	8645	8853	9229	9340		
Bi-Weekly	2801.44	2924.09	3060.53	3194.58	3350.04	3502.87	3663.31	3822.09	3989.90	4085.93	4259.45	4310.91	53.89	Top
Hourly	35.02	36.55	38.26	39.93	41.88	43.79	45.79	47.78	49.87	51.07	53.24	53.89	0.80	HHS Adjust
Merit 5	5668	5915	6189	6461	6776	7083	7409	7729	8072	8428	8805	9202	53.09	Merit Max

	1	2	3	4	5	6	7	8	9	10	11	12	13	
Deputy Health & Human Services Director (DHHSD) 88 MERIT	6443	6729	7050	7373	7707	8043	8396	8763	9148	9549	10007	10452	10890	
Bi-Weekly	2973.53	3105.69	3254.01	3402.80	3557.30	3712.28	3874.86	4044.57	4222.37	4407.29	4618.84	4824.20	5026.24	62.83 Top
Hourly	37.17	38.82	40.68	42.54	44.47	46.40	48.44	50.56	52.78	55.09	57.74	60.30	62.83	0.93 HHS Adjust
Merit 4	6331	6613	6928	7246	7574	7907	8252	8613	8992	9385	9837	10273	10729	61.90 Merit Max

	1	2	3	4	5	6	7	8	9		
Health & Human Services Director 90 COUNTY	8150	8327	8698	9091	9505	9926	10372	11022	11629		
Bi-Weekly	3761.72	3843.01	4014.62	4195.74	4386.85	4581.28	4787.12	5087.09	5367.09	67.09	Top
Hourly	47.02	48.04	50.18	52.45	54.84	57.27	59.84	63.59	67.09	0.98	HHS Adjust
Merit 7	8072	8428	8805	9202	9623	10051	10499	10966	11459	66.11	Merit Max

GOODHUE COUNTY
HEALTH & HUMAN SERVICES

426 WEST AVENUE
RED WING, MN 55066-2473
(651) 385-3232
FAX: (651) 385-3191

MEMORANDUM

DATE: January 22, 2019

TO: Goodhue County Health & Human Services Board

FROM: Mike Zorn, Deputy Director

RE: 2019 HHS Final Budget

****

The 2019 HHS budget was approved at the December 6, 2018 County Board Meeting. The levy request represents an increase in levy of $405,065 (5.75%) over the 2018 approved levy. The overall 2019 budget increased $696,019 over the 2018 budget.

	2015	2016	2017	2018	2019
Budget	$13,934,623	$14,320,943	$14,877,851	$16,246,035	$16,942,054
County Levy	$5,367,654	$5,218,251	$5,596,974	$7,044,686	$7,449,751

Budget Considerations.

- The current budget represents a 3.0% general wage adjustment for employees for 2018.
- Healthcare renewal rate of 8.1%.
- Step increases have been factored in where appropriate based on a positive performance evaluation.

Sources of Budget Financing

	2015	2016	2017	2018	2019
State Revenue	16.82%	17.38%	17.07%	15.52%	15.09%
Federal Revenue	29.42%	31.58%	31.96%	29.12%	28.50%
Misc Services, charges & fees	15.24%	14.60%	13.35%	12.00%	12.44%
County Property Tax Levy	38.52%	36.44%	37.62%	43.36%	43.97%
	100.00%	100.00%	100.00%	100.00%	100.00%

Goodhue County

USER-SELECTED BUDGET REPORT

Options: 1 = Budget Amount, 2 = Yearly Amount, 3 = Dashed Lines, 4 = Estimated

Column Selectior 1 0 0 0 0

Column Headings: 2019 Budget

Year:

Months:

Report Basi: 1

1 - Cash
2 - Modified Accrual
3 - Full Accrual

Comment:

Fund Range From 11 Thru 11

Page Break Option: 1

1 - Page Break by Fund
2 - Page Break by Dept
3 - Page Break by Program
4 - Page Break by Service

Line Spacing: 1

1 - Single Spaced
2 - Double Spaced

Print Subtotal By Fund N
Print Subtotal By Dept N
Print Subtotal By Program N
Print Subtotal By Service N
Print Subtotal By Object Range N

Include on the Report 1

1 - All G/L Accounts
2 - Only G/L Accounts with Budget Amts.
3 - Only G/L Accounts without Budget Amts.
4 - Only Budget Accounts with zero Amts.
5 - Only Active G/L Accounts

Include Zero Dollar Accts: N
Round Amounts: Y
Save Report: N

Account Number	Account Description	2019 Budget
400 Dept	Health & Human Services General	
11-400-000-0000-5001	Current Real & Personal Property T	7,355,626 -
11-400-000-0000-5207	PILT-Wildlife Management	3,537 -
11-400-000-0000-5208	PILT-Gross Shelter Rent	5,500 -
11-400-000-0000-5209	PILT-30% Rental Reimbursement Ta	60 -
11-400-000-0000-5211	Market Value Credit Aid	94,125 -
11-400-000-0000-5213	PERA Rate Aid	23,422 -
11-400-000-0000-5948	Transfers In - Inter Fund	21,424 -
420 Dept	Income Maintenance-Economic Assistance	
11-420-600-0010-5401	Jail Pay To Stay	16,000 -
11-420-600-0010-6101	Salaries & Wages - Permanent	819,074
11-420-600-0010-6102	Salaries & Wages-Part Time w/ Ben	33,826
11-420-600-0010-6106	Per Diem in Lieu of Salaries	1,200
11-420-600-0010-6107	Salaries & Wages - Department Hea	71,169
11-420-600-0010-6151	Group Health Insurance	79,470
11-420-600-0010-6152	HSA Contribution	40,040
11-420-600-0010-6153	Family Insurance Supplement	56,466
11-420-600-0010-6154	Life Insurance	933
11-420-600-0010-6155	Dental Insurance-County Paid	4,860
11-420-600-0010-6156	Accident Insurance-County Paid	1,194
11-420-600-0010-6161	PERA	69,305
11-420-600-0010-6171	FICA	57,292
11-420-600-0010-6173	Workmans Compensation	2,701
11-420-600-0010-6174	Mandatory Medicare	13,399
11-420-600-0010-6201	Telephone	4,800
11-420-600-0010-6202	Cell Phone	2,800
11-420-600-0010-6203	Postage	16,200
11-420-600-0010-6206	Data Cards	1,300
11-420-600-0010-6209	Internet	960
11-420-600-0010-6241	Advertising	1,200
11-420-600-0010-6243	Association Dues/Memberships	1,400
11-420-600-0010-6244	Subscriptions	379
11-420-600-0010-6268	Software Maintenance Contracts	50,834
11-420-600-0010-6274	Audit Fees	3,000
11-420-600-0010-6283	Oth Profess,Tech & Merit Services	31,298
11-420-600-0010-6302	Copies/Copier Maintenance	6,800

Goodhue County

USER-SELECTED BUDGET REPORT

11 Fund Health & Human Service Fund

Report Basis: Cash

Account Number	Account Description	2019 Budget
11-420-600-0010-6331	Mileage	1,000
11-420-600-0010-6332	Meals & Lodging	300
11-420-600-0010-6335	Motor Pool Vehicle Usage	2,000
11-420-600-0010-6342	Rent/Lease Income Maintenance	119,444
11-420-600-0010-6345	Postage Meter	2,200
11-420-600-0010-6351	Liability Insurance	6,110
11-420-600-0010-6357	Conferences/Schools/Training	8,500
11-420-600-0010-6358	Other Charges	500
11-420-600-0010-6382	Data Processing Charges Goodhue (	17,300
11-420-600-0010-6401	Printing Services	200
11-420-600-0010-6405	Office Supplies	10,000
11-420-600-0010-6432	Other Furniture & Equipment	5,150
11-420-600-0010-6480	Equipment/Furniture<$5,000	4,200
11-420-600-0010-6663	Vehicles Purchased	12,240
11-420-600-0020-6101	Salaries & Wages - Permanent	1,131,381
11-420-600-0020-6104	Salaries & Wages-Overtime	43,400
11-420-600-0020-6151	Group Health Insurance	134,256
11-420-600-0020-6152	HSA Contribution	30,950
11-420-600-0020-6153	Family Insurance Supplement	68,692
11-420-600-0020-6154	Life Insurance	1,186
11-420-600-0020-6155	Dental Insurance-County Paid	718
11-420-600-0020-6156	Accident Insurance-County Paid	243
11-420-600-0020-6161	PERA	88,109
11-420-600-0020-6171	FICA	72,836
11-420-600-0020-6174	Mandatory Medicare	17,034
11-420-600-0020-6332	Meals & Lodging	400
11-420-610-0000-5290	DHS-State Periodic Data Match	13,992 -
11-420-610-0000-5353	93.558 TANF Co Wide Admin	102,000 -
11-420-610-0000-5830	Maxis MFIP Recoveries	10,000 -
11-420-610-0010-6386	County Attorney Fees/Fraud	5,000
11-420-610-0010-6387	Public Assistance Fraud Investigato	91,500
11-420-610-0100-6025	County Share Of State & Fed Disb	7,500
11-420-620-0000-5830	Maxis GA/GRH Recoveries	20,000 -
11-420-620-0000-6020	Group Residental Housing/GRH Re	20,000
11-420-620-0100-6025	Central Disb County Share	1,800
11-420-620-0600-6020	Co Burials Payment For Recipients	15,000
11-420-621-0000-5830	Recoveries Gamc County Share	100 -

Account Number	Account Description	2019 Budget
11-420-630-0000-5312	10.561 FS Direct Admin FSPFNS Aic	325,000 -
11-420-630-0000-5830	Maxis Food Stamp Recovery	5,000 -
11-420-630-0100-6025	Central Disb County Share	3,750
11-420-640-0000-5289	DHS-St Incent MA C/S Ins & Health	25,000 -
11-420-640-0000-5290	DHS-IVD C/S State Incentives	10,000 -
11-420-640-0000-5355	93.563 IVD Federal Admin Reimb	691,000 -
11-420-640-0000-5356	93.563 IVD Federal Incentive Incom	90,000 -
11-420-640-0000-5379	93.778 Fed MA C/S Medical Incenti	10,000 -
11-420-640-0000-5401	Child Support Service Fees	4,000 -
11-420-640-0000-5848	Admin Recovery Blood Test	800 -
11-420-640-0010-6101	Salaries & Wages - Permanent	507,690
11-420-640-0010-6151	Group Health Insurance	46,440
11-420-640-0010-6152	HSA Contribution	25,450
11-420-640-0010-6153	Family Insurance Supplement	78,766
11-420-640-0010-6154	Life Insurance	562
11-420-640-0010-6155	Dental Insurance-County Paid	2,506
11-420-640-0010-6156	Accident Insurance-County Paid	549
11-420-640-0010-6161	PERA	38,077
11-420-640-0010-6171	FICA	31,477
11-420-640-0010-6173	Workmans Compensation	708
11-420-640-0010-6174	Mandatory Medicare	7,361
11-420-640-0010-6201	Telephone	1,300
11-420-640-0010-6203	Postage	10,050
11-420-640-0010-6209	Internet	1,440
11-420-640-0010-6241	Advertising	800
11-420-640-0010-6268	Software Maintenance Contracts	37,594
11-420-640-0010-6277	Spec Costs (Sheriff Sop, Pat, Rop)	11,000
11-420-640-0010-6283	Oth Profess,Tech & Merit Service	4,830
11-420-640-0010-6285	Child Support Blood Tests	700
11-420-640-0010-6302	Copies/Copier Maintenance	3,700
11-420-640-0010-6331	Mileage	900
11-420-640-0010-6332	Meals & Lodging	100
11-420-640-0010-6335	Motor Pool Vehicle Usage	200
11-420-640-0010-6342	Rent/Lease Child Support	30,699
11-420-640-0010-6345	Postage Meter	1,500
11-420-640-0010-6351	Liability Insurance	3,071
11-420-640-0010-6357	Conferences/Schools/Training	3,500

Account Number	Account Description	2019 Budget
11-420-640-0010-6382	Data Processing Charges	3,000
11-420-640-0010-6385	Cs Federal Offset Fee	4,000
11-420-640-0010-6386	County Attorney Fees	50,000
11-420-640-0010-6405	Office Supplies	3,600
11-420-640-0010-6432	Other Furniture & Equipment	2,000
11-420-640-0010-6480	Equipment/Furniture<$5,000	7,800
11-420-650-0000-5288	DHS-State Share MA Access	93,850 -
11-420-650-0000-5378	93.778 IGR Federal Share MA Acces	93,850 -
11-420-650-0000-5381	93.778 Fed MA Admin Aid	690,000 -
11-420-650-0000-5830	Ma Recovery County Share	20,000 -
11-420-650-0010-6009	Ma Access Mileage	160,000
11-420-650-0010-6011	Ma Access Parking	1,400
11-420-650-0010-6012	Ma Access Meals	1,200
11-420-650-0010-6013	Ma Access Lodging	2,500
11-420-650-0010-6014	Ma Access Interpreter	3,900
11-420-650-0010-6016	MA Access Three Rivers	21,000
11-420-650-0100-6020	Nh < 65 Asst Living/Resid Care (90	160,000
11-420-650-0400-5240	DHS-MA Cost Eff & Med Part B Ins	199,800 -
11-420-650-0400-5379	93.778 IGR MA Cost Eff Insurance F	170,200 -
11-420-650-0400-6020	Cost Eff Insur Payments	370,000
11-420-680-0000-5358	93.566 Federal Administration - Re	800 -
11-420-710-0000-5366	93.658 Federal IVE IM Admin	5,000 -
430 Dept	Health and Social Services	
11-430-700-0000-5289	DHS-Vulnerable Children & Adults	369,885 -
11-430-700-0000-5292	DHS-MA LTSS MNChoices/State S5	290,000 -
11-430-700-0000-5367	93.658 Federal SSIS Project Reimb	35,000 -
11-430-700-0000-5370	93.667 SS Block Grant Title XX F	199,770 -
11-430-700-0000-5383	93.778 MA LTSS MNChoices-Fed F	350,000 -
11-430-700-0000-5840	Admin Refunds - Swf Rep Fee & Ac	500 -
11-430-700-0010-5404	Psych Evaulations Court Services M	10,500 -
11-430-700-0010-6101	Salaries & Wages - Permanent	2,218,228
11-430-700-0010-6102	Salaries & Wages-Part Time w/ Ben	80,693
11-430-700-0010-6104	Salaries & Wages - Overtime	60,000
11-430-700-0010-6106	Per Diem in Lieu of Salaries	1,180
11-430-700-0010-6107	Salaries & Wages - Department Hea	68,378
11-430-700-0010-6151	Group Health Insurance	162,170
11-430-700-0010-6152	HSA Contribution	120,705

Account Number	Account Description	2019 Budget
11-430-700-0010-6153	Family Insurance Supplement	218,280
11-430-700-0010-6154	Life Insurance	2,144
11-430-700-0010-6155	Dental Insurance-County Paid	16,628
11-430-700-0010-6156	Accident Insurance-County Paid	3,988
11-430-700-0010-6161	PERA	182,047
11-430-700-0010-6171	FICA	150,493
11-430-700-0010-6173	Workmans Compensation	4,576
11-430-700-0010-6174	Mandatory Medicare	35,196
11-430-700-0010-6201	Telephone	5,400
11-430-700-0010-6202	Cell Phone	5,400
11-430-700-0010-6203	Postage	7,200
11-430-700-0010-6206	Data Cards	1,800
11-430-700-0010-6241	Advertising	1,153
11-430-700-0010-6243	Association Dues/Memberships	1,000
11-430-700-0010-6268	Software Maintenance Contracts	58,629
11-430-700-0010-6274	Audit Fees	2,900
11-430-700-0010-6283	Oth Profess,Techn & Merit Service	38,476
11-430-700-0010-6302	Copies/Copier Maintenance	4,000
11-430-700-0010-6331	Mileage	20,000
11-430-700-0010-6332	Meals & Lodging	1,500
11-430-700-0010-6333	Other Travel Expense	100
11-430-700-0010-6335	Motor Pool Vehicle Usage	36,000
11-430-700-0010-6342	Rent/Lease Social Services	112,625
11-430-700-0010-6345	Postage Meter	1,000
11-430-700-0010-6351	Liability Insurance	7,511
11-430-700-0010-6357	Conferences/Schools/Training	15,000
11-430-700-0010-6358	Other Charges	500
11-430-700-0010-6363	Csp Program and Activities Expens	5,000
11-430-700-0010-6382	Data Processing Charges Goodhue (	11,000
11-430-700-0010-6405	Office Supplies	10,000
11-430-700-0010-6432	Other Furniture & Equipment	2,700
11-430-700-0010-6663	Vehicles Purchased	11,760
11-430-700-3810-5380	93.778 MA Non-Waivered SSTS Adı	152,000 -
11-430-710-0000-5289	Child Protection State Grant S04	122,399 -
11-430-710-0000-5401	Out-Of-Home Placement Fees	60,000 -
11-430-710-3110-6020	Mental Health Screenings	16,592
11-430-710-3150-6020	Interpretation Services	500

Account Number	Account Description	2019 Budget
11-430-710-3390-6020	GCED Edu Assist Settting IV Special	531,870
11-430-710-3410-5401	Ehm Fees M1	3,000 -
11-430-710-3410-6020	Electric Home Monitoring	7,000
11-430-710-3460-5372	93.674 Federal Grants - Self Regula	7,800 -
11-430-710-3460-6020	Self-Regular	7,800
11-430-710-3620-6020	Family Based Counseling	20,000
11-430-710-3621-6021	SS Sex Offender Therapy	2,000
11-430-710-3624-6020	Fernbrook Contract	3,000
11-430-710-3640-5289	DHS-Alternative Response State 27	4,383 -
11-430-710-3640-5352	93.556 Alternative Response IVB2 4	7,142 -
11-430-710-3640-5364	93.645 Alternative Response IVB1 2	4,707 -
11-430-710-3640-6020	Family Assessment Response	17,000
11-430-710-3650-6020	Concurrent Permanency Planning F	63,000
11-430-710-3660-6020	Family Group Decision Making	30,000
11-430-710-3670-5289	DHS-Parental Support Outreach St	34,764 -
11-430-710-3670-5352	93.556 Parental Support IVB2 F08	1,337 -
11-430-710-3670-5361	93.590 Children's Trust Funds F09	26,742 -
11-430-710-3670-5364	93.645 Parental Support IVB1 F08	4,011 -
11-430-710-3670-6020	Parental Support Outreach	66,854
11-430-710-3710-6020	Child Shelter-SS	7,500
11-430-710-3750-6025	Northstar Kinship Assistance Co Sh	7,500
11-430-710-3780-6025	Northstar Adoption Assistance Co S	6,000
11-430-710-3800-6057	Rule 4 Trmt Foster Care - SS	60,000
11-430-710-3810-5289	NS Care for Children Fiscal FC S03	2,300 -
11-430-710-3810-5366	93.658 Foster Care IV-E Federal	50,000 -
11-430-710-3810-5367	93.658 Foster Care IV-E SSTS Admi	70,000 -
11-430-710-3810-5402	Foster Care Fees (Iv-E) M1	4,000 -
11-430-710-3810-6057	Regular Foster Care-Ss	575,000
11-430-710-3810-6058	Regular Foster Care-Ss-Cs Expense	35,000
11-430-710-3810-6063	Foster Parent Training	500
11-430-710-3810-6064	Background Check/Daycare & Foste	1,200
11-430-710-3814-6056	Emergency Foster Care Provider	8,000
11-430-710-3814-6057	Emergency Foster Care	5,000
11-430-710-3830-6020	Foster Care Rule 8 - SS	75,000
11-430-710-3831-6020	Foster Care - Rule 8 CS	9,000
11-430-710-3850-6020	Dept Of Corr Group Facility Ss	425,000
11-430-710-3852-6020	Dept Of Corr Group Facility Cs	80,000

Account Number	Account Description		2019 Budget	
11-430-710-3880-6020	Extend Foster Care-Ind Living 18-2		30,000	
11-430-710-3890-6020	Short Term Foster Care		5,000	
11-430-710-3930-5381	93.778 IGR MA Fed CW/TCM		350,000	-
11-430-710-3930-5832	GCED Child Gen Case Mgmt		165,000	-
11-430-710-3970-5366	93.658 FSC LCTS IV-E Admin	F(	55,000	-
11-430-710-3970-5379	93.778 MA FSC LCTC Admin	F	52,000	-
11-430-710-3970-5832	GCFSC No Seagr		3,600	-
11-430-710-3970-6020	Gc Family Services Collaborative		107,000	
11-430-720-3110-5290	DHS-State Child Care BSF Admin		8,000	-
11-430-720-3110-5362	93.575 Federal Child Care BSF Adm		11,000	-
11-430-720-3110-6026	Bsf County Match		23,800	
11-430-720-3120-5289	DHS-Child Care MFIP Admin State		5,000	-
11-430-720-3120-5362	93.575 Child Care MFIP Admin Fed		5,000	-
11-430-720-3140-6069	Other Child Care Fee		25,000	
11-430-720-3140-6077	Day Care Other/Ive		3,000	
11-430-720-3370-5289	DHS-MFIP Employment Services TA		30,439	-
11-430-720-3370-5353	93.558 MFIP Employment Services		173,586	-
11-430-720-3370-6020	Pmts For Recipients-Stride/Mfip Er		178,151	
11-430-720-3980-5401	Daycare Licensing Application Fee		2,000	-
11-430-730-3021-6020	Drug Tests-RS Eden		20,000	
11-430-730-3050-5380	93.778 MA/SSTS Rule 25	F	65,000	-
11-430-730-3050-6020	Payments For Recipients Rule 25 As		10,000	
11-430-730-3590-5289	DHS-State Share CCDTF Admin		35,000	-
11-430-730-3590-6020	Purchase Of Serv State Of Mn Ccdtf		200,000	
11-430-730-3712-5401	Detox Fees/Rule 25	M9	100,000	-
11-430-730-3712-6020	Detox Costs		176,000	
11-430-740-3030-5289	DHS-Adult CSP/Rule 78/IMD Alt		190,750	-
11-430-740-3030-5290	DHS-Adult MH Initiative Olmsted S		65,537	-
11-430-740-3080-6020	Mh Assessments		88,500	
11-430-740-3160-6020	Transportation Mh Proact Txx		22,000	
11-430-740-3161-6020	Transportation-MH Client-Gas Car		4,000	
11-430-740-3180-6020	Client Flex Funds ADMHI		12,000	
11-430-740-3300-5289	DHS-Childrens MH Screening		61,673	-
11-430-740-3310-6020	Mobile Crisis Services		41,000	
11-430-740-3360-6020	Adult Crisis Stabilization		1,000	
11-430-740-3370-6050	Comm Based Supp Empl-Not Armh		25,000	
11-430-740-3371-6050	Center Based Supp Empl-Not Armh		30,000	

Account Number	Account Description	2019 Budget	
11-430-740-3430-6020	Housing Subsidy	6,500	
11-430-740-3520-6020	Adult Outpatient Psychotherapy	125,000	
11-430-740-3540-6050	TXX Medication Management	85,000	
11-430-740-3720-6020	Recipients-Living In State/Private H	325,000	
11-430-740-3722-6020	Sex Offender Prgm State Oper Serv	52,000	
11-430-740-3830-5366	93.658 Foster Care IV-E Rule 5	15,000	-
11-430-740-3830-5382	93.778 IGR MA Residential Treatme	50,000	-
11-430-740-3830-6020	Rule 5 Social Services	450,000	
11-430-740-3831-6020	Rule 5 Court Services	7,000	
11-430-740-3890-5289	DHS-MH Respite Services S6	25,000	-
11-430-740-3890-6020	Respite MH Child - Fernbrook	25,000	
11-430-740-3900-5381	93.778 IGR MA MH Case Mgmt/Chi	20,000	-
11-430-740-3900-5401	Children MH-TCM SCHA	10,000	-
11-430-740-3900-5832	GCED Child Rule 79 Case Mgmt	120,000	-
11-430-740-3900-6025	Non Fed Share Mh-Tcm Cont Vend	200,000	
11-430-740-3910-5240	DHS-State MH Case Mgmt Adult	3,000	-
11-430-740-3910-5381	93.778 IGR MA Fed MH Case Mgmt	175,000	-
11-430-740-3910-5401	Adult MH-TCM SCHA/MEDICA	410,000	-
11-430-740-3910-6020	Adult Rule 79 Case Mgmnt	7,000	
11-430-740-3930-5401	Healthy Pathways M13	75,000	-
11-430-740-3930-6020	General Case Mgmt Purchased	1,800	
11-430-750-3160-6050	Transportation Dd Proact Txx	23,000	
11-430-750-3340-5289	DHS-DD SILS Program S:	60,575	-
11-430-750-3340-6050	Txx Purchase Of Service-Sils	86,536	
11-430-750-3350-5289	DHS-DD Family Support Program	78,108	-
11-430-750-3350-6083	Family Support Program Subsidy	78,108	
11-430-750-3381-6020	Community Based Employment	45,000	
11-430-750-3382-6020	Center Based Employment	21,000	
11-430-750-3740-6020	Icf/Mr +7	20,000	
11-430-750-3910-5832	GCED DD Waiver Case Mgmt M	90,873	-
11-430-760-3022-6020	Caregiver Support Faith in Action	1,854	
11-430-760-3580-5240	DHS-Consumer Support Grant	4,000	-
11-430-760-3930-5381	93.778 IGR MA VA/DD-TCM Adlt 1	45,000	-
11-430-760-3950-6050	Guardianship/Conservatorship Txx	165,000	
11-430-760-3980-5401	Adult Foster Care Licensing & Bg	1,500	-
463 Dept	Quality Assurance-Health Srvs		
11-463-463-0000-5290	DHS-Alternative Care Waiver	14,000	-

Account Number	Account Description	2019 Budget
11-463-463-0000-5291	DHS-Billable Waivers/State	110,000 -
11-463-463-0000-5292	DHS-HHS Staff Waiver CM State	240,000 -
11-463-463-0000-5381	93.778 IGR Billable Waivers/Federa	110,000 -
11-463-463-0000-5382	93.778 IGR DHS HHS Staff Waiver C	240,000 -
11-463-463-0000-5402	SCHA Programs	325,000 -
11-463-463-0000-5410	Consultation Fees/Contract Fees	2,000 -
11-463-463-0000-5428	Spenddown Fees From Client	15,000 -
11-463-463-0000-5429	SCHA/Elderly Waiver/Care Coordin	190,000 -
11-463-463-0000-5859	SCHA/CCC Reimbursement	89,000 -
11-463-463-0000-6010	Billable Service Options Items	75,000
11-463-463-0000-6020	Contracted Case Management	145,000
11-463-463-0000-6101	Salaries & Wages - Permanent	1,112,678
11-463-463-0000-6102	Salaries & Wages-Part Time w/ Ben	70,587
11-463-463-0000-6151	Group Health Insurance	81,870
11-463-463-0000-6152	HSA Contribution	38,734
11-463-463-0000-6153	Family Insurance Supplement	99,389
11-463-463-0000-6154	Life Insurance	990
11-463-463-0000-6155	Dental Insurance-County Paid	3,491
11-463-463-0000-6156	Accident Insurance-County Paid	808
11-463-463-0000-6161	PERA	88,749
11-463-463-0000-6171	FICA	73,362
11-463-463-0000-6174	Mandatory Medicare	17,157
11-463-463-0000-6202	Cell Phone	480
11-463-463-0000-6206	Data Cards	1,680
11-463-463-0000-6209	Internet	960
11-463-463-0000-6245	State Required Registration or Licer	255
11-463-463-0000-6331	Mileage	14,000
11-463-463-0000-6332	Meals & Lodging	600
11-463-463-0000-6333	Other Travel Expense	50
11-463-463-0000-6335	Motor Pool Vehicle Usage	9,000
11-463-463-0000-6357	Conferences/Schools/Training	3,000
466 Dept	Healthy Communities/Behaviors	
11-466-450-0000-5203	Local Follow Along Program (FSC)	5,000 -
11-466-450-0000-5280	MDH-Local Public Health Grant	60,586 -
11-466-450-0000-5284	MDH-State Follow Along Program F	1,933 -
11-466-450-0000-5289	DHS-Medical Assistance-State	3,000 -
11-466-450-0000-5291	DHS-MA FHV FFS State	10,080 -

Account Number	Account Description	2019 Budget
11-466-450-0000-5347	93.251 EHDI & BD Followup	600 -
11-466-450-0000-5353	93.558 TANF Grant - Federal Funds	47,462 -
11-466-450-0000-5379	93.778 IGR Medical Assistance-Fed	3,000 -
11-466-450-0000-5381	93.778 IGR FHV FFS Federal	10,080 -
11-466-450-0000-5389	93.994 MCH Block Grant	44,234 -
11-466-450-0000-5410	Daycare/Nurse Consultation Fees	4,500 -
11-466-450-0000-5424	Health Insurance Fees	6,500 -
11-466-450-0000-5431	SCHA FHV Billing	28,800 -
11-466-450-0000-5434	Family Home Visiting Local Grant	194,911 -
11-466-450-0000-5435	SCHA/MA & PHN Clinic	80,000 -
11-466-450-0000-6101	Salaries & Wages - Permanent	279,197
11-466-450-0000-6102	Salaries & Wages-Part Time w/ Ben	118,511
11-466-450-0000-6151	Group Health Insurance	10,403
11-466-450-0000-6152	HSA Contribution	11,913
11-466-450-0000-6153	Family Insurance Supplement	52,312
11-466-450-0000-6154	Life Insurance	377
11-466-450-0000-6155	Dental Insurance-County Paid	1,178
11-466-450-0000-6156	Accident Insurance-County Paid	258
11-466-450-0000-6161	PERA	29,828
11-466-450-0000-6171	FICA	24,658
11-466-450-0000-6174	Mandatory Medicare	5,767
11-466-450-0000-6202	Cell Phone	960
11-466-450-0000-6232	Publications & Brochures	1,200
11-466-450-0000-6245	State Required Registration or Licer	300
11-466-450-0000-6331	Mileage	2,220
11-466-450-0000-6332	Meals & Lodging	500
11-466-450-0000-6335	Motor Pool Vehicle Usage	8,375
11-466-450-0000-6357	Conferences/Schools/Training	6,800
11-466-450-0000-6405	Office Supplies	450
11-466-450-0000-6407	Grant Supplies	1,850
11-466-458-0000-5292	DHS-CTC Outreach/State	48,111 -
11-466-458-0000-5382	93.778 IGR CTC Outreach/Federal	48,111 -
11-466-458-0000-6101	Salaries & Wages - Permanent	42,330
11-466-458-0000-6102	Salaries & Wages-Part Time w/ Ben	4,397
11-466-458-0000-6103	Salaries & Wages-Part Time w/o Be	553
11-466-458-0000-6151	Group Health Insurance	7,105
11-466-458-0000-6152	HSA Contribution	1,327

Account Number	Account Description	2019 Budget
11-466-458-0000-6153	Family Insurance Supplement	1,101
11-466-458-0000-6154	Life Insurance	54
11-466-458-0000-6155	Dental Insurance-County Paid	50
11-466-458-0000-6156	Accident Insurance-County Paid	11
11-466-458-0000-6161	PERA	3,505
11-466-458-0000-6171	FICA	2,897
11-466-458-0000-6174	Mandatory Medicare	678
11-466-458-0000-6203	Postage/Freight	2,200
11-466-458-0000-6331	Mileage	100
11-466-458-0000-6335	Motor Vehicle Pool	400
11-466-458-0000-6357	Conferences/Schools/Training	150
11-466-458-0000-6402	Copy Machine Paper & Toner	2,400
11-466-458-0000-6405	Office Supplies	80
11-466-458-0000-6407	Grant Supplies	1,900
11-466-462-0000-5310	10.557 WIC Grant	170,236 -
11-466-462-0000-6021	BF Consulting Contracts	3,000
11-466-462-0000-6024	BF Peer	5,000
11-466-462-0000-6101	Salaries & Wages - Permanent	101,653
11-466-462-0000-6102	Salaries & Wages-Part Time w/ Ben	1,368
11-466-462-0000-6103	Salaries & Wages-Part Time w/o Be	17,896
11-466-462-0000-6151	Group Health Insurance	1,579
11-466-462-0000-6152	HSA Contribution	2,955
11-466-462-0000-6153	Family Insurance Supplement	20,054
11-466-462-0000-6154	Life Insurance	135
11-466-462-0000-6155	Dental Insurance-County Paid	25
11-466-462-0000-6156	Accident Insurance-County Paid	6
11-466-462-0000-6161	PERA	9,069
11-466-462-0000-6171	FICA	7,497
11-466-462-0000-6174	Mandatory Medicare	1,753
11-466-462-0000-6202	Cell Phone	1,400
11-466-462-0000-6245	State Required Registration or Licer	100
11-466-462-0000-6248	Insurance (Work.Comp., Liability)	800
11-466-462-0000-6331	Mileage	400
11-466-462-0000-6332	Meals And Lodging	150
11-466-462-0000-6335	Motor Pool Vehicle Usage	850
11-466-462-0000-6357	Conferences/Schools/Training	1,000
11-466-462-0000-6405	Office Supplies	200

Goodhue County

USER-SELECTED BUDGET REPORT

11 Fund Health & Human Service Fund

Report Basis: Cash

Account Number	Account Description	2019 Budget	
11-466-462-0000-6407	Grant Supplies	2,000	
11-466-466-0000-5218	Indian Casino Aid	30,000	-
11-466-466-0000-5280	MDH-Local Public Health Grant	41,376	-
11-466-466-0000-6023	Special Projects	4,500	
11-466-466-0000-6101	Salaries & Wages - Permanent	116,244	
11-466-466-0000-6151	Group Health Insurance	3,918	
11-466-466-0000-6152	HSA Contribution	4,628	
11-466-466-0000-6153	Family Insurance Supplement	20,423	
11-466-466-0000-6154	Life Insurance	99	
11-466-466-0000-6155	Dental Insurance-County Paid	208	
11-466-466-0000-6156	Accident Insurance-County Paid	71	
11-466-466-0000-6161	PERA	8,718	
11-466-466-0000-6171	FICA	7,207	
11-466-466-0000-6174	Mandatory Medicare	1,686	
11-466-466-0000-6331	Mileage	500	
11-466-466-0000-6332	Meals & Lodging	260	
11-466-466-0000-6333	Other Travel Expenses	50	
11-466-466-0000-6335	Motor Pool Vehicle Usage	205	
11-466-466-0000-6357	Conferences/Schools/Training	1,000	
11-466-466-0000-6405	Office Supplies	380	
11-466-468-0000-5336	20.600 TZD Grant (Toward Zero De	12,232	-
11-466-468-0000-6101	Salaries & Wages - Permanent	15,040	
11-466-468-0000-6151	Group Health Insurance	1,486	
11-466-468-0000-6152	HSA Contribution	732	
11-466-468-0000-6154	Life Insurance	14	
11-466-468-0000-6155	Dental Insurance-County Paid	79	
11-466-468-0000-6156	Accident Insurance-County Paid	27	
11-466-468-0000-6161	PERA	1,128	
11-466-468-0000-6171	FICA	932	
11-466-468-0000-6174	Mandatory Medicare	218	
11-466-468-0000-6202	Cell Phone	120	
11-466-468-0000-6331	Mileage	640	
11-466-468-0000-6332	Meals & Lodging	313	
11-466-468-0000-6335	Motor Pool Vehicle Usage	293	
11-466-468-0000-6357	Conferences/Schools/Training	300	
11-466-468-0000-6401	Printing Services	350	
11-466-468-0000-6407	Grant Supplies	325	

Account Number	Account Description	2019 Budget
11-466-468-0000-6414	Food & Beverages	150
11-466-472-0000-5282	MDH-SHIP Grant	177,598 -
11-466-472-0000-6024	Contracts	77,089
11-466-472-0000-6101	Salaries & Wages - Permanent	77,426
11-466-472-0000-6151	Group Health Insurance	1,351
11-466-472-0000-6152	HSA Contribution	665
11-466-472-0000-6154	Life Insurance	75
11-466-472-0000-6155	Dental Insurance-County Paid	72
11-466-472-0000-6156	Accident Insurance-County Paid	24
11-466-472-0000-6161	PERA	5,807
11-466-472-0000-6171	FICA	4,800
11-466-472-0000-6174	Mandatory Medicare	1,123
11-466-472-0000-6241	Advertising	500
11-466-472-0000-6278	Consultant Fees	500
11-466-472-0000-6331	Mileage & Transportation	305
11-466-472-0000-6332	Meals & Lodging	400
11-466-472-0000-6335	Motor Pool Vehicle Usage	1,560
11-466-472-0000-6342	Land & Building Lease/Rent	75
11-466-472-0000-6357	Conferences/Schools/Training	500
11-466-472-0000-6401	Printing Services	1,925
11-466-472-0000-6405	Office Supplies	331
11-466-472-0000-6407	Grant Supplies	2,500
11-466-472-0000-6414	Food & Beverages	500
467 Dept	Disaster Preparedness	
11-467-467-0000-5346	93.069 PHEP (EP Grant)	39,228 -
11-467-467-0000-6101	Salaries & Wages - Permanent	38,080
11-467-467-0000-6154	Life Insurance	62
11-467-467-0000-6161	PERA	2,856
11-467-467-0000-6171	FICA	2,361
11-467-467-0000-6174	Mandatory Medicare	552
11-467-467-0000-6331	Mileage & Transportation	80
11-467-467-0000-6335	Motor Pool Vehicle Usage	367
11-467-467-0000-6357	Conferences/Schools/Training	75
471 Dept	Infectious Disease	
11-471-471-0000-5280	MDH-Local Public Health Grant	45,809 -
11-471-471-0000-5407	Immunizations-Private	3,000 -

Account Number	Account Description	2019 Budget
11-471-471-0000-6020	Non-Billable Medical Supplies	500
11-471-471-0000-6101	Salaries & Wages - Permanent	17,086
11-471-471-0000-6102	Salaries & Wages-Part Time w/ Ben	73,798
11-471-471-0000-6151	Group Health Insurance	1,578
11-471-471-0000-6152	HSA Contribution	2,390
11-471-471-0000-6153	Family Insurance Supplement	16,338
11-471-471-0000-6154	Life Insurance	73
11-471-471-0000-6161	PERA	6,816
11-471-471-0000-6171	FICA	5,635
11-471-471-0000-6174	Mandatory Medicare	1,318
11-471-471-0000-6331	Mileage	500
11-471-471-0000-6335	Motor Pool Vehicle Usage	400
11-471-471-0000-6357	Conferences/Schools/Training	200
11-471-471-0000-6405	Office Supplies	60
11-471-471-0000-6431	Drugs & Medicine	3,500
11-471-471-0000-6435	Infection Control	600
479 Dept	PHS Administration	
11-479-478-0000-5280	MDH-Local Public Health Grant	7,500 -
11-479-478-0000-6173	Workmans Compensation	3,126
11-479-478-0000-6201	Telephone	1,200
11-479-478-0000-6202	Cell Phone	360
11-479-478-0000-6203	Postage/Freight	2,100
11-479-478-0000-6243	Association Dues/Memberships	1,000
11-479-478-0000-6246	Adm/Processing Fees	225
11-479-478-0000-6268	Software Maintenance Contracts	10,022
11-479-478-0000-6278	Consultant Fees	300
11-479-478-0000-6283	Other Professional & Tech Fees	4,356
11-479-478-0000-6302	Copies/Copier Maintenance	1,600
11-479-478-0000-6331	Mileage	30
11-479-478-0000-6342	Land & Building Lease/Rent	30,699
11-479-478-0000-6351	Insurance	3,587
11-479-478-0000-6405	Office Supplies	700
11-479-478-0000-6414	Food & Beverages	92
11-479-478-0000-6420	Other General Supplies	185
11-479-478-0000-6998	Transfers Out - Inter Fund	7,500
11-479-479-0000-5948	Transfers In - Inter Fund	11,200 -
11-479-479-0000-6101	Salaries & Wages - Permanent	83,816

Account Number	Account Description	2019 Budget
11-479-479-0000-6151	Group Health Insurance	10,217
11-479-479-0000-6152	HSA Contribution	4,810
11-479-479-0000-6153	Family Insurance Supplement	7,624
11-479-479-0000-6154	Life Insurance	100
11-479-479-0000-6155	Dental Insurance-County Paid	627
11-479-479-0000-6156	Accident Insurance-County Paid	137
11-479-479-0000-6161	PERA	6,286
11-479-479-0000-6171	FICA	5,197
11-479-479-0000-6173	Workmans Compensation	12,221
11-479-479-0000-6174	Mandatory Medicare	1,215
11-479-479-0000-6201	Telephone	3,000
11-479-479-0000-6202	Cell Phone	1,050
11-479-479-0000-6203	Postage/Freight	1,600
11-479-479-0000-6243	Association Dues/Memberships	2,000
11-479-479-0000-6268	Software Maintenance Contracts	23,730
11-479-479-0000-6278	Consultant Fees	700
11-479-479-0000-6283	Other Professional & Tech Fees	8,656
11-479-479-0000-6302	Copies/Copier Maintenance	6,800
11-479-479-0000-6331	Mileage	70
11-479-479-0000-6332	Meals & Lodging	500
11-479-479-0000-6342	Land & Building Lease/Rent	75,071
11-479-479-0000-6351	Insurance	8,371
11-479-479-0000-6357	Conferences/Schools/Training	400
11-479-479-0000-6405	Office Supplies	1,300
11-479-479-0000-6414	Food & Beverages	158
11-479-479-0000-6480	Equipment/Furniture<$5,000	11,200

Final Totals		
	Revenue	16,942,054 -
	Expend.	16,942,054
	Net	0

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (GCHHS)

REQUEST FOR BOARD ACTION

Requested Board Date:	January 22, 2019	**Staff Lead:**	Kathy Rolfer
Consent Agenda:	☒ Yes ☐ No	**Attachments:**	☒ Yes ☐ No
Action Requested:	Approve Regional Contract for Additional Employment and Training Services for Supplemental Nutrition Assistance Program (SNAP) Customers.		

BACKGROUND:

The Department of Human Services has continued to offer some additional employment and training funding for SNAP customers. Each county grant amounts are small so it has made sense for counties that wish to seek these funds to come together and contract with the state and regional employment and training service provider – Workforce Development Inc.

This is now our fourth year collaborating for this additional funding. Wabasha County has agreed to continue to act as the fiscal agent.

The Workforce Development Inc. will utilize the available funds of $15,671 10-01-18 through 9-30-2019 designated for direct program expenses and $1021.00 designated for support services for the four counties.

RECOMMENDATION: HHS department recommends approval of the above.

AGREEMENT FOR PROVISION OF
SUPPLEMENTAL NUTRITIONAL ASSISTANCE PROGRAM (SNAP)

The Wabasha County Board of Commissioners through its designated agency, the Wabasha County Department of Human Services, 625 Jefferson Avenue, Wabasha, MN 55981-1589 (651) 565-3351, acting as Fiscal Agent for the counties of Goodhue, Houston, Mower and Wabasha or any successor organization developed with at least one of the participating counties hereinafter referred to as the "Counties" and the Workforce Development, Inc., 1302 Seventh Street NW, Rochester, MN 55901 (507) 292-5166, hereinafter referred to as the "Contractor" enter into this agreement for the period of October 1, 2018 through September 30, 2019.

WITNESSETH

WHEREAS, M.S. 256D.051 requires counties to provide a SNAP Program to eligible persons and allows counties to subcontract for duties under subd.2 of M.S. 256D.051, and

WHEREAS, the Job Training Program, under WIA, administered by the Workforce Development, Inc. is knowledgeable regarding M.S. 256S.051 and of the methods and techniques involved in providing the services in M.S. 256D.051;

NOW, THEREFORE, in consideration of the mutual understandings and agreements set forth, the Counties and Contractor agree as follows;

Available Funds $15,817 10-01-2018 through 09-30-2019 designated for direct program expenses; $1282.00 (7.5% admin) and $1,223.00 designated for support services for the four counties.

I. Services to be Provided

A. SNAP Orientation
B. Employability assessment and development plan
C. Job search classes
D. Referrals to available employment assistance programs/agencies

II. Delivery

The Contractor agrees to the following:

A. The SNAP Program services will be made available at the Workforce Development, Inc. office locations in each county.

B. The services available for regular WIA participants may be available for SNAP participants, depending on the funding.

C. The program will be a minimum of 20 hours per week and a maximum of 32 hours per week for period of eligibility.

D. Upon referral of a SNAP registrant, the Contractor will provide an orientation to the SNAP Program and notify the Counties of attendance.

E. An employment plan with all of the required SNAP activities and individual responsibilities will be prepared by the Contractor and submitted to the participant each month. This employment plan will prescribe the necessary activities to be undertaken during the month by the participant in order to continue receiving monthly SNAP benefits. A copy will be sent to the Counties.

F. The Contractor agrees that in order to protect itself, as well as the Counties, under the indemnity agreement, it will at all times have and keep in force a professional liability insurance policy with limits of $1,000,000.00.

G. To facilitate interagency cooperation, the Counties and Contractor shall be considered adjunct agencies for the purpose of meeting the training requirements of the SNAP Program. Participant referral information and related contracts to provide training services and participation information shall be communicated between program related personnel involved with this program. Program participants will be apprised of the service agreement between the Counties and Contractor.

III. County's Responsibilities

A. Refer all persons eligible for the SNAP program to the Workforce Development, Inc. by completing a WF1 referral. The program moves to a voluntary status on December 1, 2018. Referrals will be made noting the participants opportunity for employment services at no cost to the participant.

B. The Counties will reimburse the Contractor for invoiced costs at the following rate: $400.00 per SNAP enrollment for staff services, including orientation, assessment, preparation of an Employment Plan, individualized counseling, Job Search instruction, and vocational assessment, referrals to other agencies, job referrals and direct marketing contracts with employers. Actual costs for services will be billed each month up to $15,817.00 direct program, $1,282.00 administration and $1,223.00 support funds for this program year. This includes the time spent sending notices to the participants and the Counties, in addition to tracking the participants' compliance.

C. Complete any state mandated Information System forms or reports for SNAP registrants at time of registration.

D. Inform Contractor prior to referring any participant who is unable to communicate in the English language. The Contractor will then arrange for an interpreter.

IV. Contractor Responsibility

A. The Contractor agrees that during the existence of this agreement that it will indemnify and hold harmless the Counties from any and all liability which may be claimed against the Contractor (1) by reason of any reimbursable cost resulting from an eligible client suffering injury, death, or property loss while participating in services from the Contractor or while being transported to/from said premises in any vehicle owned, operated, chartered, or otherwise contracted for by the Contractor or (2) by reason of any said client causing injury/damage to another person or property during any time when the Contractor has undertaken or is furnishing the service called for under this agreement.

B. The Contractor agrees to comply with the Civil Rights Act of 1964 (Titles VI and VII); Rehabilitation Act of 1973 (Section 504); and Minnesota Human Rights Act (Chapter 363).

V. Financial Arrangements and Reporting Procedures

A. The Contractor agrees to furnish the following reports to the Counties:

1. Verification that the participant kept their initial appointment as scheduled.

2. A copy of the employment plan.

3. Monthly communication with the Counties verifying each participant's program participation.

4. Any Management Information Systems forms or subsequent reports for SNAP required by the Counties.

VI. Other Conditions of the Contract

A. The Contractor shall allow personnel of the Counties, Minnesota Department of Human Services, and the Minnesota Department of Employment and Economic Development, access to the Contractor's

records at reasonable hours in order to exercise their responsibility to monitor the services and audit the financial records.

B. Audit and Records Disclosure:

The Contractor agrees to maintain records at 1302 Seventh Street N.W., Rochester, MN 55901 for a period of six years to allow persons from the Minnesota Department of Human Services and the Minnesota Department of Employment and Economic Development, or their designees, access to records at reasonable times for audit purposes.

C. The use or disclosure, by a party, of information concerning a client in violation of the Data Privacy Act or for any purpose not directly connected with the administration of the County's or Contractor's responsibility with respect to the Purchased Services hereunder is prohibited except on written consent of such eligible client his/her responsible parent or guardian.

D. This contract may be cancelled by either party, upon 30 days notice, in writing, delivered by mail, or in person.

E. Alteration to or waivers of provisions of this contract shall be valid only if they are in writing and duly signed by both parties.

F. In the event there is a revision of state regulations which might affect this agreement, all parties will review the contract and renegotiate those provisions necessary to bring it into compliance with the new regulations.

G. Subcontractors are subject to all requirements outlined in this agreement.

H. The Counties agrees to provide for a Fair Hearing and Grievance Procedure in conformance with Minnesota Statues, Sections 256.045, and in conjunction with the Fair Hearing and Grievance Procedures established by administrative rules of the State Department of Human Services.

VII. Non-Discrimination Statement: The CONTRACTOR will comply with:

A. Title VI of the Civil Rights Act of 1964, as amended by the Equal Employment Opportunity Act of 1972, which generally prohibits discrimination on the grounds of race, color, or national origin, and applies to any program or activity receiving federal financial aid.

B. Title VII of the Civil Rights Act of 1964, as amended by the Equal Employment Opportunity Act of 1972, which generally prohibits discrimination because of race, color, religion, sex, or national origin and

applies to all employers, including State and local governments, public and private employment agencies and labor organizations. Any employment and training program sponsor or contractor, which falls within one of these definitions, would, of course, be covered by Title VII.

C. The Rehabilitation Act of 1973, as amended, which generally prohibits discrimination on the basis of handicap in all federally funded programs.

D. The Age Discrimination in Employment Act of 1967, as amended which generally prohibits discrimination on the basis of age against persons 40 years of age and over.

E. The Equal Pay Act of 1963 amended the Fair Labor Standards Act and which generally provides that an employer may not discriminate on the basis of sex by paying employees of different sexes differently for doing the same work.

F. Title IX of the Education Amendments of 1972, as amended, generally provides that no person shall, on the basis of sex, be excluded from participation, be denied the benefits of, be treated differently from another person or otherwise be discriminated against in any interscholastic, intercollegiate, club or intramural athletics offered and no recipient shall provide any such athletics separately on such basis.

G. The Age Discrimination Act of 1975, as amended, prohibits unreasonable discrimination on the basis of age in programs or activities receiving federal financial assistance.

H. The Americans with Disabilities Act of 1990 (P.L.101-336), as amended, which prohibits discrimination based on disabilities in the areas of employment, public services, transportation, public accommodations and telecommunications.

IX Affirmative Action: The Contractor certifies that it has received a Certificate of Compliance from the Commissioner of Human Rights pursuant to Minnesota Statues, Section 363.073.

A. The Contractor agrees to comply with the requirements the Uniform Relocation Assistance and Real Property Acquisitions Act of 1970 (Public Law 91-646), which provides for fair and equitable treatment of persons displaced as a result of federal or federally assisted programs.

B. The Contractor agrees that program participants shall not be employed in the construction, operation or maintenance of that part of any facility, which is used for religious instructions or worship.

C. The Contractor agrees to comply with the provisions of Chapter 15, Title 5 of the United States Code with regard to political activity.

D. The Contractor further understands and agrees that it shall be bound by the Minnesota Government Data Practices Act (Minnesota Statutes 13.03-13.04) with respect to "data on individuals", (as defined in 13.02, subd. 5 of that statute) which it collects, receives, stores, uses, creates or disseminates pursuant to this agreement. The Contractor provides assurances to the Counties that it will comply with Health Information Portability and Accountability Act (HIPPA) requirements necessary to protect individual identifying health information (IIHI). Use and disclosure will require that all IIHI be: appropriately safeguarded; any misuse of IIHI will be reported to the Counties; secure satisfactory assurances from any subcontractor; grant individuals access and ability to amend their IIHI; make available an accounting of disclosures; release applicable records to the Department of Human Services if requested; and upon termination, return or destroy all IIHI in accordance with conventional record destruction practices.

E. The Contractor agrees to comply with all applicable standards, orders, or requirements issued under section 306 of the Clear Air Act (42 U.S.C. 1857 (h), section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15).

It is understood and agreed that the entire agreement of the parties is contained herein and that this agreement supersedes all oral agreements and negotiations between the parties related to the subject matter hereof, as well as any previous agreements presently in effect between the Counties and the Contractor.

IN WITNESS WHEREOF, The Counties and Contractor have executed this contract as of the day and year first above mentioned:

FOR
WABASHA CO.
BOARD OF COMMISSIONERS

By _____
Board Chair

By _____
Director

Date _____

By _____
County Attorney

Date _____

FOR THE CONTRACTOR
Workforce Development, Inc.

_____
Director

Date 11/13/18

FOR
MOWER CO. BOARD OF COMMISSIONERS

By _____
Board Chair

By _____
Director

Date _____

By _____
County Attorney

Date _____

FOR THE CONTRACTOR
Workforce Development, Inc.

_____
Director

Date 11/13/18

FOR
HOUSTON CO. BOARD OF COMMISSIONERS

By _____
Board Chair

By _____
Director

Date _____

By _____
County Attorney

Date _____

FOR THE CONTRACTOR
Workforce Development, Inc.

_____
Director

Date _____

FOR
GOODHUE CO. BOARD OF COMMISSIONERS

By _____
Board Chair

By _____
Director

Date _____

By _____
County Attorney

Date _____

FOR THE CONTRACTOR
Workforce Development, Inc.

_____
Director

Date 11/13/18

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (GCHHS)

REQUEST FOR BOARD ACTION

Requested Board Date:	January 22, 2019	**Staff Lead:**	Mike Zorn
Consent Agenda:	☐ Yes ☒ No	**Attachments:**	☐ Yes ☒ No
Action Requested:	Approve December 2018 HHS Warrant Registers		

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

	Date of Warrant		Check No. Series			Total Batch
IFS	December 7, 2018	ACH	26888	26894	$	16,954.16
IFS	December 7, 2018		442259	442304	$	26,065.62
IFS	December 14, 2018	ACH	26895	26902	$	2,458.89
IFS	December 14, 2018		442305	442344	$	27,249.44
IFS	December 21, 2018	ACH	26933	26937	$	5,331.78
IFS	December 21, 2018		442461	442493	$	13,805.41
IFS	December 28, 2018	ACH	27024	27033	$	2,601.44
IFS	December 28, 2018		442559	442645	$	28,200.46
SSIS	December 28, 2018	ACH	26938	26965	$	53,759.21
SSIS	December 28, 2018		442494	442547	$	165,698.82
IFS	December 28, 2018	ACH	16966	27023	$	18,086.49
IFS	December 28, 2018		442548	442558	$	49,895.08
				total	$	410,106.80

RECOMMENDATION: Goodhue County HHS Recommends Approval as Presented.

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (GCHHS)

REQUEST FOR BOARD ACTION

Requested Board Date:	January 22, 2019	**Staff Lead:**	Nina Arneson
Consent Agenda:	☐ Yes ☒ No	**Attachments:**	☒ Yes ☐ No
Action Requested:	Approve the following two requests - Reclassification Request and Live Well Goodhue County Grant Changes		

BACKGROUND:

The following two requests will be brought forward for the Goodhue County Personnel Committee's review on January 22, 2019 8:30 am.

- **Reclassification Request from Case Aide to Eligibility Worker**
- **Live Well Goodhue County Grant Changes – FTE Changes and Additions**

Please see attached two memos. The HHS Department staff will inform the HHS Board of the Personnel Committee's actions at our January 22, 2019 Health and Human Services Board meeting.

RECOMMENDATION: GCHHS Department recommends approval as requested.

Goodhue County
Health and Human Services

DATE: January 17, 2019

TO: Goodhue County Personnel Committee

FROM: Nina Arneson, GCHHS Director

RE: Reclassification Request

BACKGROUND:

At Goodhue County Health and Human Services an employee classified as a Case Aide, has administered our Child Care Assistance Program (CCAP). The Child Care Assistance Program provides financial assistance to help families with low incomes pay for child care; so that a parent may pursue employment or education leading to employment, and children are well cared for and prepared to enter school. The state child care system is called MEC² (Minnesota Electronic Child Care System).

There is essentially no covered backup for these duties since only one employee is currently doing CCAP eligibility. HHS does have another Case Aide that has access to MEC² Pro, which is setting up daycare providers in the state system. Separate staff do this because separation of duties is necessary to avoid any potential fraud.

With our Departments continued integration work and quality improvement, we are looking at making some changes to incorporate backup coverage for CCAP and streamline the application process for families to receive child care assistance.

Currently customers schedule an interview with the family unit of Income Maintenance to determine eligibility for income maintenance programs and services. If the customer then wants to apply for day care assistance then they must schedule another interview on another day with the CCAP worker.

After researching this area and consulting with the MN Merit System, we learned that Eligibility Workers from Income Maintenance divisions determine child care assistance in almost all of the counties in region 10. This is also the norm statewide. The Merit System views the Child Care Assistance as an eligibility program and therefore the duties performed by our one Case Aide, align much better with Eligibility Worker duties rather than Case Aide.

Based on our agency and customer needs and the MN Merit System recommendation, the reclassification change will result in better customer service and system efficiencies including the following:

- All family unit staff will interview customers on the same day for income maintenance programs and CCAP eligibility. HHS will now have backup coverage for CCAP eligibility determinations and customers will only need to have one interview for determining eligibility programs.

- HHS Finance will take over the approving/verifying MEC² provider payments. We will have two staff that have this access, so we will have backup coverage for approving payments.

- HHS Finance will take over the MEC² Pro, which is the CCAP portion that sets up daycare providers in the system. We will have two staff that have this access, so we will have backup coverage for setting up daycare providers.

- This should also provide some additional time to the family unit for the administration of Income Maintenance Programs, since that area continues to increase along with changing rules and regulations of the programs.

This position already is in the Income Maintenance Cost Pool and already participates in the Income Maintenance Random Moments Time Study, so there would be no changes in those areas.

Because of a classification change, the employee would move to the next highest step on the Eligibility Worker scale with a minimum of 2% increase. The employee would go from $29.03 to $29.75. This will be managed within the HHS 2019 budget and it will not result in county levy increase.

RECOMMENDATION:

The HHS Department recommends approving this reclassification from a Case Aide to an Eligibility Worker, effective; a day after review and approval has been received from Goodhue County Health and Human Services Board.

Goodhue County
Health and Human Services

DATE: January 17, 2019

TO: Goodhue County Personnel Committee

FROM: Nina Arneson, HHS Director

RE: Live Well Goodhue County Grant Changes

BACKGROUND:

The GCHHS Public Health Division, Healthy Communities Unit operates 100% Minnesota Department of Health (MDH) Statewide Health Improvement Partnership (SHIP) grant funded program called Live Well Goodhue County. The program's mission is to improve the health of our residents by making it easier to be active, eat nutritious foods and live tobacco-free.

Based on our agency and customers' needs, and after receiving an approval from MDH, we request to make the following changes to Goodhue County's SHIP program staffing structure:

Reduce current Live Well Goodhue County Coordinator position from 1.0 FTE to 0.5 FTE and hire a new 1.0 Public Health Educator in addition to our current employee working at 0.5 FTE. Both positions will continue to be provisional and 100% covered by the SHIP grant.

These staffing budget changes are possible in part because of reductions in outside contracted services. Our plan is to bring grant evaluation and communication contracted services back to HHS and then also make adjustments with our mini-grants based on actual utilization.

Our current 1.0 provisional Live Well Goodhue County Coordinator is classified as a planner and has been in the position since 2013. The current rate of pay for this Coordinator is $29.79 per hour and will continue at this rate at 0.5 FTE. The starting pay (step 1) for a Public Health Educator position is $26.11 per hour. These are both provisional positions covered entirely by the SHIP grant. These grant revenues and costs are included in GCHHS 2019 approved budget. These changes will not result in County levy increase.

Public Health Educator	2019 **Single Health** step 1	2019 **Family Health** step 1
Rate	$26.11	$26.11
Gross	$54,309.00	$54,309.00
PERA/FICA/Medicare/Life	$8,291.00	$8,291.00
Health Coverage/H.S.A.	$10,638.00	$23,426.00
	$73,238.00	$86,026.00

RECOMMENDATION:

The HHS Department recommends approving the following:

1. Moving forward immediately to post for 1 Public Health Educator (1 FTE) utilizing the MN Merit system. This posting would be for internal and external candidates. If an internal candidate is selected then move forward immediately to back fill that position until an external candidate has been hired to finish the process.

2. Hire Public Health Educator after GCHHS Board's review and approval.

3. Reduce Planner position from 1.0 to 0.5 after Public Health Educator is hired.

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (GCHHS)

REQUEST FOR BOARD ACTION

Requested Board Date:	January 22, 2019	**Staff Lead:**	Nina Arneson
Consent Agenda:	☐ Yes ☒ No	**Attachments:**	☐ Yes ☒ No
Action Requested:	Approve a 3.0% general wage adjustment for the 24/7 child protection on-call assignment compensation.		

BACKGROUND:

On December 20, 2016, the GCHHS Board approved a State mandated child protection 24/7 Assignment Plan for Goodhue County Health and Human Services, with a modification for the HHS Board to review and approve annual wage adjustments, if any.

On December 18, 2018, the Goodhue County Board approved a 3.0% general wage adjustment for non-union employees, which includes all GCHHS employees.

This is to request, a 3.0% general wage adjustment for the 24/7 child protection on call assignment compensation. This has been factored into the 2019 GCHHS approved budget.

Child Protection On Call Hourly Rates:

	2017 Hourly Rate	2018 Hourly Rate	**2019 Proposed Rate**
Child Protection Holiday (CPH)	$3.29	$3.37	**$3.47**
Child Protection On-Call (CPO)	$2.25	$2.31	**$2.38**

Below is a summary of the total annual cost of having the State mandated child protection 24/7 assignment plan that was implemented January 1, 2017.

Child Protection On Call Annual Cost

		2017	Hours	Total Cost
Holidays	12	$3.29	24.00	$947.52
Weekend Days	105	$2.25	24.00	$5,670.00
Working Days	248	$2.25	15.50	$8,649.00
Total Days	365			**$15,266.52**

2.50% COLA Increase

		2018	Hours	Total Cost
Holidays	12	$3.37	24.00	$970.56
Weekend Days	104	$2.31	24.00	$5,765.76
Working Days	249	$2.31	15.50	$8,915.45
Total Days	365			**$15,651.77**

Increase over the 2017 Budget **$385.24**

3.00% Proposed COLA Increase

		2019	Hours	Total Cost
Holidays	12	$3.47	24.00	$999.36
Weekend Days	104	$2.38	24.00	$5,940.48
Working Days	249	$2.38	15.50	$9,185.61
Total Days	365			**$16,125.45**

Increase over the 2018 Budget **$473.69**

RECOMMENDATION: The GCHHS Department recommends approval as requested.

GCHHS Child Protection On Call Report

January 22, 2019

Kris Johnson, GCHHS Social Services Supervisor, Child & Family

Statutory Requirements

- In January, 2017, Minnesota Statute required all child protection agencies to be available 72 hours, 7 days per week to respond to law enforcement regarding child protection cases
  - Agencies are NOT required to be available to the public to take child protection reports or respond to emergencies.
  - This is only to be available to law enforcement for advisement on child protection issues, and to see a child within 24 hours in imminent danger situations, which includes when a child is placed on a 24 hour hold.

Staffing

- **Twelve child protection social workers rotate on-call duty**
  - Each worker is on-call for one week at a time
    - Friday 4:30pm to the following Friday at 8:00am
  - Child protection social workers are required to keep the phone with them at all times, including by their bed so they can respond overnight.
  - The rotating schedule averages to being on call approximately 5-7 weeks per year, depending on staffing patterns, and most are on-call for one holiday per year
    - new staff do not go on-call for their first 6 months of employment

- **A supervisor or designee must be on-call and available to screen reports with staff as needed**
  - Lead worker is on-call as a supervisor designee 12 weeks per year
  - CP supervisor is on-call 40 weeks per year

2018 Statistics

- **Approximately 250 total calls to and from the on call phone**
  - For example, an officer calls about a situation, the worker makes several calls to address it, so there may be 10 incoming and outgoing calls on one situation. Every situation is different.
  - 250 is an estimate because the December call sheet was not available as of this report.

- **Timing of calls**
  - Approximately 70% of calls occur from 5:00 to 10:00pm
  - Approximately 30% of calls occur in the middle of the night or early morning

- **Calls are steadily increasing as Law Enforcement becomes more familiar with system**

- **Two situations required a worker to make face to face contact with a child after hours**

2018 Statistics

- **Calls fall roughly into four categories**

1. Brief Law Enforcement calls regarding new child protection/child welfare situations
   - Approximately 25% of the situations are brief and involve new CP/CW situations
   - Usually resolved in 1-2 phone calls in less than 10 minutes
2. Law Enforcement calls regarding new child protection/child welfare situations
   - Approximately 25% of the calls are new and involve complex CP/CW situations
   - Usually require 2-10 follow up calls and take 20 minutes to several hours to address
3. Calls regarding current open child protection cases
   - Approximately 25% are crisis situations involving current CP/CW cases
   - Usually require 2-10 follow up calls and take 20 minutes to several hours to address
4. Other (wrong number, calls regarding non-child protection situations etc)
   - Approximately 25% are brief issues that are quickly resolved

2018-2023 GOODHUE COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

Ruth Greenslade,
Goodhue County Health and Human Services

WHAT IS A COMMUNITY HEALTH IMPROVEMENT PLAN?

A strategic plan for improving community health

COMMUNITY HEALTH IMPROVEMENT PLAN

- Long-term plan
- Builds on Community Health Assessment
- Describes work of
  - local public health *and*
  - broad set of community partners
- Explains how we are addressing top issues together

OUR VISION

2017 Top 10 Health Issues

+

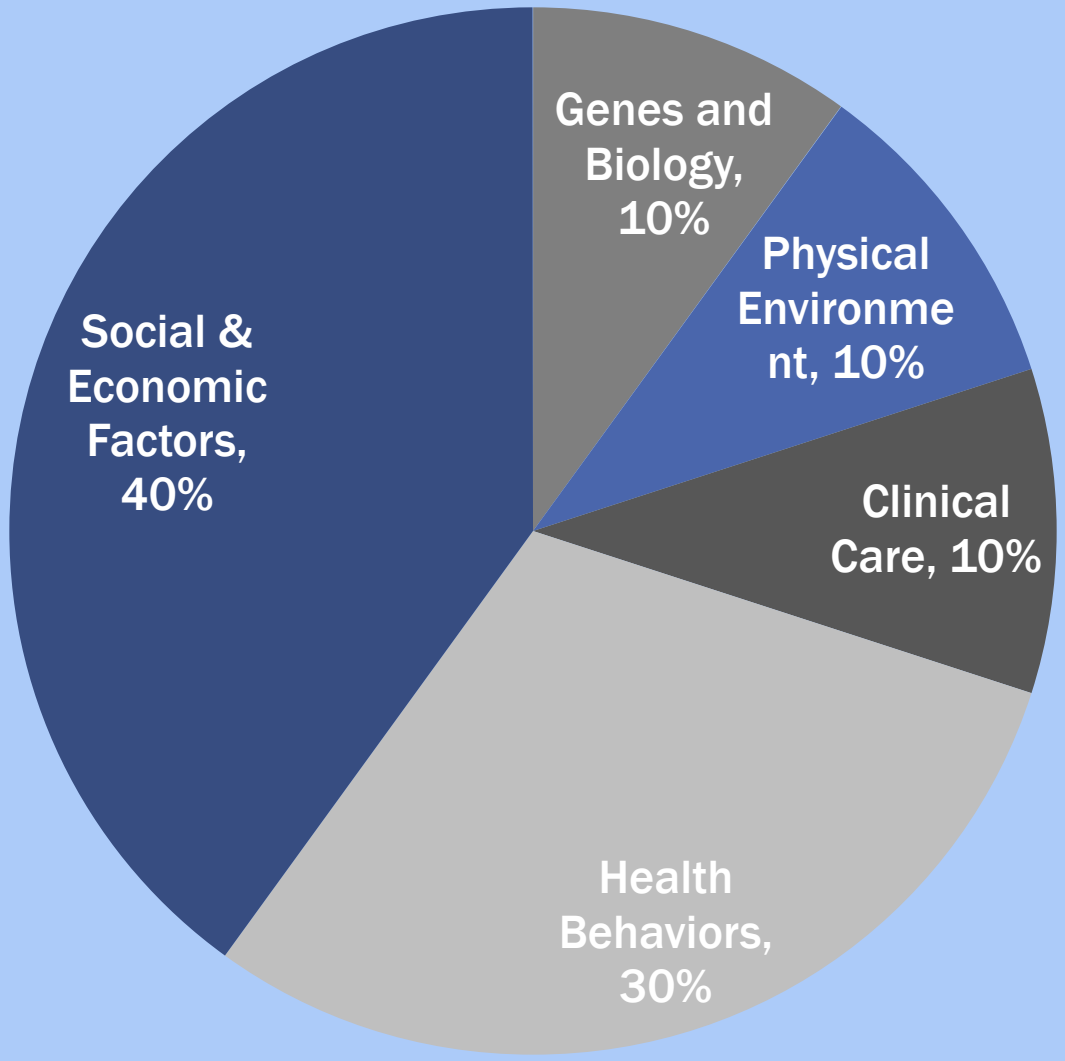
2018-2023 Action Plans

→

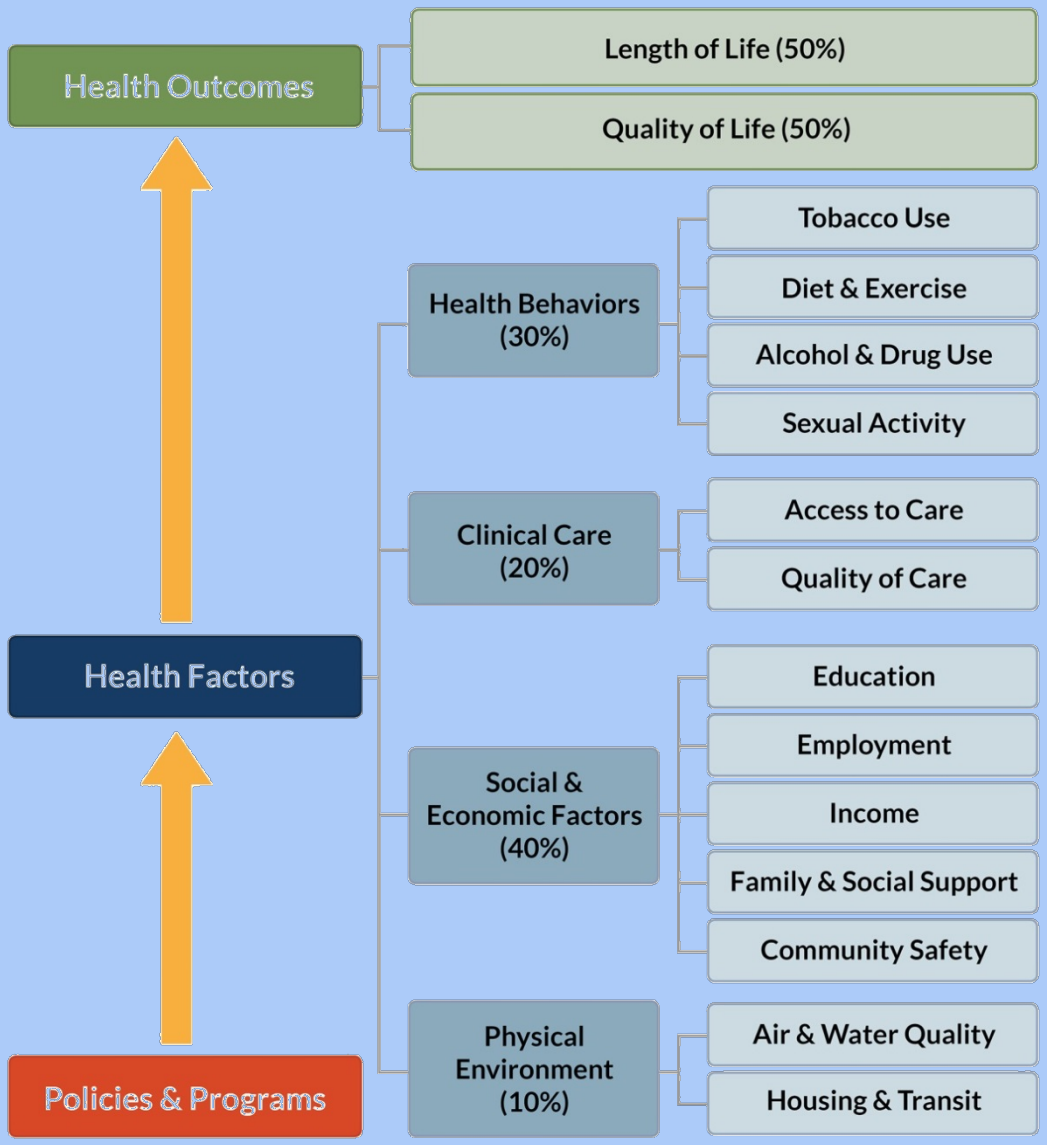
WHAT IS HEALTH?
WHAT AFFECTS HEALTH?

Health Outcomes & Health Factors

FACTORS AFFECTING HEALTH



Determinants of Health Model based on frameworks developed by: Tarlov, AR. *Ann NY Acad Sci* 1999; 896: 281-93; and Kindig, D., Asada Y, Booske B. *JAMA* 2008; 299 (17): 2081-2083

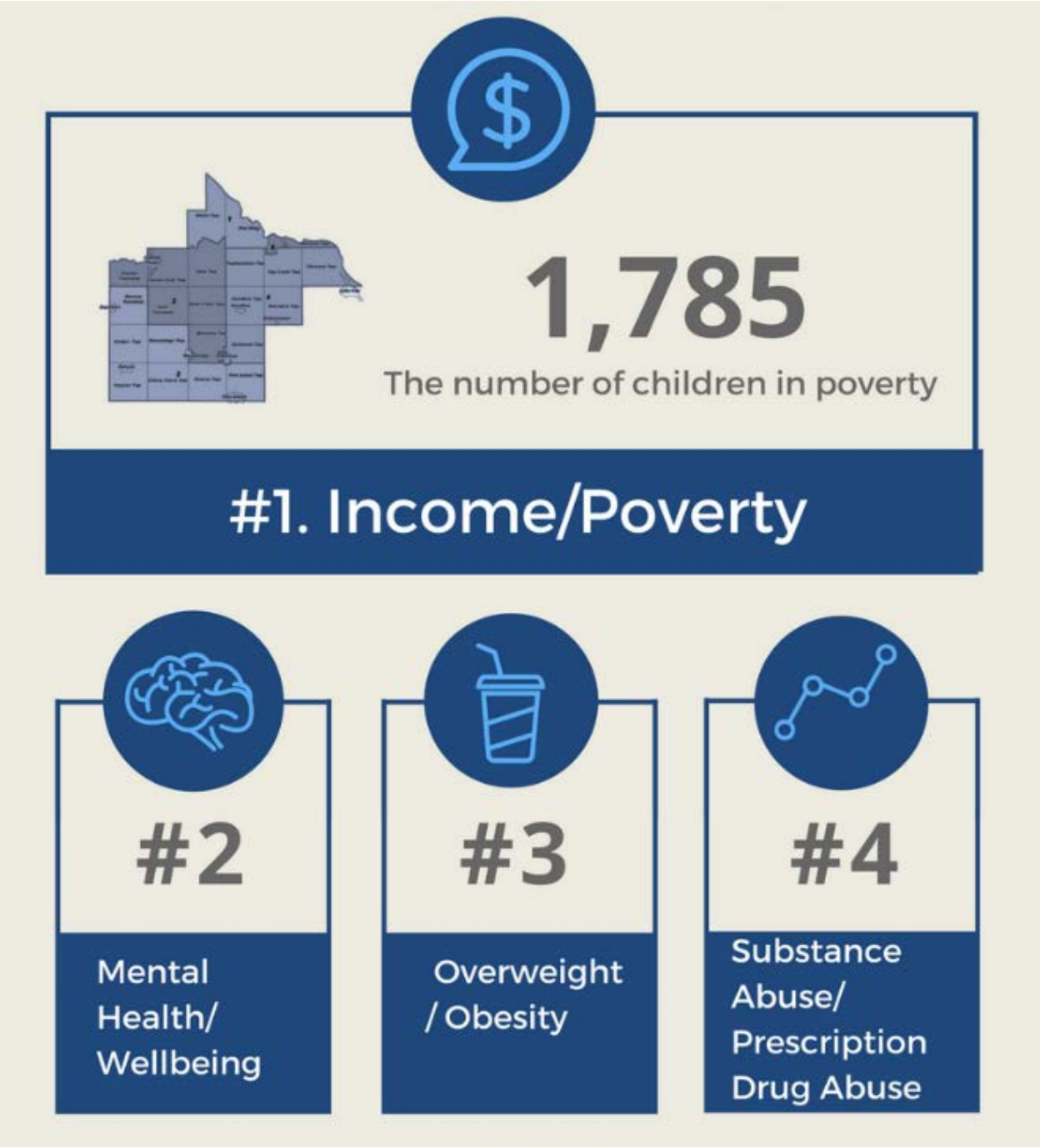


POPULATION HEALTH

County Health Rankings model © 2016 UWPHI

WHAT ARE THE TOP 10 HEALTH ISSUES IN GOODHUE COUNTY?

Issues to focus efforts and build partnerships/ collaboration



2017 TOP HEALTH ISSUES

Goodhue County Community Health Assessment

2017 TOP HEALTH ISSUES

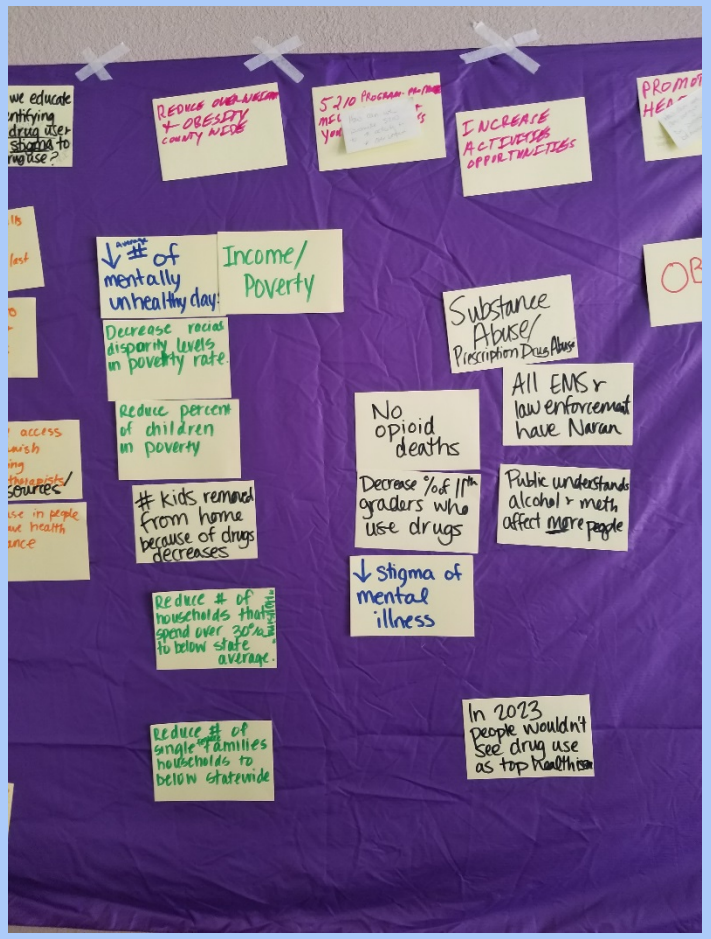
Goodhue County Community Health Assessment

HOW DO WE ADDRESS THESE ISSUES AS A COMMUNITY?

The 2018-2023 Community Health Improvement Plan

PRIORITIES ARE…

- Underlying challenges that impact more than one health issue
- More strategic if
  - Require us to change the way we function
  - Have long-term consequences
  - Create tension



TALK ABOUT THE IMPACT OF POVERTY ON HEALTH

What can we do to expand conversations on what's needed to be healthy and increase awareness regarding poverty as a root cause of some substance abuse, obesity, and mental health issues?

REDUCE BARRIERS TO MENTAL HEALTH CARE

How can we reduce barriers to mental health care so people in our county do not live with untreated symptoms of mental illness?

ENGAGE PRIORITY POPULATIONS

How can we authentically engage single moms, people of color, and Indigenous people in determining strategies that reduce their barriers to optimal health?

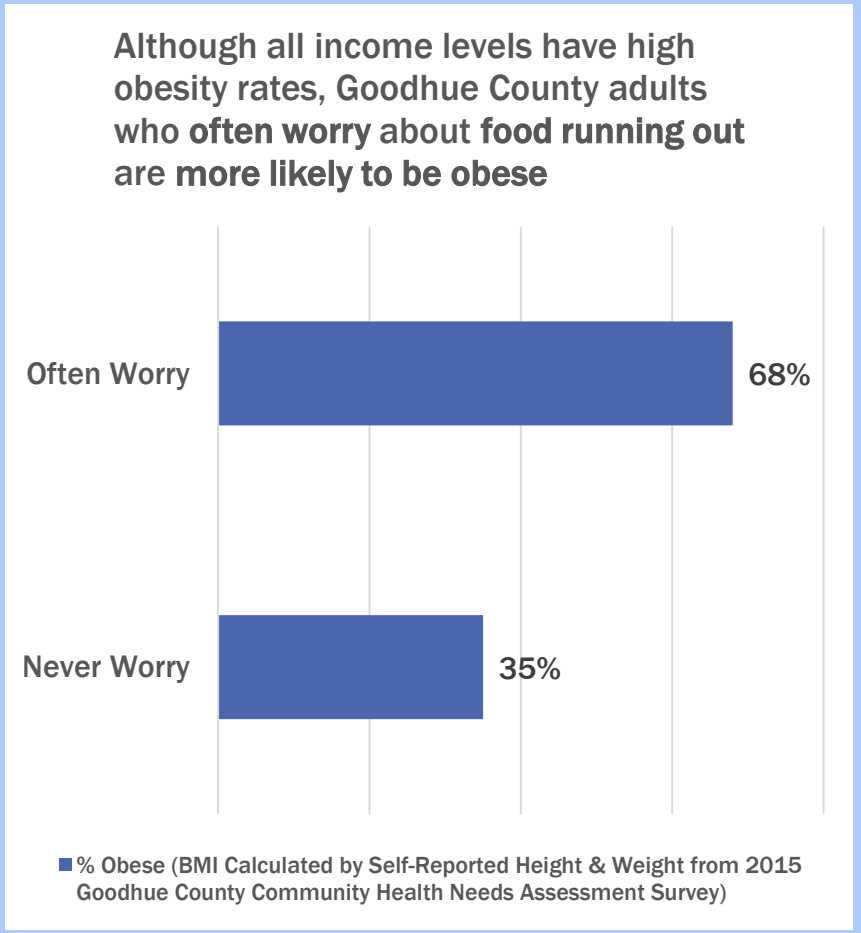
TOP HEALTH PRIORITIES

Goodhue County Community Health Improvement Plan

2018-2023

PRIORITY 1 ACTION PLAN

- **Strategy 1-1** Communicate the impact of poverty on health
- **Partners:**
  - Mayo Clinic Health System
  - United Way Poverty Simulations
  - Blandin LPEP Program



PRIORITY 2 ACTION PLAN

- **Strategy 2-1**
  Expand Make it OK Anti-Stigma Campaign
- **Partners:**
  - Make it OK Advisory Committee
  - Make it OK Ambassadors

PRIORITY 2 ACTION PLAN, CONTINUED

- **Strategy 2-2**
  Form a Mental Health Coalition to create a unified framework for improved mental health.

- **Partners:**
  - Fernbrook Family Services
  - Mayo Clinic Health System
  - Family Services Collaborative
  - Live Healthy Red Wing
  - Make it OK
  - Community Members

PRIORITY 3 ACTION PLAN

- **Strategy 3-1**
  Authentically engage low-income audiences in selecting, planning, and implementing Live Well Goodhue County strategies
- **Partners:**
  - U of M Extension
  - Food Shelves

LEGACY PRIORITY ACTION PLAN

- **Strategy L-1**
  Home visiting
- **Partners**
  - GCHHS Family Home Visiting
  - GCHHS Healthy Families America
  - GCHHS Parent Support Outreach Program
  - Three Rivers Head Start & Early Head Start
  - School Birth to Three (ECSE) Programs

QUESTIONS

2018-2023

Goodhue County Community Health Improvement Plan

Goodhue County
Health and Human Services
December 2018

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GOODHUE COUNTY COMMUNITY HEALTH ASSESSMENT COMMITTEE, DECEMBER 2018

Jane Adams-Barber (Three Rivers Community Action)
Kanko Akakpovi (University of Minnesota Extension)
David Anderson (Goodhue County Health and Human Services)
Becky Brown (First English Lutheran Church, Cannon Falls)
Stephanie Bartelt (South Country Health Alliance)
Aimee Clites (Every Hand Joined)
Jennifer Cook (Red Wing Housing & Redevelopment Authority)
Paul Drotos (Goodhue County Commissioner)
Randal Hemmerlin (Red Wing Housing & Redevelopment Authority)
Dave Hill (Community Member, Red Wing)
Pam Horlitz* (Mayo Clinic Health System in Red Wing, Cannon Falls, and Lake City)
Kris Johnson (Goodhue County Health and Human Services)
Jessica Kitzmann (Red Wing Housing & Redevelopment Authority)
Kris Klassen (Red Wing Public Schools)
Kris Kvols (Hope Coalition)
David LeGarde (CareerForce)
Gene Leifeld (Live Well Goodhue County Community Leadership Team, Zumbrota)
Michelle Leise (City of Red Wing)
Julie Malyon (C.A.R.E. Clinic)
Mike Melstad (Red Wing Family YMCA)
Alan Muller (Community Member, Red Wing)
Maureen Nelson* (United Way of Goodhue, Wabasha, and Pierce Counties)
Elaine O'Keefe (Live Healthy Red Wing)
Anita Otterness (National Alliance on Mental Illness-NAMI Southeast Minnesota)
Laura Prink* (United Way of Goodhue, Wabasha, and Pierce Counties)
Lucy Richardson (Hispanic Outreach)
Jessica Seide* (Goodhue County Health and Human Services)
Laura Smith (Goodhue County Health and Human Services)
Abby Villaran (Goodhue County Health and Human Services)
Dawn Wettern (Red Wing Community Education & Recreation)

For more information, contact:

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*Community Health Assessment Core Group

Executive Summary

A community health improvement plan is a long-term plan, describing how the local health department and a broad set of community partners are addressing needs identified in the last community health assessment. This 2018-2023 plan is based on a community health assessment completed for Goodhue County in 2017. The Community Health Assessment Committee reviewed the top 10 health issues from the 2017 assessment and identified three underlying health priorities for 2018-2023 (see priorities on page 3).

Many organizations are involved in addressing these priorities and the legacy priority from the 2014 plan, Family & Parenting. Completing and monitoring the plan, in collaboration with community stakeholders and partners, is a responsibility of Goodhue County Health and Human Services (GCHHS) under Minnesota Statutes §145A and is required by the Public Health Accreditation Board. GCHHS leads the Community Health Assessment committee and will compile updates and revisions to the plan in annual reports.

"Community" refers to the whole population of Goodhue County, as opposed to the health of any one individual. "Health" includes not only our health outcomes but also the health factors that influence health. This plan is about improving the health of the community together and achieving the Community Health Assessment Committee's vision.

Community Health Assessment Committee Mission:

to identify health disparities and top health issues for Goodhue County and implement and evaluate strategies, policies, and programs.

Community Health Assessment Committee Vision:

"…opportunity for all Goodhue County residents to experience optimal health…"

Overview of 2018-2023 Action Plans & Strategies

Action Plans	Strategies	
Action Plan 1: Talk about the Impact of Poverty on Health	Strategy 1-1:	Communicate the impact of poverty on health
Action Plan 2: Reduce Barriers to Mental Health Care	Strategy 2-1: Strategy 2-2:	Expand Make It OK Anti-Stigma Campaign Form a Mental Health Coalition to create a unified framework for improved mental health
Action Plan 3: Engage Priority Populations	Strategy 3-1:	Authentically engage low-income audiences in selecting, planning, and implementing Live Well Goodhue County strategies
Legacy Action Plan: Family & Parenting	Strategy L-1:	Home Visiting

3

HEALTH PRIORITIES

GOODHUE COUNTY 2018-2023

TALK ABOUT THE IMPACT OF POVERTY ON HEALTH

What can we do to expand conversations on what's needed to be healthy and increase awareness regarding poverty as a root cause of some substance abuse, obesity, and mental health issues?

REDUCE BARRIERS TO MENTAL HEALTH CARE

How can we reduce barriers to mental health care so people in our county do not live with untreated symptoms of mental illness?

ENGAGE PRIORITY POPULATIONS

How can we authentically engage single moms, people of color, and Indigenous people in determining strategies that reduce their barriers to optimal health?

TABLE OF CONTENTS

INTRODUCTION

DESCRIPTION OF GOODHUE COUNTY

This Community Health Improvement Plan is about improving the health of all community members in the geographic area of Goodhue County, which is located in southeast Minnesota. In 2017, Goodhue County's estimated population was 46,304 (U.S. Census Bureau, Population Division), an increase of 2,177 or 5% since the 2000 Census. According to US Census 2017 Population Estimates, 92% of the population is non-Hispanic white, 3% is Hispanic, 1.5% is American Indian, 1% is Black, 0.7% is Asian, and people who are two or more races make up about 2% of the population.

Goodhue County has 10 cities and 21 townships. The county is on the Highway 52 corridor between the Twin Cities and Rochester, including the towns of Cannon Falls, Zumbrota, and Pine Island. The Mississippi River town of Red Wing, on U.S. Highway 61, is the county seat. Other rural communities include Goodhue, Kenyon, Wanamingo, Bellechester, Dennison, and Lake City. Most of Lake City and a portion of Pine Island are in neighboring counties.

Households with children under 18 make up 31% of households in Goodhue County (U.S. Census Bureau, 2013-2017). School districts include Cannon Falls, Goodhue, Kenyon-Wanamingo, Pine Island, Red Wing, and Goodhue County Education District, plus portions of seven others including Zumbrota-Mazeppa and Lake City, which are officially Wabasha County districts. On average, 26% of students in Goodhue County districts receive free or reduced price lunch (Minnesota Department of Education, 2018). As of 2016, an estimated 7.7% of the population in Goodhue County lived below the poverty line, and households in Goodhue County, MN had a median income of $66,038 compared to the state at $65,583 (U.S. Census Bureau SAIPE).

The county has 780 square miles, much of it prime farmland in active production. Outside of agriculture, the economy of Goodhue County is specialized in manufacturing and utilities, and other large industries include healthcare and retail. A major demographic shift is underway. In 2015, 19% of Goodhue County residents were over age 65, but projections from the Minnesota Department of Employment and Economic Development are that by 2045, 27% will be over age 65.

AGRICULTURAL SCENE IN RURAL GOODHUE COUNTY

DEFINITIONS

Community Health Improvement Plan

A community health improvement plan is part of a strategic planning process for improving community health, describing how the local health department and a broad set of community partners are addressing needs identified in the last community health assessment. Because writing and updating such a plan is a health department requirement, Goodhue County Health and Human Services (GCHHS) leads the Community Health Assessment Committee. However, the only way we can improve these things is together. The credit for the work goes to the organizations who actively participate and the community members listed.

Community Health

"Community health" refers to the health of the whole population, as opposed to the health of individuals. For example, community health strategies would aim to lower the county's diabetes rate overall, or for groups most at risk. This is different than offering health tips for individuals on how to prevent diabetes. To improve health at the community level requires convening partners and engaging the community. Community health improvement often includes using evidence-based strategies and making changes to policies and systems. There are many collaborative initiatives in Goodhue County, led by a variety of organizations. Efforts to improve equity, education, housing, or access to mental health care can all prevent illness, prevent injury, and prevent health care costs. That's community health.

Health

Our Community Health Assessment Committee's definition of health is contained in our vision statement (see page 20). This vision describes our desired future. "Health" includes not only our health outcomes but also the health factors that influence health. ***Health outcomes*** are morbidity and mortality—average quality of life and length of life in Goodhue County. ***Health factors*** include not only genetics, personal behaviors, and clinical care, but also the physical environment and social and economic factors that influence health outcomes.

RATING DATA BY SIZE, SERIOUSNESS, AND UNFAIRNESS AT A COMMUNITY HEALTH ASSESSMENT COMMITTEE MEETING, 2017

Health Equity

As a Community Health Assessment Committee, we are interested in addressing inequities in the county. The Minnesota Department of Health defines health equity as "the opportunity for every person to realize their health potential—the highest level of health possible for that person—without limits imposed by structural inequities" (Advancing Health Equity in Minnesota: Report to the Legislature, 2014). ***Health inequities*** are differences in health between groups due to social, economic, environmental, geographic, and political conditions, also known as the social determinants of health. While other health disparities are the consequence of genetic or biological differences between groups, *health inequities* specifically result from social conditions we can change through the implementation of policies and practices.

Terms Used in Action Plans

Priority

Underlying challenges that need to be addressed to achieve our vision

Goal

Answers the question "What do we want to achieve by addressing this priority?"

Strategy

Answers the question, "How do we want to achieve our goal? What action is needed?"

Action Plan Objectives

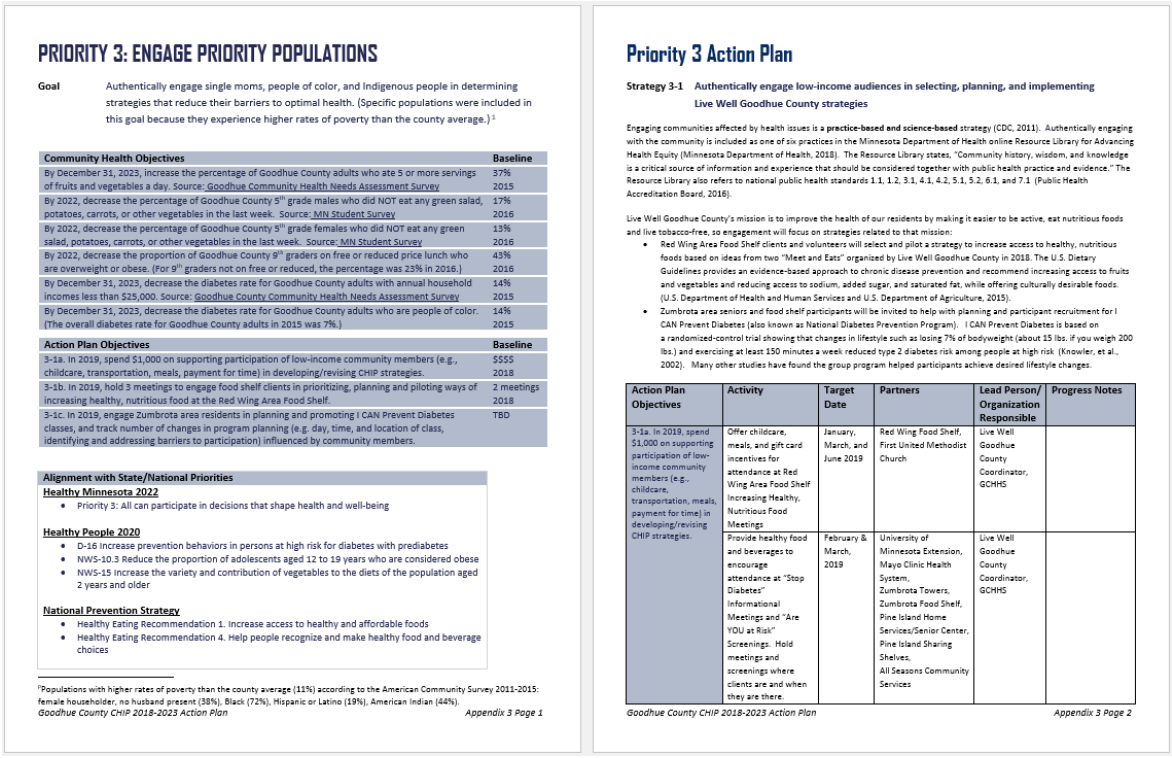
Measure the amount or quality of activities related to the strategy. Specific, measureable, and time-bound.

Community Health Objectives

Population indicators or conditions to which the action plan activities make a contribution. Health outcomes or factors.

Baseline

Most recent data for action plan and community health objectives. The starting point, for comparison.



PRIORITY 3: ENGAGE PRIORITY POPULATIONS

Goal Authentically engage single moms, people of color, and Indigenous people in determining strategies that reduce their barriers to optimal health. (Specific populations were included in this goal because they experience higher rates of poverty than the county average.)[1]

Community Health Objectives	Baseline
By December 31, 2023, increase the percentage of Goodhue County adults who ate 5 or more servings of fruits and vegetables a day. Source: Goodhue Community Health Needs Assessment Survey	37% 2015
By 2022, decrease the percentage of Goodhue County 5th grade males who did NOT eat any green salad, potatoes, carrots, or other vegetables in the last week. Source: MN Student Survey	17% 2016
By 2022, decrease the percentage of Goodhue County 5th grade females who did NOT eat any green salad, potatoes, carrots, or other vegetables in the last week. Source: MN Student Survey	13% 2016
By 2022, decrease the proportion of Goodhue County 9th graders on free or reduced price lunch who are overweight or obese. (For 9th graders not on free or reduced, the percentage was 23% in 2016.)	43% 2016
By December 31, 2023, decrease the diabetes rate for Goodhue County adults with annual household incomes less than $25,000. Source: Goodhue County Community Health Needs Assessment Survey	14% 2015
By December 31, 2023, decrease the diabetes rate for Goodhue County adults who are people of color. (The overall diabetes rate for Goodhue County adults in 2015 was 7%.)	14% 2015

Action Plan Objectives	Baseline
3-1a. In 2019, spend $1,000 on supporting participation of low-income community members (e.g., childcare, transportation, meals, payment for time) in developing/revising CHIP strategies.	$$$$ 2018
3-1b. In 2019, hold 3 meetings to engage food shelf clients in prioritizing, planning and piloting ways of increasing healthy, nutritious food at the Red Wing Area Food Shelf.	2 meetings 2018
3-1c. In 2019, engage Zumbrota area residents in planning and promoting I CAN Prevent Diabetes classes, and track number of changes in program planning (e.g. day, time, and location of class, identifying and addressing barriers to participation) influenced by community members.	TBD

Alignment with State/National Priorities

Healthy Minnesota 2022

- Priority 3: All can participate in decisions that shape health and well-being

Healthy People 2020

- D-16 Increase prevention behaviors in persons at high risk for diabetes with prediabetes
- NWS-10.3 Reduce the proportion of adolescents aged 12 to 19 years who are considered obese
- NWS-15 Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older

National Prevention Strategy

- Healthy Eating Recommendation 1. Increase access to healthy and affordable foods
- Healthy Eating Recommendation 4. Help people recognize and make healthy food and beverage choices

[1]Populations with higher rates of poverty than the county average (11%) according to the American Community Survey 2011-2015: female householder, no husband present (38%), Black (72%), Hispanic or Latino (19%), American Indian (44%).

Goodhue County CHIP 2018-2023 Action Plan *Appendix 3 Page 1*

Priority 3 Action Plan

Strategy 3-1 Authentically engage low-income audiences in selecting, planning, and implementing Live Well Goodhue County strategies

Engaging communities affected by health issues is a **practice-based and science-based** strategy (CDC, 2011). Authentically engaging with the community is included as one of six practices in the Minnesota Department of Health online Resource Library for Advancing Health Equity (Minnesota Department of Health, 2018). The Resource Library states, "Community history, wisdom, and knowledge is a critical source of information and experience that should be considered together with public health practice and evidence." The Resource Library also refers to national public health standards 1.1, 1.2, 3.1, 4.1, 4.2, 5.1, 5.2, 6.1, and 7.1 (Public Health Accreditation Board, 2016).

Live Well Goodhue County's mission is to improve the health of our residents by making it easier to be active, eat nutritious foods and live tobacco-free, so engagement will focus on strategies related to that mission:

- Red Wing Area Food Shelf clients and volunteers will select and pilot a strategy to increase access to healthy, nutritious foods based on ideas from two "Meet and Eats" organized by Live Well Goodhue County in 2018. The U.S. Dietary Guidelines provides an evidence-based approach to chronic disease prevention and recommend increasing access to fruits and vegetables and reducing access to sodium, added sugar, and saturated fat, while offering culturally desirable foods. (U.S. Department of Health and Human Services and U.S. Department of Agriculture, 2015).
- Zumbrota area seniors and food shelf participants will be invited to help with planning and participant recruitment for I CAN Prevent Diabetes (also known as National Diabetes Prevention Program). I CAN Prevent Diabetes is based on a randomized-control trial showing that changes in lifestyle such as losing 7% of bodyweight (about 15 lbs. if you weigh 200 lbs.) and exercising at least 150 minutes a week reduced type 2 diabetes risk among people at high risk (Knowler, et al., 2002). Many other studies have found the group program helped participants achieve desired lifestyle changes.

Action Plan Objectives	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
3-1a. In 2019, spend $1,000 on supporting participation of low-income community members (e.g., childcare, transportation, meals, payment for time) in developing/revising CHIP strategies.	Offer childcare, meals, and gift card incentives for attendance at Red Wing Area Food Shelf Increasing Healthy, Nutritious Food Meetings	January, March, and June 2019	Red Wing Food Shelf, First United Methodist Church	Live Well Goodhue County Coordinator, GCHHS	
	Provide healthy food and beverages to encourage attendance at "Stop Diabetes" Informational Meetings and "Are YOU at Risk" Screenings. Hold meetings and screenings where clients are and when they are there.	February & March, 2019	University of Minnesota Extension, Mayo Clinic Health System, Zumbrota Towers, Zumbrota Food Shelf, Pine Island Home Services/Senior Center, Pine Island Sharing Shelves, All Seasons Community Services	Live Well Goodhue County Coordinator, GCHHS	

Goodhue County CHIP 2018-2023 Action Plan *Appendix 3 Page 2*

ACTION PLANS CAN BE FOUND ONLINE AT HTTP://WWW.CO.GOODHUE.MN.US/982/COMMUNITY-HEALTH-IMPROVEMENT-PLAN

Other Assessments and Plans

The Community Health Improvement Plan is meant to complement other action planning documents produced by governmental and community partners. The Goodhue County Community Health Improvement Plan is different:

- Entire Goodhue County population
- 5 year timeframe
- Addresses top health issues (including factors that influence health, see definition of "health" on page 6)
- Required by Public Health Accreditation Board and Minnesota Statute

Hospital Community Health Needs Assessments

In Goodhue County, Mayo Clinic Health System uses local community health needs assessment survey and key informant interview data collected in collaboration with the health and human services department in preparing their Cannon Falls, Lake City, and Red Wing hospitals' CHNAs. The last CHNAs were in 2016 and the next will be in 2019.

- Population served by each hospital
- 3 year timeframe
- Assesses needs so hospitals can provide community benefits that meet the needs of their communities
- Required by IRS and Affordable Care Act to maintain tax-exempt status

View the CHNA reports online: https://mayoclinichealthsystem.org/about-us/community-health-needs-assessments

MAYO CLINIC HEALTH SYSTEM CANNON FALLS HOSPITAL AND CLINIC

United Way of Goodhue, Wabasha & Pierce Counties Key Goals

United Way organizations often do a community assessment and planning processes. The United Way of Goodhue, Wabasha, and Pierce Counties reviews one focus area annually, rotating through Health, Education, and Basic Needs on a three-year grant cycle.

- Multi-county population
- Rotating 3-year timeframe
- Determines focus of Community Investment grant making

To view the United Way of Goodhue, Wabasha, and Pierce Counties' Key Goals, visit their Community Investment grant webpage: https://www.uw-gwp.org/our-impact/community-investment/

Comprehensive Plans (such as Red Wing 2040)

Minnesota gives cities and counties the authority to regulate land use through three tools: zoning ordinances, subdivision ordinances, and comprehensive plans ("comp plans"). A comp plan, like Red Wing 2040, contains a community's vision for the future and its goals and strategies. Smaller cities may do comp plans but are not required.

- Population of city (for city comp plans) or population of county (for the county comp plan)
- Long-term (such as 10-20 years)
- Guides the overall future development and improvement of the city or county

2015 Bellechester Comprehensive Plan: https://bellechestermn.com/documents/
2012 Lake City Comprehensive Plan: https://www.ci.lake-city.mn.us/comprehensiveplan
2010 Pine Island Comprehensive Plan: http://www.pineislandmn.com/city_hall/comprehensive_plan.php#.XBvFEVVKjIU
Red Wing 2040 Comprehensive Community Plan: https://www.red-wing.org/354/Red-Wing-2040
2016 Zumbrota Comprehensive Plan: https://www.ci.zumbrota.mn.us/?SEC=F53D243D-7140-4F30-B944-00C1C6354E2D
2016 Goodhue County Comprehensive Plan: https://www.co.goodhue.mn.us/925/Ordinances-and-Plans

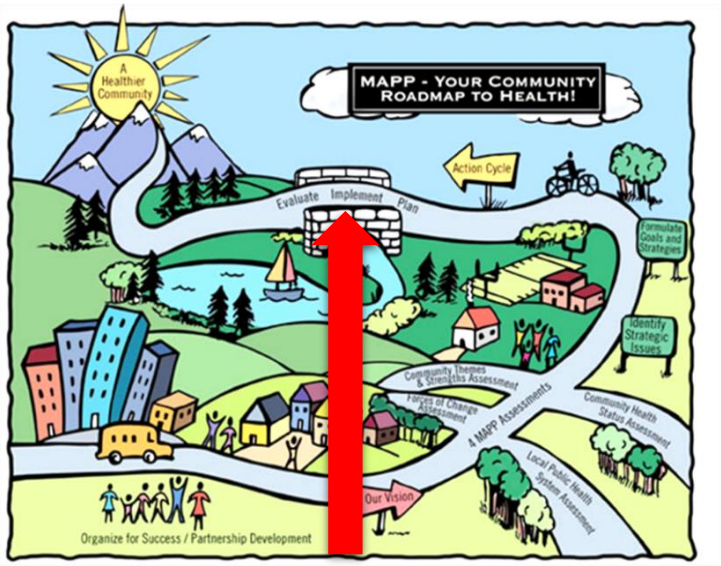
The Red Wing 2040 planning process and the Community Health Improvement Plan process both took place in 2018. Strategy 2-2, Form a Mental Health Coalition to create a unified framework for improved mental health, is a collaborative effort also included in the Red Wing 2040 plan.

BOAT HOUSES IN RED WING NEAR BAY POINT PARK

Writing This Plan

MAPP Model

Mobilizing for Action through Planning and Partnerships (MAPP) is a national model for health assessment and planning. It is a community-driven strategic planning process to prioritize public health issues and identify resources to address them (National Association of County and City Health Officials, 2018). Writing this plan involved these MAPP phases: Identify Priorities, Formulate Goals and Strategies, and the Action Cycle. The plan is now ready to implement. We will evaluate progress on action plans in annual reports.



THE MAPP COMMUNITY ROADMAP: WE ARE HERE

Selecting Top Health Issues

In 2017, the Community Health Assessment Committee reviewed data summaries on all of the following health topics:

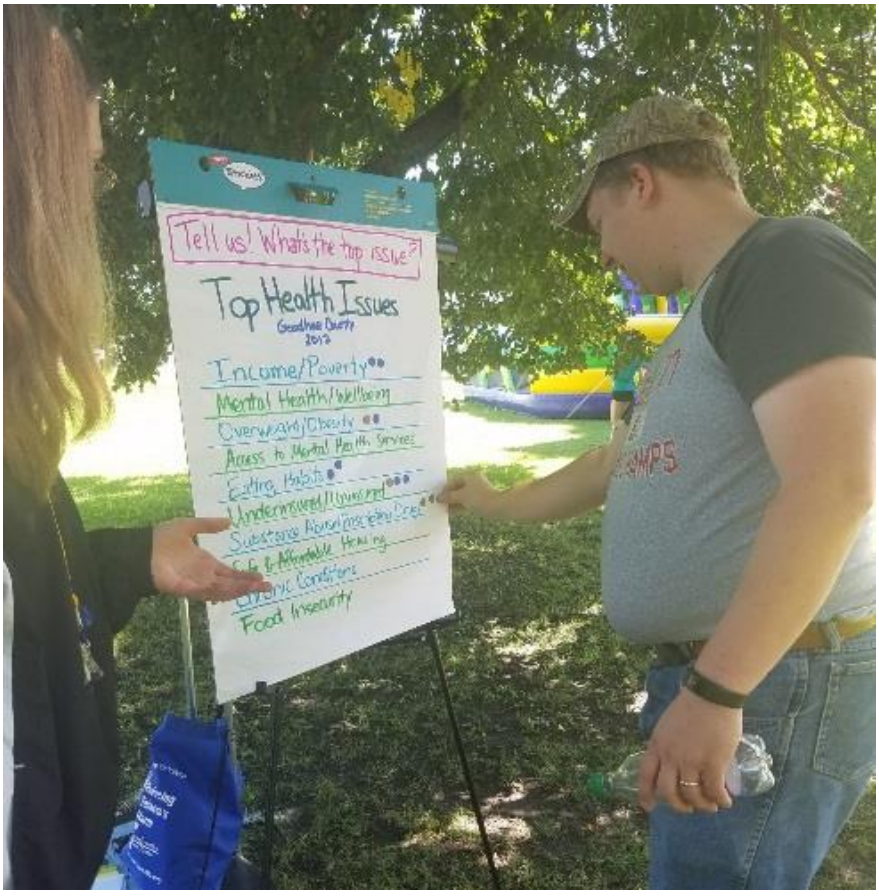
- Access to Dental Care
- Access to Medical Care + Uninsured
- Access to Mental Health Care
- Aging Populations + Falls + Disabilities
- Air Quality + Asthma + Water Quality
- Alcohol
- Animal/Vector-borne Disease
- Bullying
- Cancer + Screenings
- Child Abuse and Domestic Violence
- Child Care Shortage
- Chronic Health Conditions
- Crime
- Educational Attainment + K-12 Education
- Family Planning
- Family and Parenting
- Foodborne Illnesses
- Food Insecurity
- Healthy Eating
- Housing + Homelessness + Affordability
- Lead
- Sexually Transmitted Disease
- Substance Abuse + Prescription Drug Abuse
- Maternal, Infant, and Child Health
- Mental Health
- Mental Health: Youth
- Motor Vehicle Crashes + Driving Behaviors
- Overweight and Obesity
- Parks and Recreation
- Physical Activity
- Population Growth
- Poverty + Income Inequality + Unemployment
- Racially Diverse Populations
- Radon
- Tobacco, E-Cigarettes, and Secondhand Smoke
- Transportation Cost
- Vaccine Preventable Disease

Using the data, they rated health topics by size, seriousness, and unfairness:

- Size is the number of people potentially or actually affected by the health topic.
- Seriousness refers to the impact upon disability, premature death, social burdens or health care costs.
- Unfairness means all people do not have an equal opportunity to be healthy surrounding this topic based upon factors like gender, race, age, or income.

For the 15 topics with the highest average ratings, the committee listed which 3 topics were most important/ most related. For example, Income/Poverty was related to 11 of the top 15 health issues, and Mental Health/Wellbeing was related to 7 of the top 15 health issues. This determined which issues were included in the top 10.

A sub-committee finalized the order of the top 10 issues with public input from informal dot surveys. For example, Substance Abuse/Prescription Drug Abuse was moved up from number 7 to number 4 based on public input.



COMMUNITY INPUT AT KENYON ROSE FEST 2017

All health topics are important to monitor. Data on all of the health topics is included in the 2017 Goodhue County Community Health Assessment: http://www.co.goodhue.mn.us/981/Community-Health-Assessment

SELECTING PRIORITIES

In 2018, the Community Health Assessment Committee looked again at data from the six top health issues in the 2017 Community Health Assessment. The task was to identify which data or indicators we hoped would change over the next 5 years in our county. The intent was to look back at the data that were most concerning to our Committee last year in terms of size, seriousness, and unfairness (health inequity), before we brainstormed possible priorities. We wrote answers on cards and posted on a sticky wall. We rearranged and grouped cards.

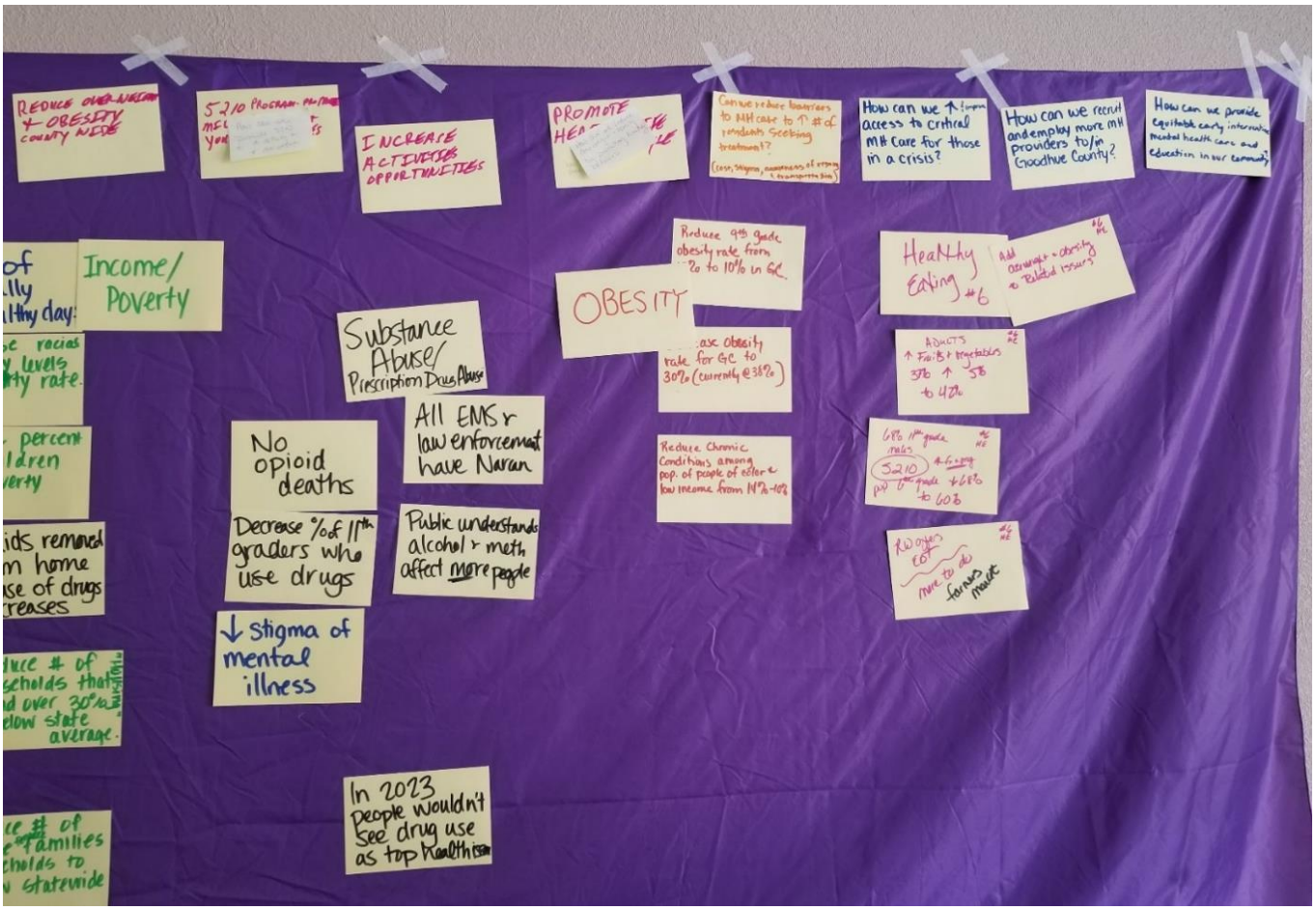
Next, we brainstormed priorities. A priority is different from a top health issue because it affects more than one issue. The more it requires us to change the way we function, has long-term consequences, and creates tensions in our community, the more strategic it is. After the meeting, the Committee selected these priorities in an online survey:

1. What can we do to expand conversations on what's needed to be healthy and increase awareness regarding poverty as a root cause of some substance abuse, obesity, and mental health issues?
2. How can we reduce barriers to mental health care so people in our county do not live with untreated symptoms of mental illness?

3. How can we authentically engage single moms, people of color, and Indigenous people in determining strategies that reduce their barriers to optimal health? (Specific populations were included in this priority because they experience higher rates of poverty than the county average.)[2]

This plan also includes a Legacy priority from the 2014-2018 plan, Family & Parenting.

The Committee can reassess and revise community priorities in the future using new or additional information or data.



BRAINSTORMED INDICATORS AND PRIORITIES AT A COMMUNITY HEALTH ASSESSMENT COMMITTEE MEETING 2018

"IT'S THE COMMUNITY'S PLAN"

The Community Health Improvement Plan is not about the community telling the health department what to do. It's meant to be the community's plan. It describes what the community is doing together with the health department to address the top health issues.

Priorities emerge because organizations agree this is something they are working on or want to work on. We have the perspective, "if no one wants to work on it, maybe we haven't identified the right problem to work on." Many different agencies, programs, and initiatives in Goodhue County contribute to improving the community's health.

The credit for the action plan work goes to the people and organizations who actively participate in meetings about how to improve the community's health and agree to take on responsibilities. These people and groups are listed in the action plans. All are welcome to join our committee and contribute to future revisions of this plan.

[2] These populations have higher rates of poverty than the county average (11%) according to the American Community Survey 2011-2015: female householder, no husband present (38%), Black (72%), Hispanic or Latino (19%), American Indian (44%).

Completing and monitoring the plan, in collaboration with community stakeholders and partners, is a responsibility of Goodhue County Health and Human Services (GCHHS) under Minnesota Statutes §145A and is required by the Public Health Accreditation Board standard 5.2. The county provides leadership and support for the planning process in order to meet these requirements. County staff also participate in implementing strategies related to their roles at GCHHS.

Resources for implementing strategies

The action plans are implemented with existing GCHHS and partner organization staff time and volunteer time. Organizations can seek grants or donations or pool money for joint projects. GCHHS budgets $4,500 a year from the state Local Public Health Act grant for the assessment and planning process and implementation. Community Health Assessment Committee members offering grants and donations include:

- United Way Community Investment Grant funding www.uw-gwp.org
- Live Well Goodhue County mini-grants https://www.co.goodhue.mn.us/1264/Live-Well-Goodhue-County
- Mayo Clinic Health System community benefit dollars https://www.mayo.edu/pmts/mc14300-mc14399/mchs14350.pdf

CALL TO ACTION

How can you help improve community health in Goodhue County?

Throughout the planning process, community members and organizations have been actively involved, and our goal is for that to continue. As you think about what you read here, please think about ways YOU can contribute to building an even healthier Goodhue County.

Community health improvement requires partners in a variety of sectors. Therefore, we are always looking for partners from a variety of sectors interested in helping with our mission, which is to identify health disparities and top health issues for Goodhue County and to implement and evaluate strategies, policies, and programs.

Here are some things you might consider:

Expand the work of the plan by advocating for the plan's priorities

Organizations from all sectors of the community – schools, health care providers, local government, faith organizations, service providers, and others – could potentially use this plan's priorities to inform their own changes.

In our daily lives, we touch other's lives throughout our community. Think about the specific priorities listed in this plan. How could you talk about the impact of poverty on health, or engage priority populations, in the places where you learn, work, and play? How can you personally help advocate change? Advocating for changes like this across all sectors of our community is important if we want to see true change.

Stay involved with groups working to implement the plan

Within the community, there are already groups, advisory committees, coalitions, and other action teams implementing strategies to improve community health related to these priorities. These groups are listed in the action plans.

If you, or your organization, are the missing partner in the Community Health Improvement Plan, please contact us. You can contact anyone listed as the "Lead Person/Organization Responsible" in the action plans in the appendices. Or, you can contact Goodhue County Health and Human Services using the contact information on page 1.

We would be happy to get you more information about how you can help support our efforts to improve community health. We look forward to working with you!

PRIORITIES

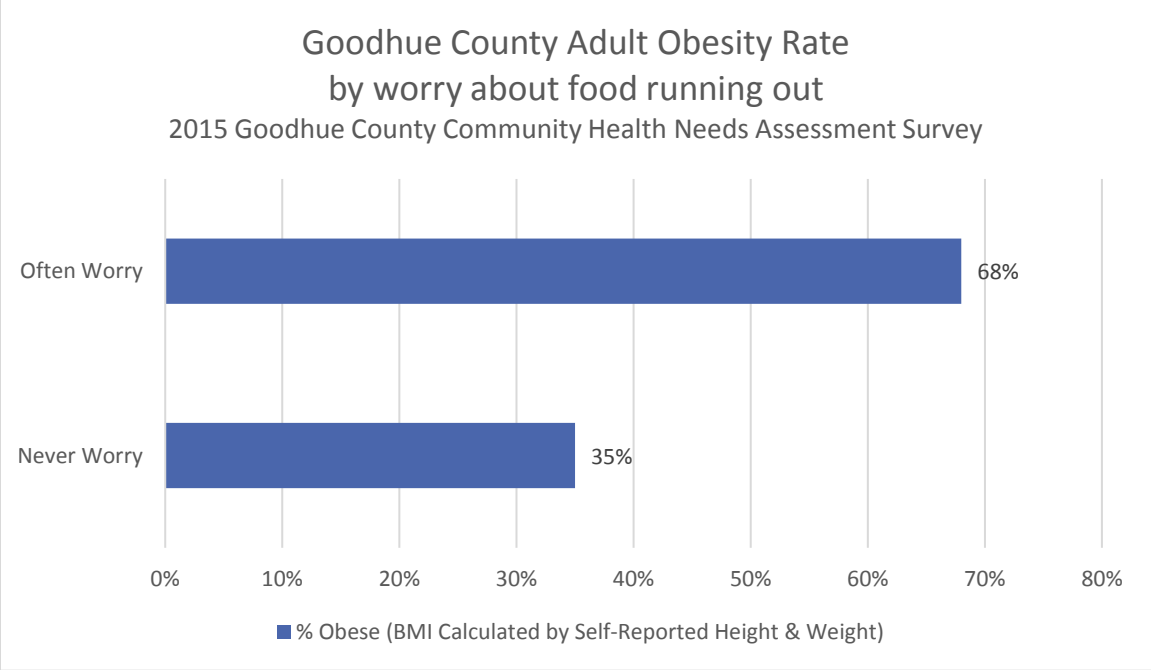
TALK ABOUT THE IMPACT OF POVERTY ON HEALTH

What can we do to expand conversations on what's needed to be healthy and increase awareness regarding poverty as a root cause of some substance abuse, obesity, and mental health issues?

Why talking about the impact of poverty on health is a health priority

Poverty creates barriers to access to health services, healthy food, and other necessities, contributing to poor health. Poverty was the #1 top health issue in 2017. Educating about poverty's relationship to substance abuse, obesity, and mental health relates back to the #2, #3, and #4 top health issues.

As an example of how poverty relates to obesity, nearly twice as many Goodhue County adults who say they "often" worry about running out of food before having money to buy more are obese, as compared to those who "never" worry.



Community engagement

The Community Health Assessment Committee brainstormed existing groups working on poverty issues. Core Group members Pam Horlitz and Laura Prink agreed to co-lead this strategy. They reviewed the list and selected the United Way Poverty Simulations and the Blandin Leaders Partnering to End Poverty (LPEP) to help with this strategy. Blandin staff were consulted in writing the action plan, which includes inviting LPEP participants to revise this strategy in 2019.

Existing community assets and resources

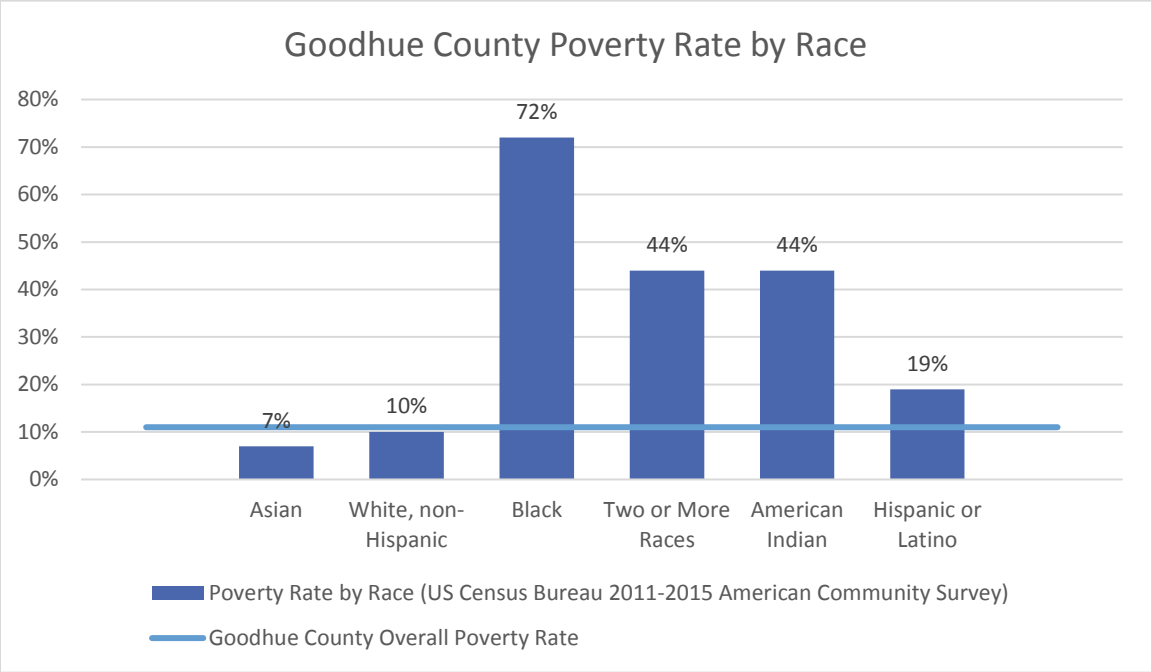
- United Way Poverty Simulations
- Blandin LPEP
- Red Wing Homeless Response Team
- Three Rivers' Goodhue County Homeless Response Team
- Hunger-Free Kids Network
- Red Wing 2040 Economy Team

About Strategy 1-1: Communicate the impact of poverty on health

- This is a **practice-based** strategy. We will use best practices for communication.
- This strategy involves **organizational-level** change.

See Appendix 1 for the Priority 1 action plan.

Note that Goodhue County residents who are Black, two or more races, American Indian, or Hispanic or Latino experience higher rates of poverty.



REDUCE BARRIERS TO MENTAL HEALTH CARE

How can we reduce barriers to mental health care so people in our county do not live with untreated symptoms of mental illness?

Why reducing barriers to mental health care is a health priority

Mental illness is related to higher rates of chronic disease and risk behaviors including inactivity, smoking, and drinking. Barriers to accessing mental health services lead to unmet health needs, delayed care, and preventable hospitalizations. Treatable conditions like depression and other mental illnesses often contribute to suicidal behavior.

Stigma and discrimination can be a barrier to seeking mental health care. People with a history of mental illness were less likely (56%) than those with no history of mental illness (67%) to agree that people are kind to people with mental illness (Goodhue County Community Health Needs Assessment Survey, 2015). As an agricultural county, we are in a position to raise awareness about the stress farmers can face (Minnesota Department of Agriculture, 2018).

A lack of providers and gaps in the service array are also barriers. According to the 2018 County Health Rankings, there is 1 mental health provider for every 1,080 residents in Goodhue County, as compared to 1 mental health provider for every 470 residents in the state of Minnesota. A focus group conducted for the Community Health Assessment identified lack of psychiatrists for medication management as a gap. At the Mental Health Coalition meeting, children's outpatient and adolescent chemical dependency were also listed as gaps.

Community engagement

Our 2014-2018 plan included the Make it OK anti-stigma campaign, which came out of an earlier Greater Red Wing Area Mental Health Initiative. Goodhue County Make it OK has many partners at the table from all sectors: businesses, faith communities, schools, nonprofit organizations and more. The advisory committee helped write the action plan.

In June 2018, the Community Health Assessment Committee brainstormed who should be invited to a "larger meeting" about mental health. Our 2017 assessment, the hospital's assessment, and the city of Red Wing 2040 assessment had all identified mental health was still an issue. Representatives from these three assessments, plus from Family Services Collaborative, Fernbrook Family Center, Make it OK, and a volunteer (the "mental health conveners") planned a

November 2018 Mental Health Coalition Meeting attended by 62 people who provided input and wrote action plans around three themes (or "buckets") from the assessments: service array, improve wellness, and resource directory.

THE "EDUCATE ABOUT MENTAL HEALTH AND IMPROVE MENTAL WELLNESS" GROUP AT THE NOVEMBER 2018 MENTAL HEALTH COALITION MEETING.

Existing community assets and resources

- Family Services Collaborative—ACES/ Trauma Training
- SCHA Healthy Pathways Program
- Crisis hotlines
- SE MN Crisis Response
- MDA Coping with Farm and Rural Stress website
- New regional mental health crisis centers
- Emergency Departments
- Make it OK
- School-linked mental health services
- Youth Mental Health First Aid
- United Way 211
- People's Pamphlet

About Strategy 2-1: Expand Make it OK Anti-Stigma Campaign

- This is an **evidence-based** strategy.
- This strategy involves **community-level change**.

About Strategy 2-2: Form a Mental Health Coalition to create a unified framework for improved mental health

- "Mobilize community partnerships to identify and solve health problems" is an **essential public health service.**
- Measureable objectives have not yet been identified but may involve community- or policy-level change

See Appendix 2 for the Priority 2 action plan.

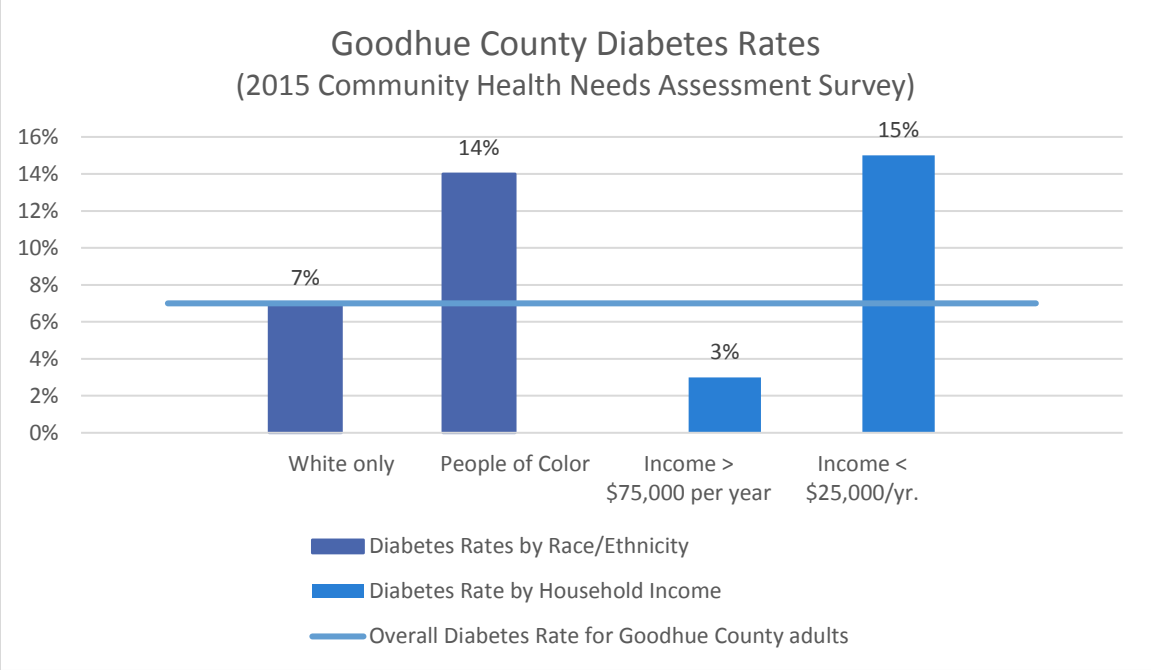
ENGAGE PRIORITY POPULATIONS

How can we authentically engage single moms, people of color, and Indigenous people in determining strategies that reduce their barriers to optimal health? (Specific populations were included in this priority because they experience higher rates of poverty than the county average.)[3]

Why engaging with low-income audiences and populations with higher rates of poverty is a health priority

Advancing health equity requires including and engaging with those in poverty and others experiencing health disparities. Efforts will be more successful if they are designed with—not for—community members. True partnerships are not about confirming or advancing a pre-existing idea or agenda, but listening and allowing the community to lead the work (Minnesota Department of Health, 2018).

People of color and people with low incomes both have higher rates of diabetes than the general adult population of Goodhue County.



Community engagement

The Community Health Assessment Committee recommended that the Live Well Goodhue County Community Leadership Team lead this priority due to their existing work. In 2016, Live Well Goodhue County completed a Health Equity Data Analysis (HEDA) about the health disparity of higher diabetes rates in low income populations in our county. In 2017, Goodhue County Health and Human Services received a Health Equity Learning Community grant from the Minnesota Department of Health that led to staff carrying groceries for food shelf clients and organizing Meet and Eats. With Red Wing Area Food Shelf and University of Minnesota Extension, Live Well Goodhue County planned two Meet and Eats in 2018 for food shelf clients and volunteers to work together to brainstorm and prioritize a strategy to increase access to healthy, nutritious foods. This work will continue. The action plan also includes new engagement strategies for I CAN Prevent Diabetes.

[3] These populations have higher rates of poverty than the county average (11%) according to the American Community Survey 2011-2015: female householder, no husband present (38%), Black (72%), Hispanic or Latino (19%), American Indian (44%).

Existing community assets and resources

- Live Well Goodhue County
- school teachers and social workers
- ECFE programs
- Food shelves
- All Seasons Community Services in Kenyon
- Baby Café in Cannon Falls
- Hispanic Outreach
- MOPS members
- Prairie Island Indian Community
- WIC
- people in poverty
- Brown Girls club of young women of color at RW high school
- county HHS clients

About Strategy 3-1: Authentically engage low-income audiences in selecting, planning, and implementing Live Well Goodhue County strategies

- This is a **practice-based** and **science-based** strategy.
- This is a **system-level change** in how strategies are planned and may lead to other policy and system level changes.

See Appendix 3 for the Priority 3 action plan.

LIVE WELL GOODHUE COUNTY COORDINATOR TALKS WITH A RED WING AREA FOOD SHELF CLIENT ABOUT THE MEET AND EAT IN 2018.

FAMILY AND PARENTING

Why family and parenting is a health priority

The early years are arguably the most crucial for a child's development, influencing a child's long-term health. A baby's brain begins to develop before birth, and babies, toddlers, and preschoolers spend the years before Kindergarten building the skills necessary to learn and enjoy school. The link between education and health is significant. Better-

educated individuals are less likely to report anxiety or depression and are at lower risk of heart disease and diabetes. They are less likely to smoke, to binge drink, to be overweight or obese, or to use illegal drugs (Cutler, 2006).

The link between child abuse and health is also well established. Childhood abuse has been associated with depression, anxiety, eating disorders, PTSD, and risky health behaviors including smoking and alcohol and drug use (Springer, Sheridan, Kuo, & Carnes, 2003).

Parenting choices like smoking during pregnancy also affect children's health. Smoking can increase a woman's risk of having a low birthweight baby. Teen pregnancy also raises the risk of pregnancy complications and low birthweight. Low birthweight babies face an increased risk of serious health problems during the newborn period and chronic lifelong disabilities.

Community engagement

Family and Parenting was the #1 Priority in the 2014-2018 Community Health Improvement Plan. The selected strategy was home visiting, and agencies with home visiting programs met annually to review the action plan. Changes since 2014 included the expansion of Parent Support Outreach Program with a full-time, permanent position at GCHHS and two new evidence-based home visiting programs in Goodhue County: Early Head Start and Healthy Families of America. With so many recent changes, the agencies wanted to continue to meet annually, so Family and Parenting was included as a Legacy Priority in this plan. The agencies met in November 2018 to write the action plan for 2018-2023.

Existing community assets and resources

- Schools
- Child Care Providers
- Preschools
- Clinics & Hospitals
- Home Visiting Personnel
- Help Me Grow Minnesota
- Minnesota Coalition for Targeted Home Visiting
- Region 10 Interagency Early Intervention Committee
- Every Hand Joined Early Childhood Network

About Strategy L-1: Home Visiting

- This is an **evidence-based** strategy.
- This is organizational-level change with some system-level change (for example, changes to referral processes).

See Appendix 4 for the Legacy Priority action plan.

Link to Appendices (Action Plans)

The appendices can be accessed online at https://www.co.goodhue.mn.us/982/Community-Health-Improvement-Plan.

Appendix 1: Action Plan 1: Talk about the Impact of Poverty on Health

Appendix 2: Action Plan 2: Reduce Barriers to Mental Health Care

Appendix 3: Action Plan 3: Engage Priority Populations

Appendix 4: Legacy Action Plan: Family & Parenting

The CHA-CHIP visual on the final page of this plan shows our process from identifying 10 top health issues to 3 health priorities that address underlying challenges we must work on to achieve our vision for a healthy Goodhue County.

CHA-CHIP VISUAL

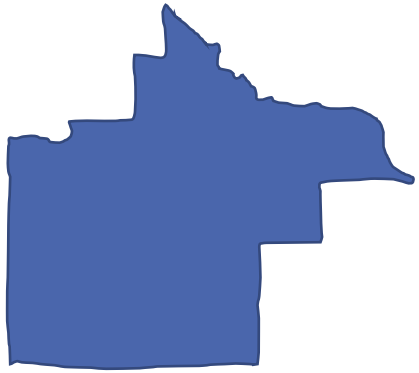
2017 10 Top Health Issues

2018 3 Health Priorities

2023 Vision

Equitable **opportunity for all Goodhue County residents to experience optimal health** across the dimensions of wellbeing (physical, social, mental, spiritual, economic, environmental, occupational, intellectual)

- Diverse residents valued for their strengths
- Access to quality healthcare
- Access to healthy foods and places to be active
- Opportunity for academic success
- Strong local economies
- Collaboration to address local needs



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PRIORITY 1: TALK ABOUT THE IMPACT OF POVERTY ON HEALTH

Goal Expand conversations on what's needed to be healthy and increase awareness regarding poverty as a root cause of some substance abuse, obesity, and mental health issues.

Community Health Objectives with Poverty-Related Disparities
Substance Abuse
• *Goodhue County 11th graders who faced severe economic hardship[1] were less likely to have no alcohol or marijuana or other drug use in the past year (37%) compared with Goodhue County 11th graders who did not face severe economic hardship (57%).* Source: Minnesota Student Survey, 2016
• *Goodhue County Health and Human Services customers surveyed[2] were much more likely to be a current cigarette smoker (45%) compared with the general adult population of Goodhue County (8%).* Source: Goodhue County Community Health Needs Assessment Survey, 2015
Obesity
• *Goodhue County 9th graders who received free or reduced price lunch were more likely to be overweight or obese (43%) compared with Goodhue County 9th graders who do not get free or reduced price lunch (23%).* Source: Minnesota Student Survey, 2016
• *Goodhue County adults who often worried about food running out before having money to buy more were more likely to be obese (68%) than adults who never worried about food running out (35%).* Source: Goodhue County Community Health Needs Assessment Survey, 2015
Mental Health
• *Goodhue County 11th graders who faced severe economic hardship[1] were more likely to have any long-term mental health, behavioral, or emotional problems that have lasted six months or more (50%) compared with Goodhue County 11th graders who did not face severe economic hardship (15%).* Source: Minnesota Student Survey, 2016
• *Goodhue County adults with household incomes less than $25,000 were more likely to have a history of anxiety, depression, or other mental illness (39%) than the general adult population of Goodhue County (27%).* Source: Goodhue County Community Health Needs Assessment Survey, 2015

Action Plan Objectives	**Baseline**
1-1a. By December 31, 2023, 50% of Goodhue County CHA Committee members will have participated in activities to communicate about what creates health or about poverty-related health disparities.	TBD
1-1b. By December 31, 2019, forge relationships and provide technical assistance to Blandin Leaders Partnering to End Poverty (LPEP) participants as they organize a community effort to impact poverty.	N/A

Alignment with State/National Priorities

Healthy Minnesota 2022

- Strategic Activity: Expand conversations about what creates health and well-being

National Prevention Strategy

- Elimination of Health Disparities Recommendation 3. Increase the capacity of the prevention workforce to identify and address disparities.

[1] Severe economic hardship is defined as either skipping meals in past 30 days or being homeless at times in past 12 months.

[2] These customers were much more likely to have household income less than $35,000 (90%) compared with the general adult population of Goodhue County (19%). A convenience sample of 50 GCHHS customers filled out the survey.

Priority 1 Action Plan

Strategy 1-1 Communicate the impact of poverty on health

The Minnesota Department of Health's guide to Health Equity Data Analysis contains a section on **best practices** for communication such as understanding your audience, matching message with messenger, crafting messages, using numbers, and selecting language (Minnesota Department of Health, 2018). According to the HEDA Guide, communication can educate potential partners, serve as a call to action, and ultimately advance health equity. The focus of this strategy in Goodhue County is twofold: first, expanding the understanding that health is not determined by individual behaviors and genetics alone, and, second, communicating differences in health outcomes or health behaviors experienced by populations living in poverty.

Action Plan Objectives	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
1-1a. By December 31, 2023, 50% of Goodhue County Community Health Assessment Committee members will have participated in activities to communicate about what creates health or about poverty-related health disparities.	Create PowerPoint slide/talking points.	2/28/2019	Healthy Communities Supervisor, GCHHS	Community Engagement Specialist, Mayo Clinic Health System	
	Create Facebook posts with sound bites, stories, and/or visuals	12/31/2023	Community Health Assessment Committee	Community Engagement Specialist, Mayo Clinic Health System	
	Create and maintain a blog	12/31/2023	Community Health Assessment Committee	Community Engagement Specialist, Mayo Clinic Health System	
	Host a Poverty Simulation with a health-focused debriefing and/or integrate the relationship between poverty and health throughout.	12/31/2023	Community Health Assessment Committee	Community Impact Manager, United Way of Goodhue, Wabasha, and Pierce Counties	
1-1b. By December 31, 2019, forge relationships and provide technical assistance to Blandin Leaders Partnering to End Poverty (LPEP) participants as they organize a community effort to impact poverty.	Provide a summary of what creates health with examples of poverty-related health disparities from the Community Health Assessment.	2/28/2019	Blandin LPEP Trainers, LPEP participants who are CHA Committee members	Healthy Communities Supervisor, GCHHS	
	Provide a summary of the Community Health Improvement Plan, especially activities related to poverty, with information about how to get involved if interested.	2/28/2019	Blandin LPEP Trainers, LPEP participants who are CHA Committee members	Healthy Communities Supervisor, GCHHS	

Action Plan Objectives	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
	Provide PowerPoint slide/talking points from objective 1-1a.	12/31/2019	Blandin LPEP Trainers, LPEP participants who are CHA Committee members	Community Engagement Specialist, Mayo Clinic Health System	
	Invite Blandin LPEP participants to select liaisons to attend 2019 quarterly CHA Committee meetings.	12/31/2019	Blandin LPEP Trainers, Blandin LPEP participants	Healthy Communities Supervisor, GCHHS	
	Review/revise this objective.	12/31/2019	Blandin LPEP participants	Healthy Communities Supervisor, GCHHS	

Plans for Sustaining Action & Monitoring Implementation	Progress Notes
Resources for Implementation • Mayo Clinic Health System, United Way of Goodhue, Wabasha, and Pierce Counties, and Goodhue County Health and Human Services will provide staff and resources. • United Way of Goodhue, Wabasha, and Pierce Counties applied to and was accepted to bring the Blandin Foundation's LPEP training to Red Wing. • Goodhue County Health and Human Services will contribute up to $500 in 2019 to support implementation. This funding comes from Minnesota's Local Public Health Act.	
Participation of Stakeholders & Partners in Monitoring Implementation • The Community Health Assessment core group will monitor the action plan quarterly. • The Community Health Assessment committee will receive an update at least annually.	
Process for Revising the Action Plan • The Healthy Communities Supervisor will contact partners as needed for progress notes. • CHA Core group will discuss the progress notes and make revisions to objective 1-1a. • The Blandin LPEP participants will decide whether any of their community efforts will be related to the impact of poverty on health and determine the future of objective 1-1b.	

PRIORITY 2: REDUCE BARRIERS TO MENTAL HEALTH CARE

Goal Reduce barriers to mental health care so people in our county do not live with untreated symptoms of mental illness.

Community Health Objectives	Baseline
By December 31, 2023, decrease the average number of mentally unhealthy days in the past 30 days. Source: Goodhue County Community Health Needs Assessment Survey	2.5 2015
By 2022, decrease the percent of Goodhue County 11th grade males who attempted suicide in the last year. Source: MN Student Survey	5% 2016
By 2022, decrease the percent of Goodhue County 11th grade females who attempted suicide in the last year. Source: MN Student Survey	6% 2016
By December 31, 2023, decrease the annual number of suicides in Goodhue County. Source: Minnesota Department of Health Center for Health Statistics	6 2016
By December 31, 2023, decrease the ratio of population to mental health providers in Goodhue County. Source: County Health Rankings	1,040:1 2017
By December 31, 2023, increase the percent of Goodhue County adults with a history of mental illness who agree people are generally caring and sympathetic to people with mental illness (56%, 2015). Source: Goodhue County Community Health Needs Assessment Survey	56% 2015
By December 31, 2023, decrease the percent of Goodhue County adults who delayed seeking mental health care in the past 12 months. Source: Goodhue County Community Health Needs Assessment Survey	7% 2015

Action Plan Objectives	Baseline
2-1a. Between January 1, 2019, and December 31, 2023, give presentations to 3,000 people.	TBD
2-1b. By December 31, 2023, participate in 5 community events per year.	5, 2018
2-1c. By December 31, 2023, maintain active advisory committee and recruit 10-15 new ambassadors.	12, 2018

Vision for future Strategy 2-2 Action Plan Objectives
2-2a. Survey, analyze and improve the array of services available to residents.
2-2b. Educate the community about mental health and on ways to improve mental wellness for all of us
2-2c. Create a comprehensive Resource Directory (or enhance current ones) for services
2-2d. Develop leadership skills and capacity in the Mental Health Coalition

Alignment with State/National Priorities

Healthy Minnesota 2022

- Priority 1: The opportunity to be healthy is available everywhere and for everyone.

Governor's Task Force on Mental Health (2016)

- Recommendation #1: Create a Comprehensive Continuum of Care

Healthy People 2020

- MHMD-1 Reduce the suicide rate.
- MDMD-2 Reduce suicide attempts by adolescents
- MHMD-6 Increase the % of children with mental health problems who receive treatment
- MHMD-9 Increase the proportion of adults with mental health disorders who receive treatment

Alignment with State/National Priorities

National Prevention Strategy

- Mental and Emotional Well-being Recommendation 3. Provide individuals and families with the support necessary to maintain positive mental well-being.
- Mental and Emotional Well-being Recommendation 4. Promote early identification of mental health needs and access to quality services.

Priority 2 Action Plan

Strategy 2-1 Expand Make it OK Anti-Stigma Campaign

Make it OK is a mental illness anti stigma campaign to stop stigma and start talking about mental illnesses. Contact-based education programs and media campaigns (both part of Make it OK) are **evidence-based interventions** that research shows are effective for changing attitudes and reducing social distance (National Academies of Sciences, Engineering, and Medicine, 2016). Make it OK is both a statewide and local campaign that spreads our message through outreach and promotion. Make it OK was first established in Red Wing in 2013. In 2015, Make it OK's efforts were expanded from Red Wing to the rest of Goodhue County. With Red Wing being the largest community in the county, much of the work started in Red Wing. Our action plan now is to maintain current relationships and to be strategic to expand into our other communities in Goodhue County.

Action Plan Objectives	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
2-1a. Between January 1, 2019, and December 31, 2023, give presentations to 3,000 people.	Presentations within the schools for both staff and students.	12/31/2023	Make it OK Ambassadors	Make it Ok Volunteer Coordinator, GCHHS	
	Presentations within worksites.	12/31/2023	Make it OK Ambassadors	Make it Ok Volunteer Coordinator, GCHHS	
	Presentations to boards and community groups.	12/31/2023	Make it OK Ambassadors	Make it Ok Volunteer Coordinator, GCHHS	
	Presentations to marginalized populations.	12/31/2023	Make it OK Ambassadors	Make it Ok Volunteer Coordinator, GCHHS	
2-1b. By December 31, 2023, participate in 5 community events per year.	Participate in 5 community events per year throughout the county such as Goodhue County Fairs, Prairie Island Health Fair, Rose Fest, Dennison Days. At least 2-3 a year need to be outside of Red Wing	12/31/2023	Make it OK Ambassadors, Make it OK Volunteer Coordinator	Community Health Specialist, GCHHS	
	Participate in statewide events such as NAMI WALK, state Make it OK volunteer recognition events, etc.	12/31/2023	Make it OK Ambassadors, MIO Volunteer Coordinator	Community Health Specialist, GCHHS	

Action Plan Objectives	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
	Annual October and May Media Campaigns including media such as newspaper ads, television, etc.	12/31/2023	Make it OK Ambassadors, Make it OK Advisory Committee	Community Health Specialist, GCHHS	
	Public screenings of mental health related shows/movies/documentaries throughout the county.	12/31/2023	Partner Locations	Community Health Specialist, GCHHS	
	Host community conversations with meal, speaker, panel discussion, and table exhibitors throughout the county	12/31/2023	Speaker, Panelists, Table Exhibitors, Make it OK Ambassadors, Make it OK Volunteer Coordinator	Community Health Specialist, GCHHS	
	Maintain current relationships with faith communities.	12/31/2023	Make it OK Ambassadors	Community Health Specialist and Make it Ok Volunteer Coordinator, GCHHS	
	Build relationships with faith communities outside of Red Wing. (Movie screenings, Make it Ok Sundays, presentations.)	12/31/2023	Make it OK Ambassadors	Community Health Specialist and Make it Ok Volunteer Coordinator, GCHHS	
	Support/promote a new or existing NAMI support group in Goodhue County	12/31/2023	NAMI Minnesota	Community Health Specialist, GCHHS	
2-1c. By December 31, 2023, maintain active advisory committee and recruit 10-15 new ambassadors.	Trainings for new MIO Ambassadors will be held annually.	12/31/2023	New Make it OK Ambassadors	Make it OK Volunteer Coordinator, GCHHS	
	Engage 30% of ambassadors annually	12/31/2023	Make it OK Ambassadors	Make it OK Volunteer Coordinator	
	Monthly Make it OK Newsletter	12/31/2023		GCHHS Community Health Specialist and Make it OK Volunteer Coordinator	
	Ask Advisory Committee, and past/newly trained ambassadors to complete annual Commitment Cards	12/31/2023	Make it OK Advisory Committee, Make it OK Ambassadors	Make it Ok Volunteer Coordinator	

Action Plan Objectives	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
	Maintain Make it OK Materials Database	12/31/2023		Make it Ok Volunteer Coordinator, GCHHS	
	Hold 6-12 advisory meetings each year	12/31/2023	Make it OK Advisory Committee	Community Health Specialist, GCHHS	
	Hold 6-12 Make it OK ambassador volunteer meetings each year	12/31/2023	Make it OK Ambassadors	Make it Ok Volunteer Coordinator, GCHHS	
	Advisory Committee meetings will have a standing agenda item where members can mention work that they have done in the community around Make it OK. (i.e. putting Make it OK articles/information in their organizations newsletters/website, worksite activities, organizations sponsoring)	12/31/2023	Make it OK Advisory Committee	Community Health Specialist, GCHHS	

Strategy 2-2 Form a Mental Health Coalition to create a unified framework for improved mental health.

"Mobilize community partnerships to identify and solve health problems" is **essential public health service** #4. The mental health conveners—a group of individuals working on mental health or assessments—came together in 2018 and organized what they had heard from the community into a practical vision with three buckets: 1. Survey/Analyze and Improve Service Array, 2. Educate and Improve Mental Wellness, and 3. Create/Enhance Resource Directory. The conveners combined their email lists from various initiatives and committees and invited a larger group to dialogue about these mental health needs in our county. At this first mental health coalition meeting in November, 62 people discussed what is already happening, the vision, and next steps. Currently, the coalition is informal, and at this stage in the planning process, there are no measureable objectives for each vision area.

Action Plan Vision	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
2-2a. Survey, analyze and improve the array of services available to residents.	Put together a linear map that groups types of services already available in order to identify gaps	1/22/2019	Service Array Group	Alyssa Meyer, MPH Capstone Student, Des Moines University	
	Identify potential strategies to increase services based on gaps	4/4/2019	Service Array Group	Administrative Director, Fernbrook Family Services	
	Identify measurable group objective(s) to work towards	4/26/2019	Service Array Group	Service Array Group	

Action Plan Vision	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
	ensuring that all services will be in Goodhue County				
2-2b. Educate the community about mental health and ways to improve mental wellness for all of us	Look into the use of Social Emotional Curriculum in all areas of the schools consistently	4/4/2019	Red Wing HRA	Burnside Social Worker, Red Wing Public Schools	
	Look into the use of the Duluth Civility Project model to spread a message of civility throughout the community – prenatal to seniors	4/4/2019	United Way of GWP	Community Engagement Specialist, Mayo Clinic Health System	
	Identify measurable group objective(s) to develop civility in our community and establish the social norms and support	4/26/2019	Improve Wellness Group	Improve Wellness Group	
2-2c. Create a comprehensive Resource Directory (or enhance current ones) for services	The group will continue the discussion via email to gather a list of information they'd like to know if 2-1-1 can incorporate into their system	12/31/2018	Resource Directory Group	Community Health Specialist, Goodhue County Health and Human Services	
	Take the list of requests to Greater Twin Cities United Way, which manages the regional 2-1-1 call center.	1/31/2019	Resource Directory Group	Community Impact Manager, United Way of Goodhue, Wabasha, and Pierce Counties	
	Confirm that 2-1-1 includes resources for coping with farm & rural stress, or find out process to add.	1/31/2019	Minnesota Department of Agriculture website, www.minnesotafarmstress.com.	Community Impact Manager, United Way of Goodhue, Wabasha, and Pierce Counties	
	Identify measurable objective(s) for expanding 2-1-1 or replicating other models (what other communities are doing)	4/26/2019	Resource Directory Group	Resource Directory Group	

Action Plan Vision	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
2-2d. Develop leadership skills and capacity in the Mental Health Coalition	Have discussion of future of current convener's group	1/31/2019	Mental Health Conveners	Community Engagement Specialist, Mayo Clinic Health System	
	Possibly schedule conveners follow up meetings	4/26/2109	Mental Health Conveners	Mental Health Conveners	

Plans for Sustaining Action & Monitoring Implementation	Progress Notes
Resources for Implementation • Goodhue County Health and Human Services provides staff leadership for Make it OK Advisory Committee and Make it OK Ambassadors (Volunteers), as well as staff participation in the Mental Health Coalition and Mental Health Conveners. • In 2019, Goodhue County Health and Human Services will contribute up to $2000 for implementation of Strategy 2-1, and up to $500 for implementation of Strategy 2-2. This funding comes from Minnesota's Local Public Health Act. • Mayo Clinic Health System has contributed staff time and resources for the work of the mental health coalition and the conveners, and will contribute $6,000 in 2019. • Live Healthy Red Wing contributed staff time and funding for the mental health coalition and the conveners in 2018 as part of the Red Wing 2040 Comprehensive Plan process. • The Make it OK Advisory Committee and Make it OK Ambassadors contribute staff time and volunteer time (see lists of names on the next page), as well as donations.	
Participation of Stakeholders & Partners in Monitoring Implementation • The Make it OK Advisory Committee will discuss the action plan at a meeting annually. • The mental health coalition will review progress at an April 2019 meeting. • The Community Health Assessment committee will receive updates at least annually.	
Process for Revising the Action Plan • GCHHS staff drafted the Strategy 2-1 Make it OK action plan, and the Make it OK Advisory Committee reviewed. They will record revisions in minutes annually. • The Strategy 2-2 Mental Health Coalition Action Plan was written at the November 2018 meeting. The Mental Health Conveners and the Mental Health Coalition groups (Service Array, Improve Wellness, and Resource Directory) will continue planning in 2019. • Make it OK advisory committee members and ambassadors can send pictures to the Community Health Specialist and Make it OK Volunteer Coordinator. The GCHHS Healthy Communities Supervisor will contact partners for Mental Health Coalition progress notes and pictures.	

Goodhue County Make It OK Advisory Committee Facilitator: Jessica Seide, Community Health Specialist (GCHHS)

Current Members	Organizational Affiliation
Mandy Arden	Red Wing Youth Outreach Program
Julie Birk-Betcher	Red Wing Shoe Company
Beth Breeden	Community Member, Red Wing
Father Tristan English	Christ Episcopal Church
Ruth Greenslade	Goodhue County Health & Human Services
Carrie Heimer	Red Wing Shoe Company
Pam Horlitz	Mayo Clinic Health System Red Wing
Phillip Martin	Goodhue County Health & Human Services
Mike Melstad	Red Wing Family YMCA
Maureen Nelson	United Way of Goodhue, Wabasha & Pierce Counties
Anita Otterness	NAMI Southeast Minnesota
Laura Smith	Goodhue County Health & Human Services
Dawn Wettern	Red Wing Community Education and Recreation
Chelsey Will	Red Wing Youth Outreach Program

Make it OK Ambassadors (Volunteers) Make it OK Volunteer Coordinator: Laura Smith, GCHHS

Current Ambassadors
Nancy Pettman
Dave Hill
Bobbi Sinn
Jessica Jacobson
Tim Dehmer
Emma Jean Anderson
Amber Gabrielson
Kristina Streich
Sonja Munson
Maggie Block
Lisa Hanson
Yanelis Jinete

Mental Health Conveners (Planning Team for Nov. 2018 Mental Health Coalition Meeting)

Mental Health Conveners	Group Represented
Chelsey Frawley	Fernbrook Family Services
Ruth Greenslade	Goodhue County Community Health Assessment Committee
Dave Hill	Community Member, Red Wing
Pam Horlitz	Mayo Clinic Health System in Cannon Falls, Lake City, and Red Wing
Kris Johnson	Goodhue County Family Services Collaborative
Elaine O'Keefe	Live Healthy Red Wing/Red Wing 2040 Comprehensive Plan
Jessica Seide	Goodhue County Make it OK

PRIORITY 3: ENGAGE PRIORITY POPULATIONS

Goal Authentically engage single moms, people of color, and Indigenous people in determining strategies that reduce their barriers to optimal health. (Specific populations were included in this goal because they experience higher rates of poverty than the county average.) [1]

Community Health Objectives	Baseline
By December 31, 2023, increase the percentage of Goodhue County adults who ate 5 or more servings of fruits and vegetables a day. Source: Goodhue Community Health Needs Assessment Survey	37% 2015
By 2022, decrease the percentage of Goodhue County 5th grade males who did NOT eat any green salad, potatoes, carrots, or other vegetables in the last week. Source: MN Student Survey	17% 2016
By 2022, decrease the percentage of Goodhue County 5th grade females who did NOT eat any green salad, potatoes, carrots, or other vegetables in the last week. Source: MN Student Survey	13% 2016
By 2022, decrease the proportion of Goodhue County 9th graders on free or reduced price lunch who are overweight or obese. (For 9th graders not on free or reduced, the percentage was 23% in 2016.)	43% 2016
By December 31, 2023, decrease the diabetes rate for Goodhue County adults with annual household incomes less than $25,000. Source: Goodhue County Community Health Needs Assessment Survey	14% 2015
By December 31, 2023, decrease the diabetes rate for Goodhue County adults who are people of color. (The overall diabetes rate for Goodhue County adults in 2015 was 7%.)	14% 2015

Action Plan Objectives	Baseline
3-1a. In 2019, spend $1,000 on supporting participation of low-income community members (e.g., childcare, transportation, meals, payment for time) in developing/revising CHIP strategies.	TBD
3-1b. In 2019, hold 3 meetings to engage food shelf clients in prioritizing, planning and piloting ways of increasing healthy, nutritious food at the Red Wing Area Food Shelf.	2 meetings 2018
3-1c. In 2019, engage Zumbrota area residents in planning and promoting I CAN Prevent Diabetes classes, and track number of changes in program planning (e.g. day, time, and location of class, identifying and addressing barriers to participation) influenced by community members.	TBD

Alignment with State/National Priorities

Healthy Minnesota 2022

- Priority 3: All can participate in decisions that shape health and well-being

Healthy People 2020

- D-16 Increase prevention behaviors in persons at high risk for diabetes with prediabetes
- NWS-10.3 Reduce the proportion of adolescents aged 12 to 19 years who are considered obese
- NWS-15 Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older

National Prevention Strategy

- Healthy Eating Recommendation 1. Increase access to healthy and affordable foods
- Healthy Eating Recommendation 4. Help people recognize and make healthy food and beverage choices

[P]Populations with higher rates of poverty than the county average (11%) according to the American Community Survey 2011-2015: female householder, no husband present (38%), Black (72%), Hispanic or Latino (19%), American Indian (44%).

Priority 3 Action Plan

Strategy 3-1 Authentically engage low-income audiences in selecting, planning, and implementing Live Well Goodhue County strategies

Engaging communities affected by health issues is a **practice-based and science-based** strategy (CDC, 2011). Authentically engaging with the community is included as one of six practices in the Minnesota Department of Health online Resource Library for Advancing Health Equity (Minnesota Department of Health, 2018). The Resource Library states, "Community history, wisdom, and knowledge is a critical source of information and experience that should be considered together with public health practice and evidence." The Resource Library also refers to national public health standards 1.1, 1.2, 3.1, 4.1, 4.2, 5.1, 5.2, 6.1, and 7.1 (Public Health Accreditation Board, 2016).

Live Well Goodhue County's mission is to improve the health of our residents by making it easier to be active, eat nutritious foods and live tobacco-free, so engagement will focus on strategies related to that mission:

- Red Wing Area Food Shelf clients and volunteers will select and pilot a strategy to increase access to healthy, nutritious foods based on ideas from two "Meet and Eats" organized by Live Well Goodhue County in 2018. The U.S. Dietary Guidelines provides an evidence-based approach to chronic disease prevention and recommend increasing access to fruits and vegetables and reducing access to sodium, added sugar, and saturated fat, while offering culturally desirable foods. (U.S. Department of Health and Human Services and U.S. Department of Agriculture, 2015).
- Zumbrota area seniors and food shelf participants will be invited to help with planning and participant recruitment for I CAN Prevent Diabetes (also known as National Diabetes Prevention Program). I CAN Prevent Diabetes is based on a randomized-control trial showing that changes in lifestyle such as losing 7% of bodyweight (about 15 lbs. if you weigh 200 lbs.) and exercising at least 150 minutes a week reduced type 2 diabetes risk among people at high risk (Knowler, et al., 2002). Many other studies have found the group program helped participants achieve desired lifestyle changes.

Action Plan Objectives	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
3-1a. In 2019, spend $1,000 on supporting participation of low-income community members (e.g., childcare, transportation, meals, payment for time) in developing/revising CHIP strategies.	Offer childcare, meals, and gift card incentives for attendance at Red Wing Area Food Shelf Increasing Healthy, Nutritious Food Meetings	January, March, and June 2019	Red Wing Food Shelf, First United Methodist Church	Live Well Goodhue County Coordinator, GCHHS	
	Provide healthy food and beverages to encourage attendance at "Stop Diabetes" Informational Meetings and "Are YOU at Risk" Screenings. Hold meetings and screenings where clients are and when they are there.	February & March, 2019	University of Minnesota Extension, Mayo Clinic Health System, Zumbrota Towers, Zumbrota Food Shelf, Pine Island Home Services/Senior Center, Pine Island Sharing Shelves, All Seasons Community Services	Live Well Goodhue County Coordinator, GCHHS	

Action Plan Objectives	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
	Offer childcare, healthy food and beverages and gift cards to encourage attendance at Healthy Community Forums in each of our communities. The forums will include engaging residents about future strategies that fit their town.	October, 2019	Cities of Cannon Falls, Goodhue, Kenyon, Pine Island, Red Wing, Wanamingo, Zumbrota; Cannon Falls, Goodhue, Pine Island, Kenyon-Wanamingo, Zumbrota-Mazeppa School Districts; Mayo Clinic Health System; All Seasons Community Services, Cannon Falls Food Shelf, Pine Island Sharing Shelves, Red Wing Food Shelf, and Zumbrota Food Shelf	Live Well Goodhue County Coordinator, GCHHS	
3-1b. In 2019, hold 3 meetings to engage food shelf clients in prioritizing, planning and piloting ways of increasing healthy, nutritious food at the Red Wing Area Food Shelf.	Increasing healthy, nutritious food pilot meeting – Selection of pilot strategy to implement	January, 2019	Red Wing Area Food Shelf clients, board, and volunteers, First UMC, U of M Extension	Live Well Goodhue County Coordinator, GCHHS	
	Increasing healthy, nutritious food pilot meeting with Food Shelf Board – Approval of select pilot strategy	February, 2019	Red Wing Area Food Shelf Board	Live Well Goodhue County Coordinator, GCHHS	
	Increasing healthy, nutritious food pilot meeting - Develop action plan for pilot strategy implementation	March, 2019	Red Wing Area Food Shelf clients, board, and volunteers, First UMC, U of M Extension	Live Well Goodhue County Coordinator, GCHHS	
	Increasing healthy, nutritious food pilot meeting - Review results from pilot implementation and discuss additional options	June, 2019	Red Wing Area Food Shelf clients, board, and volunteers, First UMC, U of M Extension	Live Well Goodhue County Coordinator, GCHHS	
	Increasing healthy, nutritious food meeting with Food Shelf Board - Review results, approve strategy implementation or new pilot strategy	June, 2019	Red Wing Area Food Shelf Board	Live Well Goodhue County Coordinator, GCHHS	

Action Plan Objectives	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
3-1c. In 2019, engage Zumbrota area residents in planning and promoting I CAN Prevent Diabetes classes, and track number of changes in program planning (e.g. day, time, and location of class, identifying and addressing barriers to participation) influenced by community members.	Stop Diabetes Presentation at Zumbrota Towers - Recruit residents to participate in stop diabetes awareness campaign planning	January, 2019	University of Minnesota Extension, Zumbrota Towers	Live Well Goodhue County Coordinator, GCHHS	
	Stop Diabetes Awareness Campaign Meeting - Identify local opportunities to host "Stop Diabetes" Informational Sessions and "Are YOU at Risk" engagement meetings	February, 2019	Will seek to meet with Zumbrota area residents who have low income or are at high risk for diabetes	Live Well Goodhue County Coordinator, GCHHS	
	Host "Stop Diabetes" Informational Sessions - Educate residents	February, 2019	Zumbrota Food Shelf, Pine Island Home Services/Senior Center, Pine Island Sharing Shelves, All Seasons Community Services	Live Well Goodhue County Coordinator, GCHHS	
	Host "Are YOU at Risk" Engagement Meetings - Recruit 4-8 low-income individuals for I CAN Prevent Diabetes class	March, 2019	Zumbrota Food Shelf, Pine Island Home Services/Senior Center, Pine Island Sharing Shelves, All Seasons Community Services	Live Well Goodhue County Coordinator, GCHHS	

Plans for Sustaining Action & Monitoring Implementation	Progress Notes
Resources for Implementation • To support implementation of 3-1a in 2019, Goodhue County Health and Human Services will contribute up to $500 in funding from Minnesota's Local Public Health Act and $500 in funding from the Statewide Health Improvement Partnership (SHIP). • Live Well Goodhue County (GCHHS), Red Wing Area Food Shelf, and First United Methodist Church provide staff/volunteer time, space, and funds for objective 3-1b. • University of Minnesota Extension, Mayo Clinic Health System, and Live Well Goodhue County (GCHHS) provide staff and funding for 3-1c., I CAN Prevent Diabetes. • Live Well Goodhue County is supported by the Statewide Health Improvement Partnership (SHIP) of Minnesota Department of Health (MDH).	
Participation of Stakeholders & Partners in Monitoring Implementation • Live Well Goodhue County Community Leadership Team will review action plan annually. • The Community Health Assessment committee will receive an update at least annually.	
Process for Revising the Action Plan • Live Well Goodhue County Community Leadership Team will discuss and record revisions in meeting minutes annually. • The Healthy Communities Supervisor and Live Well Goodhue County Coordinator will contact partners as needed for progress notes and pictures and draft revisions.	

Live Well Goodhue County Community Leadership Team Coordinator: David Anderson, GCHHS

Current Members	Organizational Affiliation
Elaine O'Keefe	Live Healthy Red Wing
Gene Leifeld	Community Member, Zumbrota
Ruth Greenslade	Goodhue County Health and Human Services
Jessica Kitzmann	Red Wing Housing and Redevelopment Authority
Kanko Akakpovi	University of Minnesota Extension
Katy Schuerman	Kenyon-Wanamingo Public Schools
Kim Wojcik	Red Wing Area Seniors, Inc.
Kirsten Ford	Focus Design
Laura Prink	United Way of Goodhue, Wabasha and Pierce Counties
Mike Melstad	Red Wing Family YMCA
Pam Horlitz	Mayo Clinic Health System in Cannon Falls, Lake City, Red Wing
Pastor Karl Rydholm	United Lutheran Church, Red Wing
Jessica Seide	Goodhue County Health and Human Services
Laura Smith	Goodhue County Health and Human Services
Teri Washburn	The Kenyon Leader
Yaneth Santiago	Community Member, Red Wing

LEGACY PRIORITY: FAMILY & PARENTING

Goal Connection between communities, schools, agencies, and families leading to healthy development for children in greatest need in Goodhue County.

Community Health Objectives	Baseline
By December 31, 2023, decrease the percentage of low birthweight babies in Goodhue County. Source: MDH	4.9% 2016
By December 31, 2023, decrease the percentage of very low birthweight babies in Goodhue County. Source: MDH	1.1% 2016
By December 31, 2023, decrease the Goodhue County teen pregnancy rate for 15-19 year olds. Source: MDH	19.8% 2016
By December 31, 2023, decrease the total number of child protection assessments and investigations per year in Goodhue County. Source: GCHHS	233 2015
By Fall 2023, increase the number of children assessed as developmentally ready for Kindergarten in the Red Wing School District. Source: Red Wing KSEP	82% Fall 2016
By Dec. 31, 2023, decrease the percentage of Goodhue County mothers who smoked during pregnancy. Source: MDH	17.0% 2016

Action Plan Objectives	Baseline
L-1a. By December 31, 2023, increase the percentage of children ages 0-3 eligible for early intervention services identified by school districts (referred for services) before early childhood screening.	TBD
L-1b. By December 31, 2023, expand the number of families served by evidence-based home visiting programs such as Early Head Start and Healthy Families of Southeast Minnesota.	10 2017
L-1c. By December 31, 2023, representatives from each home visiting program will meet 1 time per year so home visiting personnel know the criteria for other home visiting programs in order to make referrals.	0 2017

Alignment with State/National Priorities

Healthy Minnesota 2022

- Priority 1: The opportunity to be healthy is available everywhere and for everyone.
- Priority 1 Key condition: Positive early life experience

Healthy People 2020

- EMC-1 (Developmental) Increase the proportion of children who are ready for school in all five domains of healthy development: physical development, social-emotional development, approaches to learning, language, and cognitive development
- FP-8.1 Reduce pregnancies among adolescent females aged 15 to 17 years. FP-8.2 Reduce pregnancies among adolescent females aged 18 to 19 years.
- IVP-38. Reduce nonfatal child maltreatment
- MICH-8.1 Reduce low birth weight (LBW). MICH-8.2 Reduce very low birth weight (VLBW).
- MICH-11.3 Increase abstinence from cigarette smoking among pregnant women.

National Prevention Strategy

- Mental and Emotional Well-being Recommendation 1. Promote positive early childhood development, including positive parenting and violence-free homes.

Legacy Priority Action Plan

Strategy L-1 Home visiting

According to What Works for Health, early childhood home visiting programs are **scientifically supported** to reduce child maltreatment, reduce child injury, improve cognitive skills, improve social-emotional skills, improve parenting, improve birth outcomes, and improve economic security (County Health Rankings, 2018). **"**Home visiting programs" include regular visits with a nurse, social worker, parent educator, paraprofessional, teacher, or other trained personnel to provide information, support, and/or training regarding child health, development, and care for at-risk expectant parents and families with young children based on families' needs.

In 2018, there are several organizations offering different home visiting programs to Goodhue County families:

- **GCHHS Family Home Visiting**: Public health family home visiting practice is grounded in empirically-based research (Minnesota Deparment of Health - Community & Family Health Division, 2012).
- **GCHHS Healthy Families America**: According to HomVEE, the Healthy Families America model has **favorable results in high or moderate studies** of impacts on maternal health, child health, child development and school readiness, reductions in child maltreatment, family economic self-sufficiency, and linkages and referrals (U.S. Department of Human Services, 2018). Healthy Families of Southeast Minnesota uses the Growing Great Kids Curriculum (great kids, inc., 2017).
- **GCHHS Parent Support Outreach Program**: A report prepared for the Minnesota Department of Human Services found that the Parent Support Outreach Program increased services and referrals to community services and provided support for families in the form of transportation, financial assistance, help with housing and the like (Loman, Shannon, Sapokaite, & Siegel, 2009).
- **Three Rivers Head Start:** Three Rivers Head Start serves children ages 3 to 5 in the classroom and has a home visiting component as well.
- **Three Rivers Early Head Start**: According to What Works for Health, Early Head Start is **scientifically supported** and expected beneficial outcomes include improved cognitive skills, improved social-emotional skills, and improved family functioning (County Health Rankings, 2014). Three Rivers Community Action uses the Partners for Healthy Babies curriculum.
- **School Birth to 3 programs** (Early Childhood Special Education Infant and Toddler Intervention): Schools' Early Childhood Special Education programs for children ages birth to three with developmental delays or disabilities are recommended by informed clinical opinion as well as observation and normative testing.

Action Plan Objectives	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
L-1a. By December 31, 2023, school districts will increase the percentage of children ages 0-3 eligible for early intervention services identified (referred for services) before early childhood screening.	Increase Follow Along Program return rate, to ensure enrolled families get referrals to early intervention services if needed.	12/31/2019	GCHHS, Every Hand Joined, SMIF	Follow Along Nurse, GCHHS	
	Formal and informal promotion for Minnesota Help Me Grow (information regarding child development and how to make a referral).	12/31/2023	Red Wing Public School and GCED staff, GCHHS, Region 10 IEIC	Early Childhood Services Coordinator, Red Wing Public Schools	

Action Plan Objectives	Activity	Target Date	Partners	Lead Person/ Organization Responsible	Progress Notes
L-1b. By December 31, 2023, expand the number of families served by evidence-based home visiting programs such as Early Head Start and Healthy Families of Southeast Minnesota.	Apply for grant to add another 30 EHS spots between Goodhue & Wabasha counties	5/1/2019	Three Rivers Community Action	Head Start Director, Three Rivers Community Action	
	Public health will receive 16-week prenatal referrals of Goodhue County residents from Mayo Clinic Health System clinics	12/31/2019	Mayo Clinic Health System, GCHHS	Family Health Supervisor, GCHHS	
	Enroll 15 Goodhue County families in Healthy Families of SE Minnesota 2019 (HFA model) and grow to serve 25 families in 2020	12/31/2020	GCHHS	Family Home Visiting Coordinator (Healthy Families of America Program Manager), GCHHS	
	Support participation of families in the Healthy Families of SE Minnesota board through child care, transportation, meals, payment for time, etc.)	12/31/2020	GCHHS	Family Home Visiting Coordinator (Healthy Families of America Program Manager), GCHHS	
L-1c. By December 31, 2023, representatives from each home visiting program will meet 1 time per year so home visiting personnel know the criteria for other home visiting programs in order to make referrals.	Annual 90 minute meeting among agencies that provide home visiting to learn about each other's criteria and discuss how to achieve other objectives.	12/31/2023	GCHHS, Three Rivers, Red Wing Public Schools, and GCED	Healthy Communities Supervisor, GCHHS	
	Explore ways to connect the work of this meeting with the existing Every Hand Joined Early Childhood Network.	12/31/2023	Every Hand Joined	Healthy Communities Supervisor, GCHHS	

Plans for Sustaining Action & Monitoring Implementation	Progress Notes
Resources for Implementation • Goodhue County Education District, Red Wing Public School District, Three Rivers Community Action, and Goodhue County Health and Human Services all have separate sources of ongoing funding for their home visiting programs. • Minnesota Department of Health awarded a 3-year grant in 2018 to implement Healthy Families of Southeast MN home visiting program in 7 counties. • GCHHS is applying to Southern Minnesota Initiative Foundation for additional funds to increase Follow Along Referrals. • Three Rivers Community Action is applying for a Minnesota Department of Health evidence-based home visiting grant. • Goodhue County Health and Human Services will contribute up to $500 in 2019 to support implementation. This funding comes from Minnesota's Local Public Health Act.	
Participation of Stakeholders & Partners in Monitoring Implementation • Home visiting meetings will include agency representatives from each home visiting program and Every Hand Joined. The Healthy Communities Supervisor (GCHHS) will facilitate the group, and the group will explore how they can be self-sustainable. • The Community Health Assessment committee will receive an update at least annually.	
Process for Revising the Action Plan • The Healthy Communities Supervisor will contact each home visiting agency as needed for data, progress notes, and pictures. • During the annual home visiting meeting, the group will discuss the progress notes and make revisions to the action plan.	

Home Visiting Action Team Facilitator: Ruth Greenslade, Healthy Communities Supervisor (GCHHS)

Home Visiting Action Team	Organizational Affiliation
Jane Adams Barber	Head Start Director, Three Rivers Community Action
Rene Arendt	Social Worker, Goodhue County Education District
Jeanne Freier	Family Home Visiting Coordinator (Healthy Families of America Program Manager), Goodhue County Health and Human Services
Brooke Hawkenson	Family Health Supervisor, Goodhue County Health and Human Services
Min Martin-Oakes	Early Childhood Services Coordinator, Red Wing Public Schools and Goodhue County Education District
Amy Merschbrock	Parent Support Outreach Program, Goodhue County Health and Human Services
Aimee Clites	Collective Impact Specialist, Every Hand Joined

Goodhue County Home Visiting Matrix

Organization	Program	# Visits	Who Visits	Who Qualifies	Child Age	Service Area	Notes
Goodhue County Health and Human Services	Family Home Visiting	Varies based on need	Public Health Nurse	Anyone Target: low-income (200% poverty), teen pregnancy, high risk	prenatal-18 years	Goodhue County	
	Parent Support Outreach Program	Varies based on need	Social Worker	"Screened out" maltreatment reports, self-referrals, community referrals	0-10 years	Goodhue County	New in 2013
Three Rivers Community Action, Inc.	Head Start	Varies based on need (minimum 2 per year)	Teacher/ Family Advocate	Under 100% federal poverty level or homeless or in foster care	3-5 years	Goodhue County —1 classroom in Zumbrota and 2 in Red Wing	
	Early Head Start	48 weeks per year, 2 hours per visit	Teacher	Under 100% federal poverty level or homeless or in foster care	prenatal-3 years	Goodhue County	New in 2015
Goodhue County Education District	Early Childhood Special Education (ECSE) Birth to Three	Varies based on Individual Family Service Plan (IFSP)	Teacher or Other Professional	Diagnosed condition, 1 or more significant delay, or clinical opinion	0-3 years	Cannon Falls, Goodhue, K-W, and Z-M school districts*	
Red Wing Public Schools	ECSE Birth to Three	Same as above	Same as above	Same as above	Same as above	Red Wing School District*	
Zumbro Valley Education District	ECSE Birth to Three	Same as above	Same as above	Same as above	Same as above	Pine Island School District*	

*Note: Schools' Early Childhood Family Education (ECFE) and School Readiness Programs may also provide some early childhood home visits.

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The Goodhue County Community Health Improvement Plan 2018-2023
is available online:
https://www.co.goodhue.mn.us/982/Community-Health-Improvement-Plan

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (HHS)

Monthly Report

CD Placements

CONSOLIDATED FUNDING LIST FOR JANUARY 2019

In-Patient Approval:

#01201581R – 45 year old male – two previous treatments – Oakridge, Rochester

#03057976R – 46 year old male – one previous treatment – MN Adult & Teen Challenge, Mpls.

#03750419R – 24 year old male – one previous treatment – Twin Town Treatment Center, St. Paul

#01806001R – 26 year old male – four previous treatments – MN Adult & Teen Challenge, Rochester

#02276787R – 38 year old male – two previous treatments – Oakridge, Rochester

#02878209R – 53 year old male – numerous previous treatments – Douglas Place, East Grand Forks

#00382164 – 35 year old female – no previous treatment – Transformation House, Anoka

#00904336 – 26 year old female – no previous treatment – Twin Town Treatment Center, St. Paul

#01471602 – 37 year old male – five previous treatments – Burkwood, Hudson WI

#00723815R – 41 year old male – one previous treatment – MN Adult & Teen Challenge, Mpls.

#01457339R – 37 year old male – two previous treatments – Common Ground Recovery House, Winona

#01335479R – 25 year old male – one previous treatment – Cochran Recovery Services, Hastings

#01694468R – 58 year old male – five previous treatments – Common Ground Recovery House, Winona

#03664413R – 21 year old female –one previous treatment–Meadow Creek Treatment Center, Pine City

#00787077R – 34 year old male – numerous previous treatments – Oakridge, Rochester

Outpatient Approvals:

#016363191R – 50 year old male – two previous treatments – Common Ground, Red Wing

#03079655 – 36 year old male – no previous treatment – Common Ground, Red Wing

#03403329R – 21 year old female – one previous treatment – Common Ground, Red Wing

#02542599R – 37 year old male – numerous previous treatments – Midwest Recovery, Red Wing

#00851804R – 52 year old female – one previous treatment – Common Ground, Red Wing

#01741474 – 22 year old female – no previous treatment – Common Ground, Red Wing

#00354425R – 35 year old male – numerous previous treatments – Midwest Recovery, Red Wing

Halfway House Approvals: None

Promote, Strengthen, and Protect the Health of Individuals, Families, and Communities!

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	17
October	30	18	28	28
November	20	22	19	22
December	17	15	16	19
Total	**236**	**247**	**273**	**256**

DHS-5408J-ENG 11-18

DEPARTMENT OF HUMAN SERVICES

Minnesota's Child Maltreatment Report, 2017

Children and Family Services

November 2018

Minnesota Department of Human Services
Child Safety and Permanency Division
P.O. Box 64943
St. Paul, MN 55155
651- 431-4660
dhs.csp.research@state.mn.us
https://mn.gov/dhs/people-we-serve/children-and-families/services/child-protection/

For accessible formats of this information or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 651-431-4670, or use your preferred relay service. ADA1 (2-18)

As required by Minn. Stat. 3.197: This report cost approximately $10,667.30 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

Contents

The 2017 annual Child Maltreatment Report summary

Purpose

The purpose of this annual report is to provide information on children involved in maltreatment reports, and the work that happens across the state to ensure and promote the safety, permanency and well-being of children who may have experienced maltreatment. For information on all state and federal performance measures, see the Minnesota Child Welfare Data Dashboard.

Findings

The intake process

- In 2017, Minnesota child protection agencies received **84,148** reports of child maltreatment, representing a **4.8** percent increase from 2016.[1]

The screening process

- Of the **84,148** child maltreatment reports received in 2017, local agencies screened in **37,736**, **44.8** percent, of reports.
- For reports that were screened out, more than **nine of every 10** were screened out because allegations did not meet the statutory threshold for maltreatment.
- Mandated reporters made the vast majority of reports of maltreatment, nearly four of five reports (**67,101** of **84,148** reports or **79.7** percent).

Completed assessments and investigations

- There were **39,606** alleged victims involved in at least one completed assessment or investigation following a screened in child maltreatment report.
- The number of completed assessments/investigations and of alleged victims with at least one screened in and completed report has remained steady since the last year.
- Since 2008, there has been about a **75** percent increase in completed assessments/investigations; the increase in workload has greatly exceeded increases in funding for child welfare agencies.
- American Indian children were about **five** times more likely to be involved in completed maltreatment assessments/investigations than white children, while children who identify with

[1] The methodology for calculating the total number of reports was modified in 2017. See page 10 for description of methodology. Caution should be taken when comparing the 2017 total number of reports with numbers from previous publications.

two or more races and African-American children were both approximately **three** times more likely to be involved.

- Minnesota continues to struggle with opportunity gaps for families of color and American Indian families. The disproportionality seen in child protection cases is further evidence of a gap in services and opportunities for these families and children.
- Children age 8 and younger represented the majority involved in completed maltreatment assessments/investigations (**59.7** percent) in 2017.
- Alleged victims with allegations of neglect constituted the largest group of children by far, with approximately **62.2** percent of all children in 2017.
- Prenatal exposure to alcohol or substances is one form of neglect. In 2017, **1,672** children were prenatally exposed to alcohol or illegal substances. This represents a **26** percent increase since 2016, and a **121** percent increase since 2013.
- Maltreatment allegations of chronic and severe use of a controlled substance/alcohol have also seen a similar large increase. There were **2,681** children with this allegation identified in 2013, increasing to **6,321** alleged victims in 2017.

Child protection response path assignment

- The number and proportion of reports being assigned to Family Assessment (Minnesota's alternative response path) was essentially unchanged from 2016. This comes after a noticeable decrease in the number of Family Assessment responses from 2015 to 2016.
- Approximately **59** percent of the **30,927** completed maltreatment assessments/investigations were assigned to the Family Assessment path (N = **18,212**), while the rest received either a Family or Facility Investigation.

Assessment or investigation of safety, risk and service needs

- Improvements are essential in agency performance on the timeliness of first face-to-face contact with alleged victims in screened in maltreatment reports, critical for ensuring safety, with only **83.6** percent of victims seen within the time frames established in statute. This is a **2.5** percent increase from 2016, when **80.1** percent of victims were seen within time frames.
- A higher percentage of completed maltreatment assessments/investigations that were Family Investigations indicated families were at high risk of future maltreatment (**41.2** percent) than were Family Assessments (**20.7** percent).
- There were **18,660** children in completed maltreatment assessments/investigations who experienced a Family Investigation, with **46.5** percent having a determination of maltreatment; there were **1,610** children in completed assessments/investigations who received a Facility Investigation, with **25.8** percent having a maltreatment determination.
- There were **21** child deaths and **17** life-threatening injuries determined to be a result of maltreatment in 2017.

Outcomes after child maltreatment assessments/investigations conclude

- Minnesota met the federal maltreatment recurrence standard in 2017, with **8.9** percent of all children having a recurrence of maltreatment within 12 months of their first determination.

Child maltreatment appendix

The child maltreatment appendix has eight tables that break down data from 2017 by agency:

1. The number and percent of child maltreatment reports by screening status and agency
2. Number of completed child maltreatment assessments/investigations by response path and agency
3. Number of alleged victims in completed assessments/investigations by maltreatment type and rate per 1,000 children by agency
4. Number of alleged victims by age group and agency
5. Number of alleged victims by race and ethnicity and agency
6. Number of alleged and determined victims in completed assessments/investigations and rate per 1,000 children by agency
7. Number of social service agency referrals to early intervention for infants and toddlers involved in substantiated cases of maltreatment
8. Number of assessments/investigations by SDM risk assessment status and agency

Legislation

This report was prepared by the Minnesota Department of Human Services (department), Children and Family Services Administration, Child Safety and Permanency Division, for the Minnesota Legislature in response to a directive in Minn. Stat., section 257.0725. This report also fulfills reporting requirements under the Vulnerable Children and Adults Act, Minn. Stat., section 256M.80, subd. 2; the Minnesota Indian Family Preservation Act, Minn. Stat., section 260.775; required referral to early intervention services, Minn. Stat. 626.556, subd. 10n; and Commissioner's duty to provide oversight, quality assurance reviews, and annual summary of reviews, Minn. Stat., section 626.556, subd. 16.

Minn. Stat., section 257.0725: The commissioner of human services shall publish an annual report on child maltreatment and on children in out-of-home placement. The commissioner shall confer with county agencies, child welfare organizations, child advocacy organizations, courts, and other groups on how to improve the content and utility of the department's annual report. Regarding child maltreatment, the report shall include the number and kinds of maltreatment reports received, and other data that the commissioner determines appropriate in a child maltreatment report.

Minn. Stat., section 256M.80, subd. 2: Statewide evaluation. Six months after the end of the first full calendar year and annually thereafter, the commissioner shall make public county agency progress in improving outcomes of vulnerable children and adults related to safety, permanency and well-being.

Minn. Stat. 626.556, subd. 10n: A child under age 3 who is involved in a substantiated case of maltreatment shall be referred for screening under the Individuals with Disabilities Education Act, part C. Parents must be informed that the evaluation and acceptance of services are voluntary. The commissioner of human services shall monitor referral rates by county and annually report that information to the legislature beginning Mar. 15, 2014. Refusal to have a child screened is not a basis for a child in need of protection or services petition under chapter 260C.

Minn. Stat., section 626.556, subd. 16: Commissioner's duty to provide oversight, quality assurance reviews, and an annual summary of reviews. It states: (a) The commissioner shall develop a plan to perform quality assurance reviews of local welfare agency screening practices and decisions. The commissioner shall provide oversight and guidance to county agencies to ensure consistent application of screening guidelines, thorough and appropriate screening decisions, and correct documentation and maintenance of reports. Quality assurance reviews must begin no later than Sept. 30, 2015. (b) The commissioner shall produce an annual report of the summary results of the reviews. The report must only include aggregate data and may not include any data that could be used to personally identify any subject whose data is included in the report. The report is public information and must be provided to the chairs and ranking minority members of the legislative committees having jurisdiction over child protection issues.

Introduction

Caring for and protecting children is one of the critical functions of any society. Communities can only be successful when children have opportunities to grow, develop and thrive. [Annie E. Casey, 2017] No factor may be a stronger indicator of a poorly-functioning society than high rates of child maltreatment. It is widely considered to be a public health crisis in the U.S., with far-ranging negative consequences for not only developing children, but also for families and communities in which children live.

It is critical that the department monitors and reports on the experiences of children who are alleged to have been maltreated, and the work of child protection in ensuring those children are safe and reaching their full potential.

Minnesota children

After substantial increases in both the number of child maltreatment reports and alleged victims over the last few years, 2017 showed a leveling-off. The number of maltreatment reports made and investigated decreased by a few percentage points from 2016. The reason for the slight decrease is unknown. One explanation is that there has been sufficient time since a law was passed in 2015 requiring local agencies to follow revised screening and reporting guidelines to create consistency in practice over time.

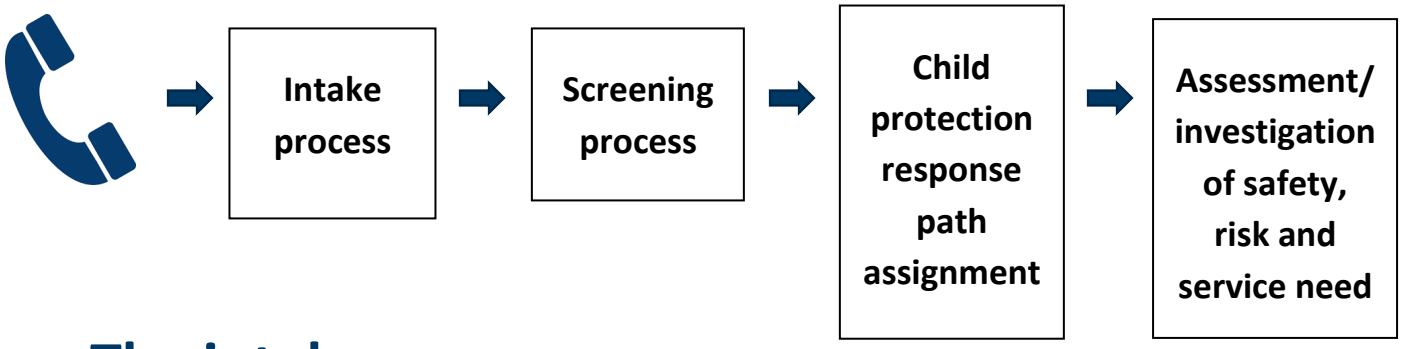
What is child maltreatment?

Minnesota Statutes provide a detailed description of what constitutes child maltreatment (see Minn. Stat. 626.556). In general, Minnesota Statutes recognize six types of maltreatment: Neglect, physical abuse, sexual abuse, mental injury, emotional harm, medical neglect and threatened injury.

Minnesota's child protection system

Minnesota is a state supervised, locally administered child protection system. This means that local social service agencies (87 counties and two American Indian Initiative tribes) are responsible for screening reports, assessing allegations of maltreatment, and providing child protective services for children and families. The Child Safety and Permanency Division, Minnesota Department of Human Services, provides oversight, guidance, training, technical assistance, and quality assurance monitoring of local agencies in support of that work. The purpose of this annual report is to provide information on the children affected, and the work that happens across the state to ensure and promote the safety, permanency and well-being of children who may have experienced maltreatment. For information about performance on all state and federal performance measures, see the Minnesota Child Welfare Data Dashboard.

How do children who may have been maltreated come to the attention of Minnesota's child protection system and receive services?



The intake process

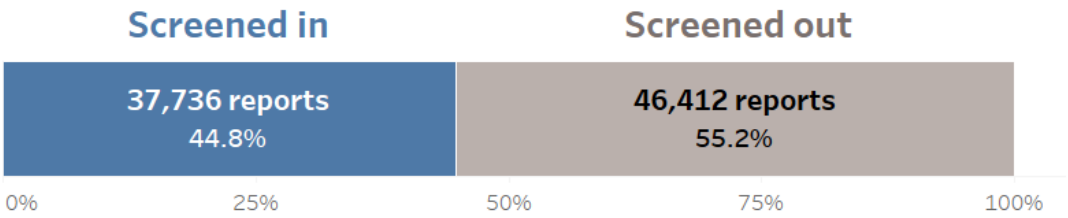
- When a community member has a concern that a child is being maltreated, they can (or must if they are a mandated reporter – see Minn. Stat. 626.556, subd. 3, for information about who is a mandated reporter) call their local child protection agency to report this concern. Local agencies document reports of maltreatment, including information about a reporter, children involved, alleged offenders, and specifics of alleged maltreatment.
- Over the past few years, data on the number of incoming child protection reports and screening rates have become more important to the overall picture of child welfare. Subsequently, attempts have been made to include this information, however, there have been several changes made to the methodology used. This, along with changes in requirements for local agency data entry, makes it difficult to compare the total number of reports from one annual report to the next.
- The 2017 report begins with information on the number of child maltreatment reports received and the screening rates for these reports at the time of intake. **All other information contained in the report will be based on assessments/investigations completed during the calendar year because it includes information not known until the assessment/investigation closes**. Although these two groups of reports are related, they aren't identical populations of reports or corresponding children. For example, some reports that were made to child protection in 2017 (i.e., reports at the intake phase) will not have an assessment or investigation of allegations completed until 2018 and will be included in that year's annual report (e.g., reports received in December 2017). Likewise, some assessments/investigations that were completed in 2017 were based on maltreatment reports received later in 2016.
- Minnesota child protection agencies received **84,148** reports of maltreatment in 2017, representing a **4.8** percent increase from 2016.

The screening process

Once a report of maltreatment has been received, local agency staff reviews the information in the report and determines if allegation(s) meet the statutory threshold for child maltreatment. If it does, and the allegations have not been previously assessed or investigated, staff screen in the maltreatment report for further assessment or investigation. The local agency cross reports all allegations of maltreatment to local law enforcement, regardless of the screening decision.

- Figure 1 shows the percent and number of reports that were screened out (**46,412** reports or **55.2** percent) and screened in for assessment or investigation (**37,736** reports or **44.8** percent).

Figure 1. Screening decisions of child maltreatment reports received in 2017

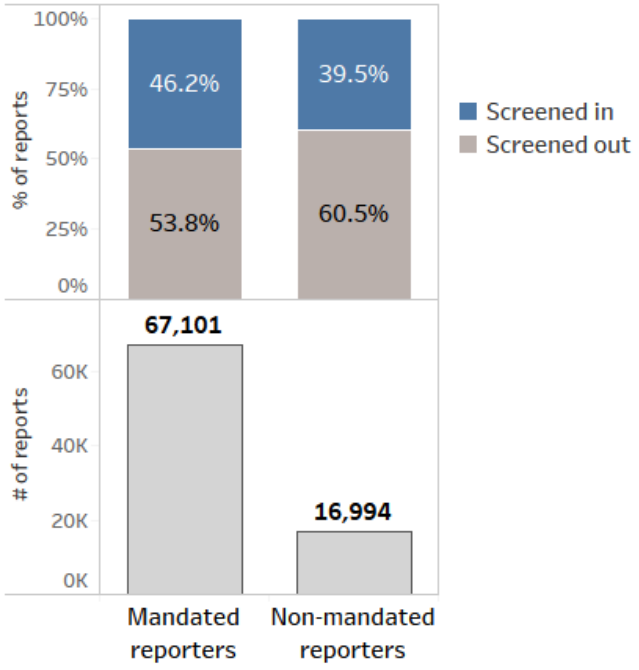


Screened out maltreatment reports

- In 2017**, 42,065** of the **46,412** screened out reports (**90.6** percent) were screened out because allegations did not meet the statutory threshold for maltreatment. The rest of the reports (**4,347** or **9.4** percent) were screened out for various reasons, including the following:
  - Report did not include enough identifying information (**2.6** percent)
  - Allegations referred to an unborn child (**4.1** percent)
  - The alleged victims were not in a family unit or covered entity (**2.7** percent) and were referred to the appropriate investigative agency.
- Information regarding the identity of alleged victims was provided and entered for **41,554** of the **46,412** screened out reports (**89.5** percent).
- The Child Safety and Permanency Division instituted a new statewide screening review process in September 2014. This process involves a review of a random selection of approximately 5 percent of screened out reports each month. Each review is completed by a team and is appraised both for screening decisions and also for the quality of information in reports. The review team requested further consultation with local agencies regarding their screening decisions in **170** of **2,934** reports reviewed (**5.7** percent) in 2017. Of those **170**, the consultation resulted in the agency screening in the report **70** times and an upholding of the screening decision **100** times.

Referral source of child maltreatment reports

Figure 2. Reports screened in and out by source of reporter in 2017

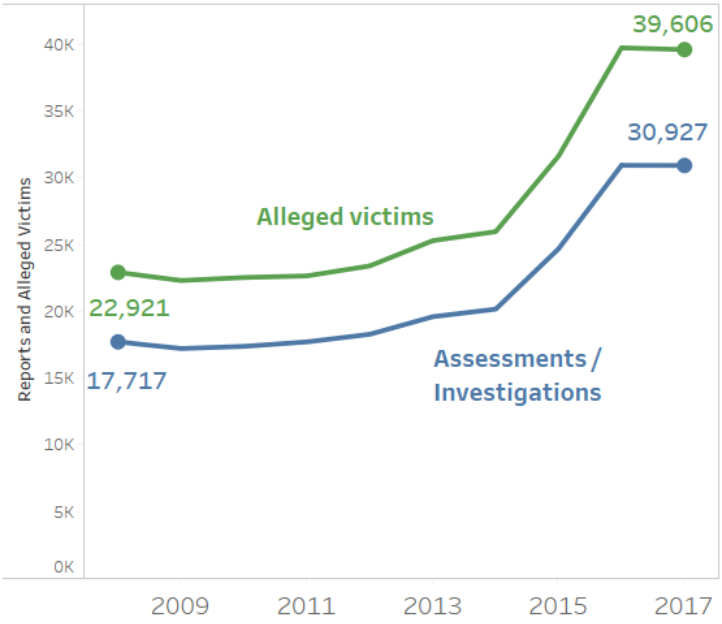


- Mandated reporters made the vast majority of reports of maltreatment to local agencies, with nearly four of five reports (**67,101** of **84,148** reports or **79.7** percent). There were 53 reports with an unidentified reporter.
- Mandated reporters include those in health care, law enforcement, mental health, social services, education and child care, among others who work with children.
- As shown in Figure 2, mandated reporters were more likely to have their reports accepted (**46.2** versus **39.5** percent). The difference in acceptance rates may be due to mandated reporters being better trained to identify maltreatment, therefore, more likely to report incidents that meet the threshold.

Completed assessments and investigations

- There were **30,927** assessments/investigations completed in 2017 after screened in reports of maltreatment; these reports involved **39,606** alleged victims.
- For the "Intake process" and "Screening process" sections, data provided are based on reports that were initially made to child welfare agencies in calendar year 2017. Beginning in this section, and for all subsequent sections, the information provided is based on maltreatment reports that led to an assessment/investigation that was completed in 2017. Therefore, the number of screened in reports shown in Figure 1 (i.e., **37,736** reports) is different than the number of completed assessments/investigations (which will also be referred to as "cases" throughout the rest of this report) in Figure 3 (i.e., 30,927 reports). All of the reports that were received in 2017, but not yet closed will be closed in the subsequent year and the outcomes will be reported in the 2018 annual Maltreatment Report.

Figure 3. Trends of completed assessments/ investigations and alleged victims, 2008 – 2017



- As shown in Figure 3, the number of completed assessments/investigations and alleged victims in at least one assessment/investigation has risen substantially over the past decade. Overall, since 2008, there has been a **74.6** percent and **72.8** percent increase in assessments/investigations and alleged victims, respectively.
- Possible explanations for the observed increases include a) an increase in opioid-related child protection cases as parental alcohol and substance use is a known risk factor for child maltreatment, [Children's Bureau, 2016] b) revisions made to maltreatment screening guidelines following the 2014 Governor's Task Force recommendations, which promoted consistency across agencies when responding to maltreatment reports, and c) increased scrutiny and tendency to report potential maltreatment following a high profile and highly publicized child death in 2013.
- While it isn't clear why this slight decline in the number of completed assessments/investigations occurred, the above mentioned changes to the guidelines and subsequent increases in consistency of screening decisions across agencies over time may be a partial explanation for this recent change.

- Some alleged victims had more than one completed assessment/investigation within the year. Table 1 provides information about how many victims had one or more completed assessment/investigation in 2017.
- There were **34,323** (86.7 percent) alleged victims who had a single completed assessment or investigation in 2017. Just over **13** percent had multiple assessments or investigations in the year.

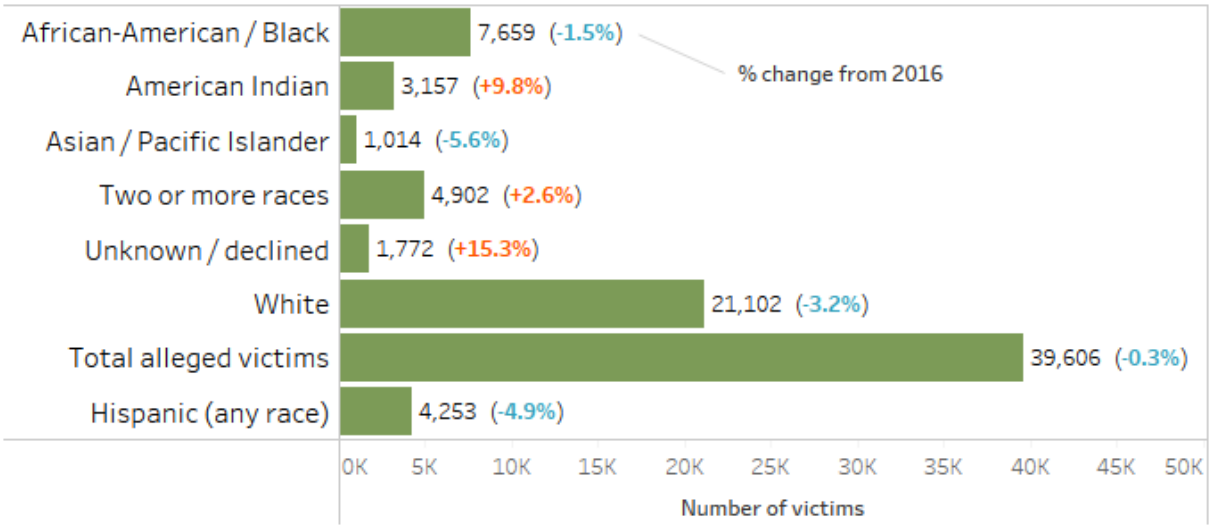
Table 1. Number of victims with one or more completed assessment/investigation in 2017

	Number	Percent
1 assmnt/inv	34,323	86.7%
2 assmnt/inv	4,322	10.9%
3 assmnt/inv	733	1.9%
4 or more assmnt/inv	228	0.6%
Total	39,606	100.0%

Characteristics of alleged victims in completed assessments/investigations

- Minnesota children involved in allegations of maltreatment live with all types of families in all parts of the state. However, there are communities that are disproportionately likely to be involved with the child protection system. Figures 5 and 6 provide information on the number of alleged victims and rates per 1000 by race.

Figure 5. Number of alleged victims with at least one completed assessment/investigation by race/ethnicity in 2017

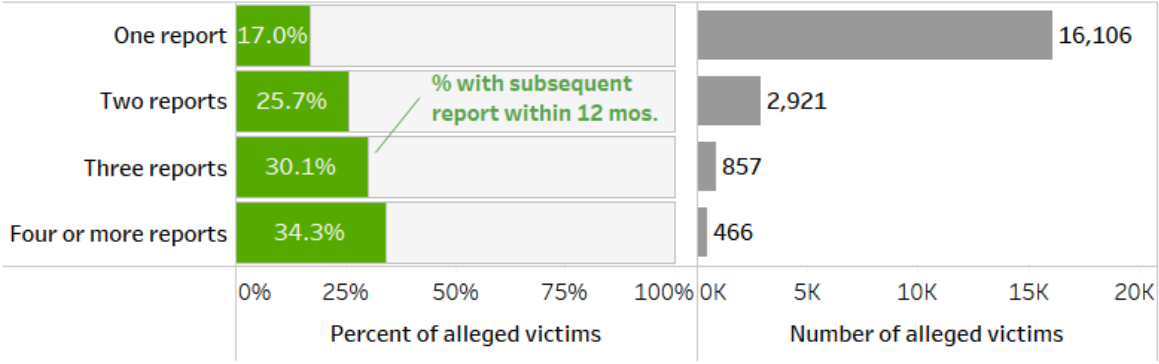


Were children who had a screened out maltreatment report in 2016 involved in a screened in report (and a subsequent completed assessment/investigation) maltreatment report within 12 months?

Following the recommendation of the Governor's Task Force in 2015, statutory changes were made that require county and tribal child welfare agencies to consider a child's prior screened out report history when making a decision to screen in a new report. A child's history of screened out maltreatment reports has been shown to be a predictor of future maltreatment. [Morley & Kaplan, 2011] The following figure examines whether children who had been involved in a screened out maltreatment report were eventually involved in a screened in maltreatment report. To conduct this examination, children who were in a screened out report during 2016 and had no prior child protection history within the last four years were followed to see if they were an alleged victim in a screened in report within 12 months of their initial screened out report.

- There were **20,350** children who had at least one screened out report in 2016 and no prior history in the previous four years. Of these children, **16,106** had one screened out report, **2,921** had two, **815** had three, and **466** had four or more screened out reports in 2016.
- Overall, **19.2** percent (N = **3,902**) of children with at least one screened out report were involved in a screened in maltreatment report within 12 months following their initial screened out report. As shown in Figure 4, children who were in multiple screened out reports were more likely to have a screened in child maltreatment report within 12 months of their first screened out report.

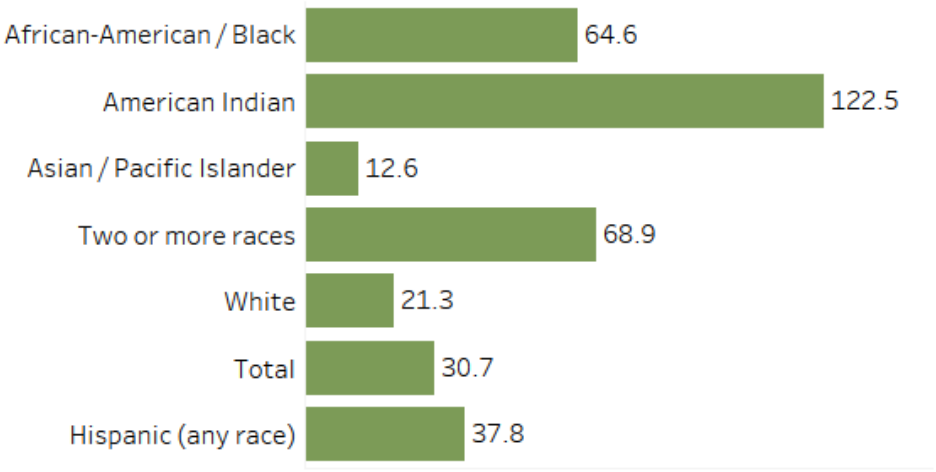
Figure 4: Percent and number of alleged victims with a screened in report by number of prior screened out reports



- Consistent with the Minnesota general population of children, the largest group with a screened in maltreatment report and a subsequent completed assessment or investigation are white (see Figure 5 below).
- Children who are African-American, American Indian, and those who identify with two or more races, were disproportionately involved in completed maltreatment assessments and investigations (see Figure 6).
- Adjusted to population rates, American Indian children were **5.8** times more likely to be involved in completed maltreatment assessments/investigations than white children, while children who identify with two or more races and African-American children were both about **three** times more likely.
- Between 2016 and 2017, the three groups increased their number of alleged victims in maltreatment assessments/investigations: Those who were identified as having two or more races and American Indian increased by **2.6** percent and **9.8** percent, respectively. The number of children with no identified race grew by **15.3** percent.
- Minnesota child welfare agencies are increasingly struggling with opportunity gaps for families of color and American Indian families across all systems serving children and families. The disproportionality seen in child protection is further evidence of this gap in services and opportunities.

Between 2016 and 2017, the number of children identified as American Indian and who were alleged victims in a screened in maltreatment report increased by about 10 percent.

Figure 6. The per 1000 rate of alleged victims in screened in reports by race/ethnicity in 2017



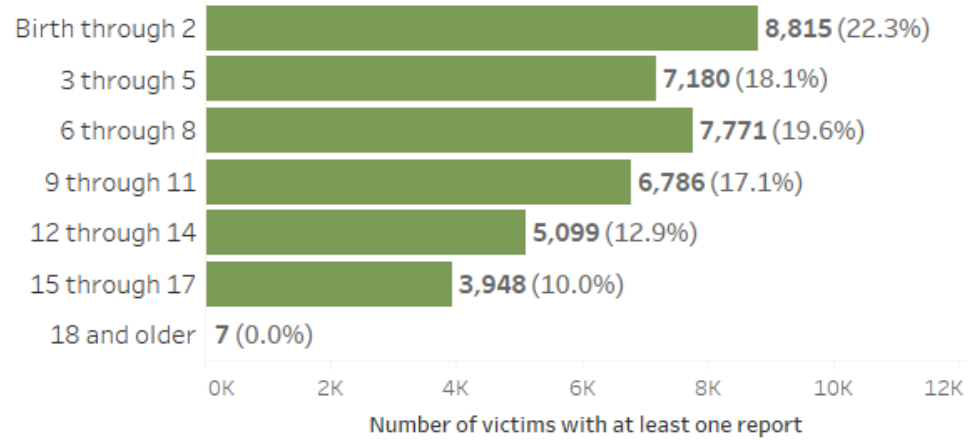
A closer look at the two or more race category

Minnesota is becoming more diverse with many children and families identifying with more than one race or ethnicity. In child welfare, the number of families self-reporting as two or more races has more than doubled since 2012. Of children who identify with more than one race:

- **88.6** percent identified at least one race as white
- **64.6** percent identified at least one race as African-American/Black
- **45.2** percent identified at least one race as American Indian
- **7.3** percent identified at least one race as Asian, and less than **2** percent identified as Pacific Islander.

- Children age 8 and younger represented the majority of children involved in maltreatment assessments and investigations (**59.6** percent) in 2017. There were likely multiple reasons why this age group constituted the greatest number involved in screened in maltreatment reports, including:
    - Young children rely almost exclusively on their caregivers for survival – this makes them particularly vulnerable to maltreatment. Data from the National Incidence Study [Sedlak et al., 2010] shows that young children are more likely to be maltreated.
    - Young children and their families often have more frequent contact with multiple family-serving systems who are mandated reporters for suspected maltreatment, increasing the likelihood that someone will report suspected maltreatment for these families.

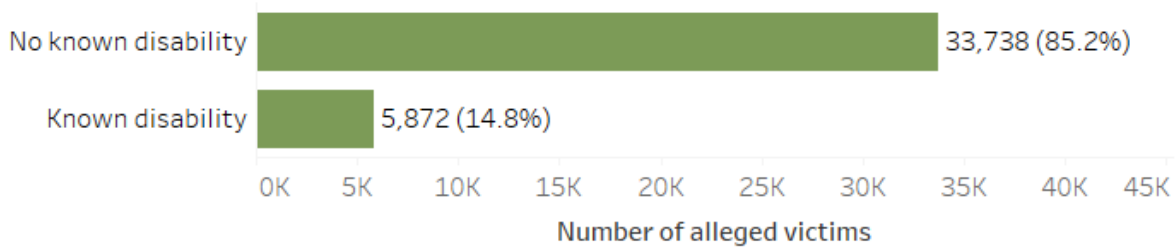
Figure 7. Number and percent of alleged victims with at least one completed assessment/investigation by age group in 2017



Note: For victims with more than one report during the report year, the age at their first screened in and completed maltreatment report was used to determine their age group.

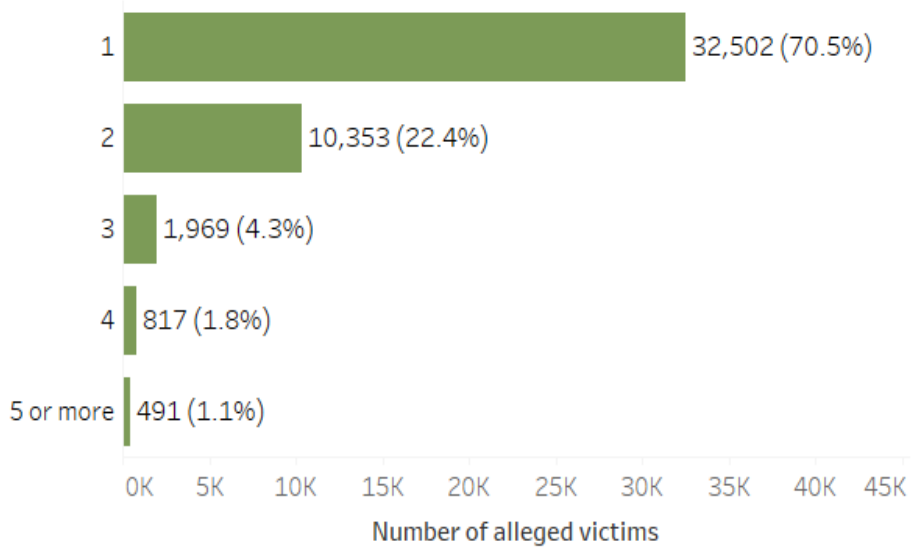
- Just under **15** percent of children who had screened in maltreatment reports in 2016 had a known disability (some disabilities may be undiagnosed). This rate of disability is **five** times more frequent than in the general population of children. [Sedlak et al., 2010]

Figure 8. Number and percent of alleged victims by disability status in 2017



- In any given report of maltreatment, a child may have one or more types of alleged maltreatment identified. There are six main categories of maltreatment: **Medical neglect** (i.e., not providing medical care for a child deemed necessary by a medical professional); **mental injury** (i.e., behavior of a caregiver that causes emotional or mental injury to a child); **neglect** (i.e., not adequately providing for the physical, mental or behavioral needs of a child); **physical abuse** (i.e., behavior that is intended to and/or results in physical harm to a child); **sexual abuse** (i.e., any behavior towards or exploitation of children by a caregiver that is sexual in manner); and **threatened injury** (i.e., attempting or threatening harm to a child or placing a child in a situation that puts them at risk for serious harm). For more exact definitions, consult the Minnesota Child Maltreatment Screening Guidelines and Minn. Stat. § 626.556, Reporting of Maltreatment of Minors.
- Figure 9 shows the number of victims with one or more allegations per completed assessment/ investigation in 2017. The vast majority of children (**70.5** percent) had a single allegation of maltreatment within each completed assessment/ investigation.

Figure 9. Number and percent of alleged victims by number of allegations per assessment/investigation in 2017



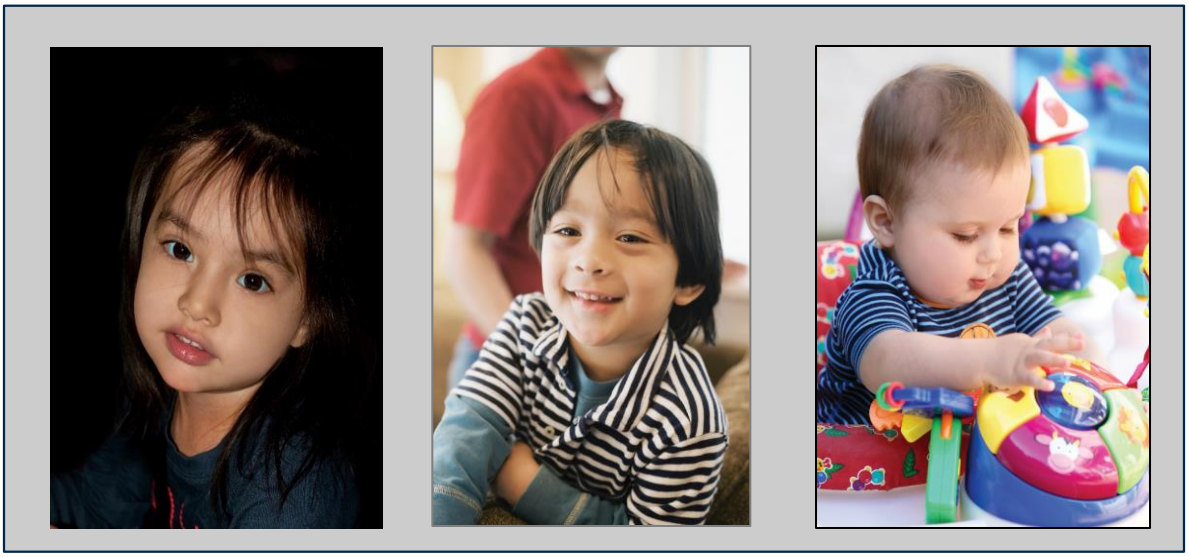
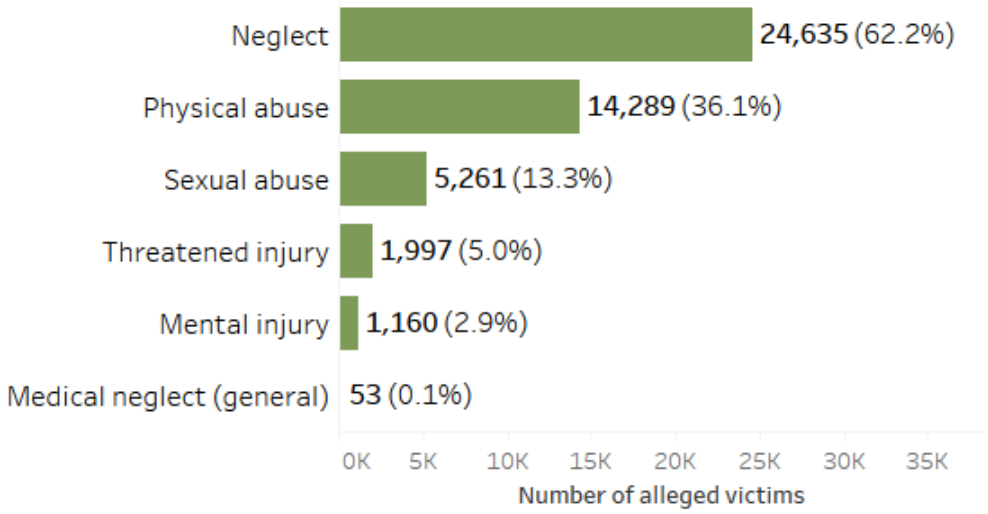


Figure 10. Number and percent of alleged victims by maltreatment type, 2017

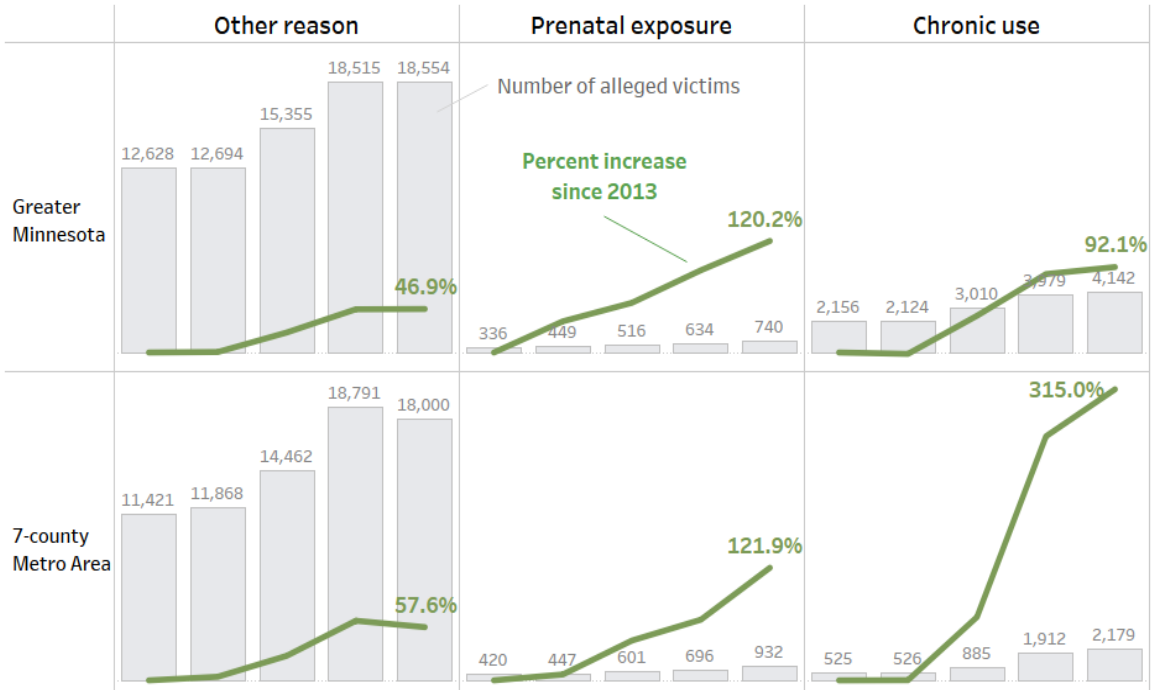


- Alleged victims with allegations of neglect was the largest group of children by far, about **62** percent of all children who experienced maltreatment in 2017 (see Figure 10).
- The relative frequency of the different types of maltreatment continues to shift. Threatened injury, a category added in 2016, was identified for 5 percent of all victims of maltreatment in 2017.

Threatened injury, a new category for maltreatment type, was identified for 5 percent of all alleged victims of maltreatment in 2017.

Drug-related maltreatment continues to climb

Figure 11. Increases in drug-related maltreatment allegations since 2013



Although the number of reports and alleged victims has risen substantially in recent years, 2016 and 2017 have seen a noticeably larger increase in drug-related allegations, including a) prenatal exposure to a controlled substance/alcohol, and b) chronic and severe use of alcohol/controlled substances. The seven-county metro area and greater Minnesota show similar increases for prenatal exposure (see Figure 11); however, the increase in documented allegations of chronic use of alcohol/controlled substances has been more dramatic in the seven-county metro. The number of alleged victims of chronic use increased to 6,321; the difference in increases for the seven-county metro compared to greater Minnesota is a pattern also seen in recent increases in opioid-related deaths in Minnesota. [Preliminary data from Minnesota Department of Health, 2018]

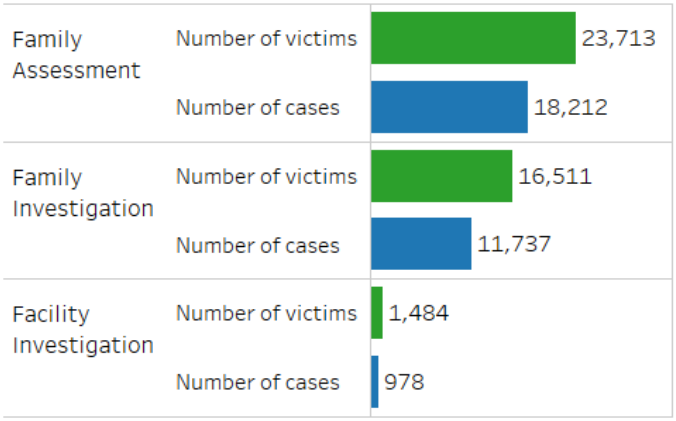
Child protection response path assignment

Once a report has been accepted and screened in, local agencies assign a case to one of three child protection responses: Family Assessment, Family Investigation, or Facility Investigation. All response paths are involuntary and families must engage with child protection or face the possibility of court action. See the sidebar on the right for information about how cases are assigned to each of the tracks. (Note: A 'case' is used to mean an investigation or assessment that has been completed.)

Assignment of child maltreatment cases to child protection response paths

- Figures 12 and 13 show just under **60** percent of child maltreatment reports were assigned to the Family Assessment path, while the rest received either a Family or Facility Investigation.

Figure 12. Number of cases and victims by path assignment in 2017



- In all types of child protection responses to maltreatment reports, there are five shared goals in the assessment or investigative phase:

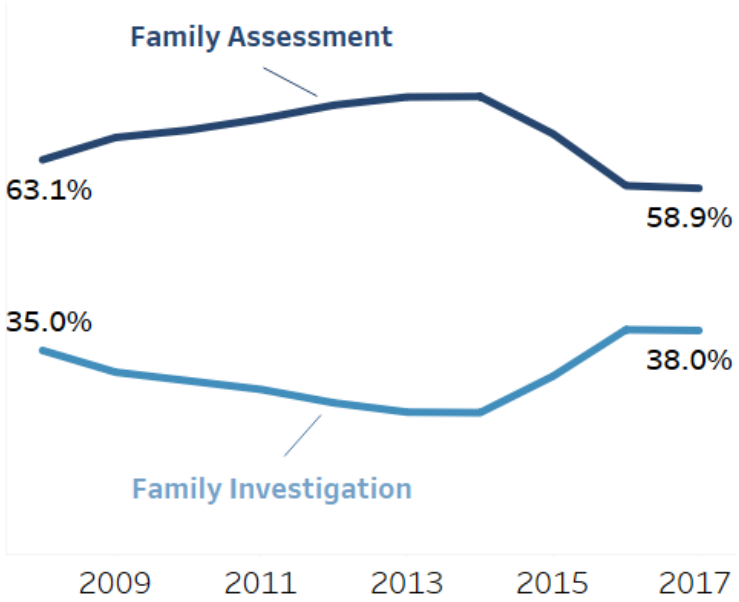
Assigning reports:

- By law, cases that include allegations of sexual abuse or substantial child endangerment (such as egregious harm, homicide, felony assault, abandonment, neglect due to failure to thrive and malicious punishment), must be assigned to a **Family Investigation**.
- Maltreatment allegations reported to occur in family foster homes or family child care homes are assigned to a **Facility Investigation**. Maltreatment occurring in state-licensed residential facilities, institutions and child care centers is investigated by the Minnesota Department of Human Services, Licensing Division, and is not included in this report.
- Cases not alleging substantial child endangerment or sexual abuse can either be assigned to **Family Assessment** or, if there are complicating factors associated with a report, such as frequent, similar, or recent history of past reports, or the need for legal intervention due to violent activities in the home, a local agency may, at its discretion, assign a report to a **Family Investigation** response.

1. Identify and resolve immediate safety needs of children.
2. Conduct fact-finding regarding circumstances described in a maltreatment report.
3. Identify risk of ongoing maltreatment.
4. Identify needs and circumstances of children (and families).
5. Determine whether child protective services are focused on providing ongoing safety, permanency and well-being for children.

- In Investigations (both family and facility), there is an additional goal: To use the evidence gathered through fact-finding to determine if allegations of maltreatment occurred. If a determination is made, the information is maintained for a minimum of 10 years.

Figure 13. Trend of percent of cases assigned to FA and FI paths, 2008 – 2017



- There was a pilot and evaluation of the Family Assessment model of child protection in 2000, and statewide implementation was completed in 2005, leading to a decline in use of Family Investigations to make determinations of maltreatment.
- After a long steady decline, there was a large increase in the percentage of reports being assigned to Family Investigation, which rose from 25 percent to 38 percent of cases from 2014 to 2016. This increase has been attributed to several factors, including but not limited to:

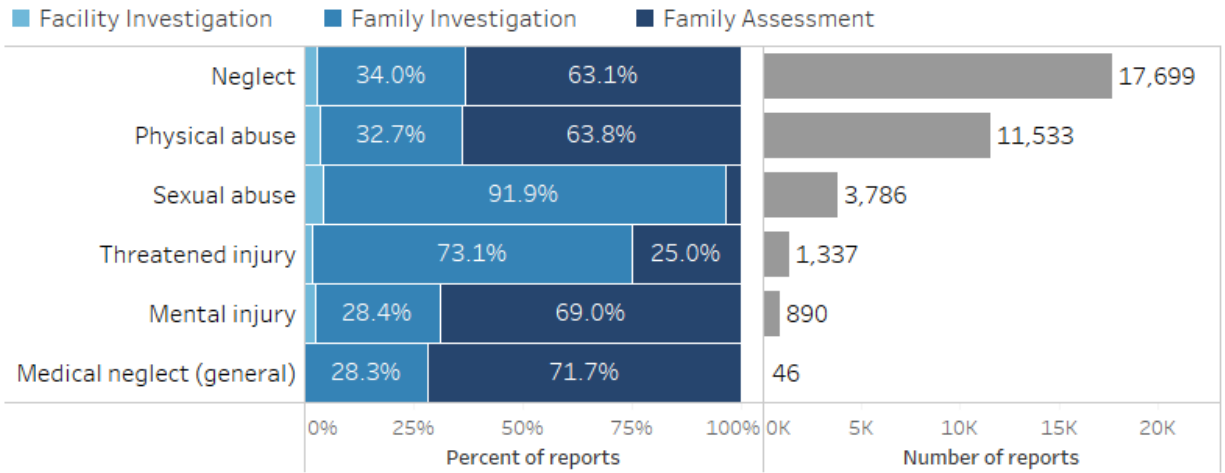
a) Updated guidance regarding intake, screening, and assignment decisions released in 2015.
b) State legislation requiring local agencies to follow this guidance.
c) Statutory changes requiring child welfare agencies to consider prior history of screened out maltreatment reports when assigning cases to a response path.
d) An increase in reporting sexual abuse, which now includes sex trafficked youth.
e) Hennepin County, which comprises about one-quarter of state cases, went from about 40 percent of its cases being assigned to Family Investigation in 2014 to almost 60 percent in 2017, meaning this agency had a strong influence on overall state trends. This steep increase has leveled off; 2017 shows almost identical rates of assignment to Family Assessment compared to Family Investigation.

Maltreatment type and child protection response paths

- Reports of neglect, physical abuse, mental injury, and medical neglect were most often assigned to the Family Assessment response path. Sexual abuse (which has a required Investigation response) and threatened injury were most often assigned to Family or Facility Investigations (see Figure 14).
- Despite a statute indicating that all sexual abuse allegations should receive a Family Investigation response**, 3.7** percent of screened in maltreatment reports (N = **140** reports) having allegations of sexual abuse were closed as having received a Family Assessment response. However, **100** (or **71.4** percent) of those reports were at some point prior to case closure assigned to a Family or Facility Investigation and were switched once further assessment indicated a Family Investigation was not needed, which is permissible under Minnesota Statutes. That leaves **40** reports**,** or about **1** percent of all reports including sexual abuse allegations, that were closed as Family Assessment and had never had an Investigation. This is down 1.7 percent of cases from 2016.

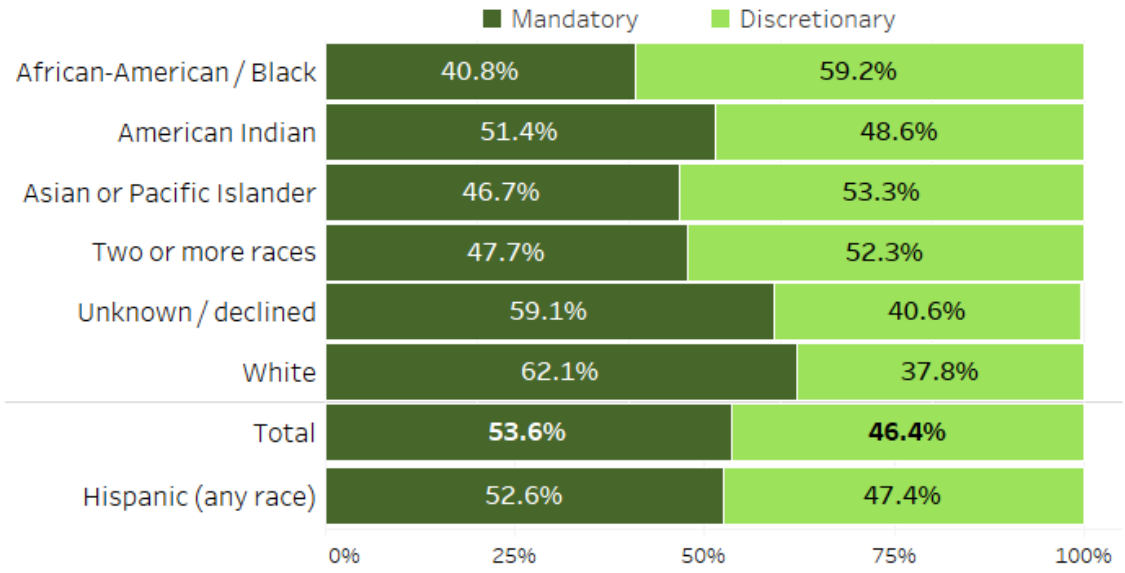
- Beginning in 2015, Child Safety and Permanency Division staff began reviewing every report that was assigned to Family Assessment and had a sexual abuse allegation, and contacting local agencies to review this decision. Beginning in September 2017, new cases that include an allegation of sexual abuse are forced by the electronic tracking system to be assigned to an investigation track.

Figure 14. The percent and number of cases by child protection response path and maltreatment type in 2017



- As mentioned previously on p. 24, there are both mandatory and discretionary reasons that local child protection agency staff will assign a case to the Family Investigation response path.
- Figure 15 shows the percent of victims that were assigned to a Family Investigation by discretionary and mandatory reasons by race. White children are assigned to a Family Investigation for a discretionary reason less frequently compared to children from other racial and ethnic groups. The most common reasons associated with discretionary assignment to a Family Investigation was frequency, similarity, or recentness of past reports (**71** percent), and need for legal intervention due to violent activities in the household (**15.8** percent).

Figure 15. The percent of alleged victims by race/ethnicity assigned to Family Investigation by discretionary versus mandatory reasons in 2017



Assessment or investigation of safety, risk and service need

After a maltreatment report has been screened in and a case has been assigned to the appropriate child protection response path, a child protection caseworker must make contact with alleged victims and all other relevant parties to assess the immediate safety of alleged victims. The specifics of how those meetings occur, when, and with whom are specific to each case and family. After initial interviews and meetings in both the Family Assessment and Family Investigation response path, child protection caseworkers make an assessment of safety, based both on professional judgement and information provided from a safety assessment tool. If a safety threat is indicated, the caseworker, along with other partners, will determine whether a safety plan can keep a child safe, or if further intervention is warranted, place a child in out-of-home care.

During the assessment or investigation phase, caseworkers also determine the risk of future maltreatment and decide whether child protective services are needed to provide ongoing safety, well-being and permanency. The assessment or investigation phase of all types of child protection responses is 45 days. If child protective services are needed, ongoing case management services are provided to a family through opening child protection case management. At closing of a Family or Facility Investigation, a determination is made as to whether or not maltreatment occurred. At any point during the assessment or investigation phase, if local agency staff feels a child is not safe, they may seek removal and place them in out-of-home care and/or seek a Child in Need of Protection or Services (CHIPS) petition to provide court oversight and monitoring.

Timeliness of face-to-face contact with alleged victims of child maltreatment

- After screening a report, the first step in all child protection responses is to have face-to-face contact with alleged victims of maltreatment to determine if a child is safe or in need of protection. Occasionally, at the time a report is received, a child may already be placed on a 72-hour hold by local law enforcement. Regardless, a child protection caseworker must see all alleged victims in a report.
- There are two response time frames that align with assignment of the child protection response. Allegations that indicate risk of substantial child endangerment or sexual abuse require an Investigation and require local agencies to see all alleged victims within 24 hours.

- The majority of alleged victims did not have allegations that involved substantial child endangerment or sexual abuse (**78.1** percent), therefore, require face-to-face contact within five days. The five-day timeline applies to children named as alleged victims in child protection cases assigned both to the Family Assessment response as well as those assigned to a Family Investigation at the discretion of local agency staff (rather than for mandatory reasons because of severity of current allegation).
- While improvement has been made since 2015, **83.6** percent of victims were seen within the time frames established in statute for face-to-face contact with alleged victims in 2017 (see Figure 16); continued efforts in this area are underway.

Figure 16. Timeliness of face-to-face contact with alleged victims, 2017

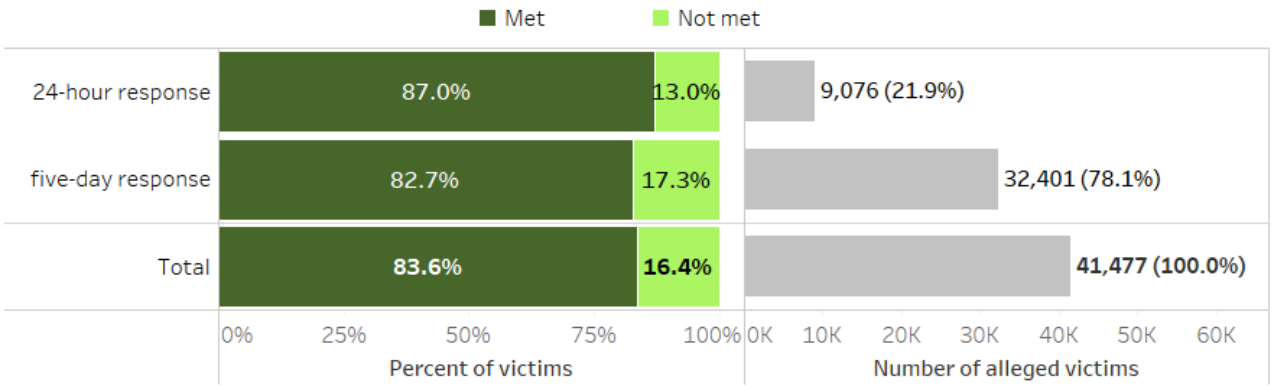
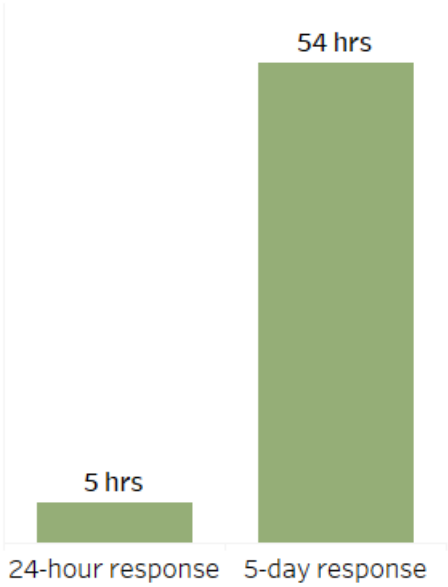


Figure 17. Median time of face-to-face contact by response type



- Despite not meeting the performance standard, the median time of face-to-face contact between a child protection worker and alleged victims with allegations indicating substantial child endangerment was just under **five** hours, and the median time of contact for all other victims was **54** hours (see Figure 17).
- The 2015 Minnesota Legislature passed a bill providing increased funding to local agencies based on the number of families being served to assist agencies in hiring more child protection caseworkers. A percentage of funding is withheld and distributed at the end of the year based in part on a local agencies' performance on timely face-to-face contact with children who are subjects of a maltreatment assessment/ investigation. Funding was first distributed in February 2015 and continued through 2018; recent increases in child protection reports and associated victims has far outpaced increases in funding allocated to social service agencies.

- Both department staff and local child protection agencies recognize the urgent need to improve performance on this measure so all children are seen in a timely manner, ensuring safety for alleged victims of maltreatment in Minnesota.

Assessment of safety and risk

- After making initial contact with alleged victims and the family, a child protection caseworker conducts a formal assessment tool regarding safety.
- A higher percentage of maltreatment cases that are assigned to Family Investigation compared to Family Assessment are rated as unsafe (**16.7** percent vs **3.4** percent; see Figure 18).
- Ratings of conditionally safe require caseworkers to create a safety plan to immediately address safety needs identified in the assessment tool for an alleged victim to remain in their home. Ratings of unsafe indicate removal of a child was necessary to achieve safety.

Figure 18. Number and percent of cases by safety levels and child protection response path

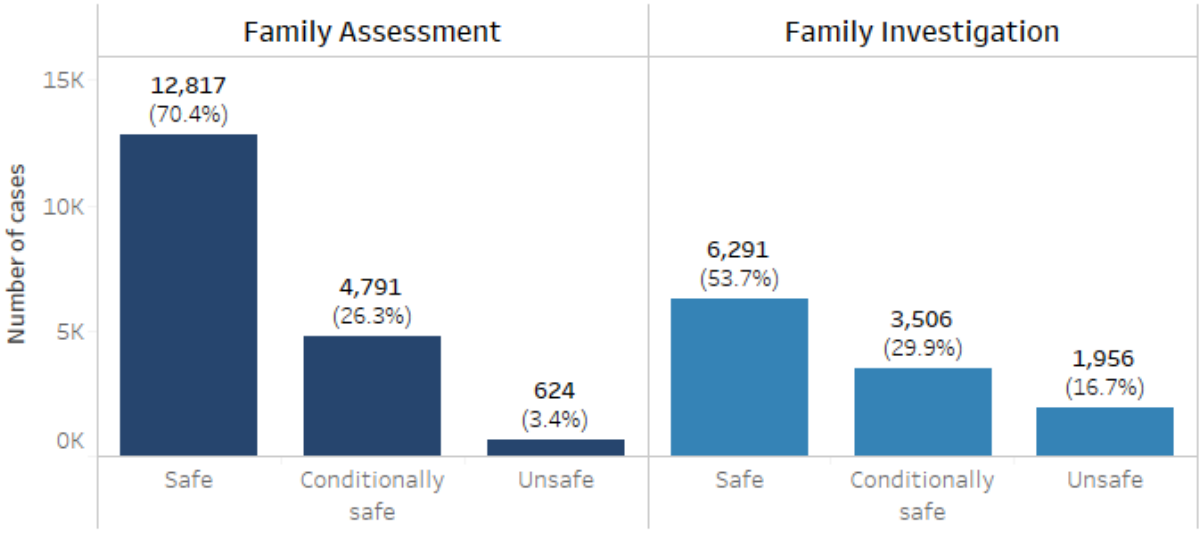
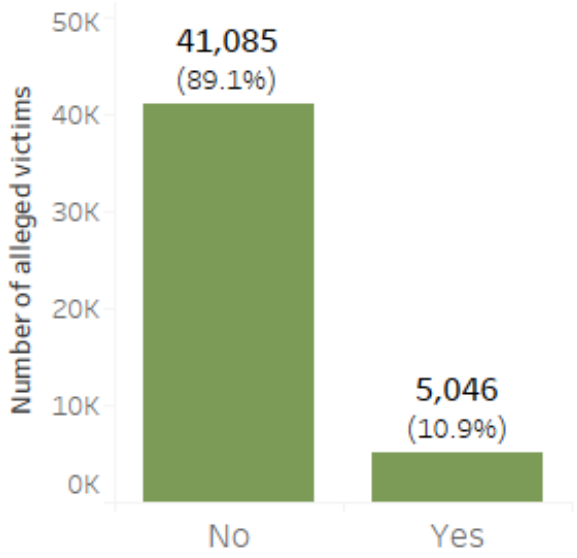
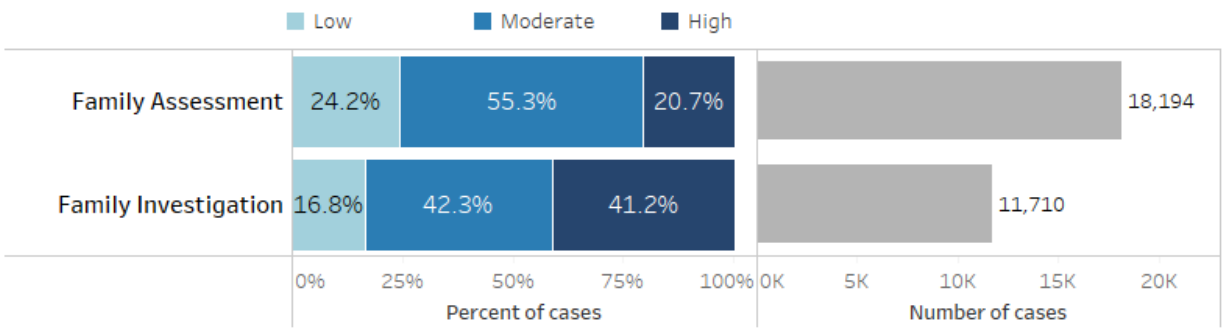


Figure 19. The number and percent of alleged victims who have an out-of-home placement during the assessment or investigation phase



- When a child is found to be in an unsafe situation in which the adult(s) responsible for their care are unable or unwilling to make necessary changes to ensure their safety, a child can be removed by law enforcement or court order from their caregiver and placed in foster care.
- Sometimes removal of a child lasts only a few days, and sometimes they are in care for many months while their families work to ensure they are able to provide for their child's safety and well-being.
- Figure 19 shows a small proportion of all children who were involved in screened in child maltreatment reports in 2017 were placed in out-of-home care during an assessment or investigation (about **11** percent). Children may enter out-of-home care at other times as a result of being maltreated or for other reasons (e.g., children's mental health needs or developmental disabilities). For more information on children in out-of-home care, see **Minnesota's 2017 Out-of-home Care and Permanency report**.
- By the end of an assessment or investigation, child protection caseworkers must also complete a standardized assessment tool of risk of future maltreatment.
- Figure 20 provides information regarding the number of assessments/investigations in which the current situation of alleged victims is at low, moderate or high risk of future maltreatment by child protection response path.
- As expected, a higher percentage of child maltreatment cases assigned to Family Investigations were high risk (**41.2** percent) than reports that were Family Assessments (**20.7** percent).

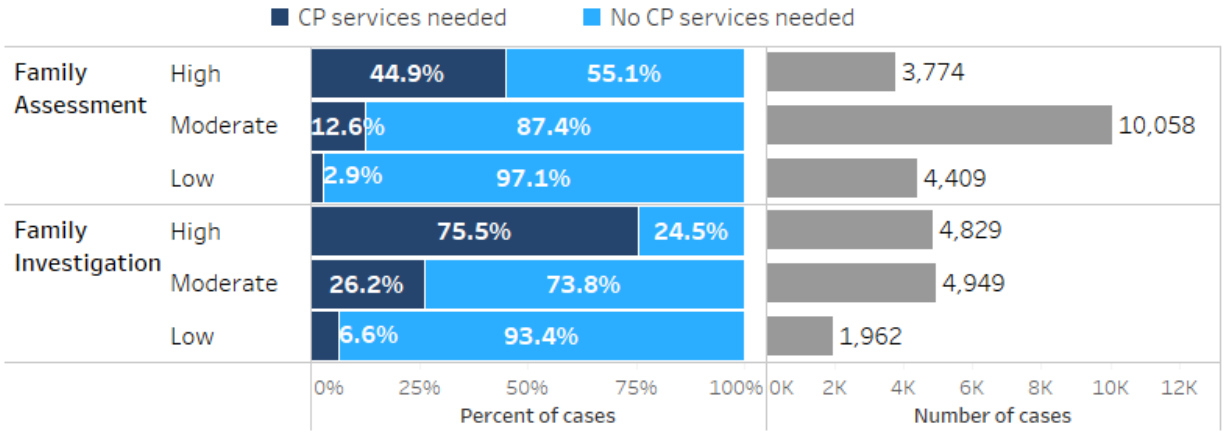
Figure 20. The number and percent of cases by risk assessment level and child protection response path



Assessing the need for ongoing child protection services post-assessment or investigation phase

- At the conclusion of a Family Assessment or Family Investigation, child protection caseworkers indicate whether an alleged victim and/or family needs ongoing child protective services to maintain safety, and promote permanency and well-being.
- Figure 21 provides information regarding whether the need for child protective services was indicated by risk levels identified through the risk assessment completed during the assessment or investigation phase.
- Cases that received a Family Investigation are more likely to indicate a need for post-investigation child protective services at all levels of risk.
- Although cases that are rated as high risk during an assessment or investigative phase were more likely to indicate a need for ongoing child protective services across both response paths, a majority of high risk reports that received a Family Assessment were not indicated as needing ongoing child protective services by caseworkers.
- In 2016, the department revalidated the tool used for risk assessment. This included revisions to some of the item scores used to generate the overall risk level. Department staff will continue to monitor the relationship between risk assessments and the need for child protection case management.

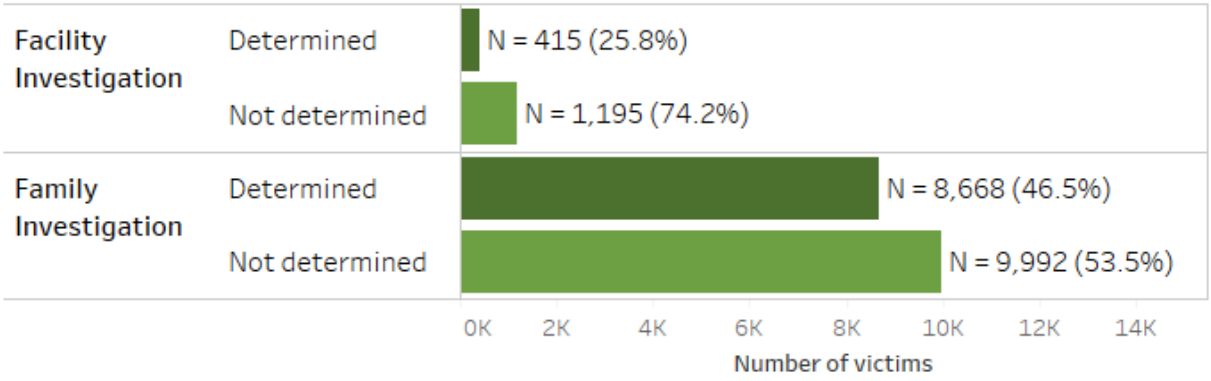
Figure 21. The percent and number of cases where child protective services were indicated by response category and risk level



Determining maltreatment

- For both Family and Facility Investigations, there is a final step at the conclusion of a child maltreatment case that is not made in a Family Assessment. The final step is to make a determination of whether maltreatment occurred based on information gathered during the investigation.
- Figure 22 provides information about the number of determined reports and victims by Family or Facility Investigation. There were **8,668** children in Family Investigations and **415** in Facility Investigations who had a maltreatment determination in 2017.
- For less than half of all victims in reports that were in either type of investigation, there was a determination that maltreatment occurred (**44.8** percent). However, the pattern is different for Facility and Family Investigations, with about **one quarter** of all victims in Facility Investigations, and just under **half** of victims in Family Investigations having a determination.

Figure 22. The number of determined victims by Family Investigation and Facility Investigation response paths



Relationship of alleged offenders to alleged victims in completed assessments/ investigations by determination

- The overwhelming majority of alleged and determined offenders in child maltreatment cases were biological parents (see Table 2 below).
- Parents, unmarried partners of parents, and step-parents had the highest rate of being determined to have maltreated a child.
- Non-relative foster parents had the lowest determination rate, at **18.1** percent.
- There were **32** alleged offenders who had a relationship status entered in the data system that indicated they should have had an investigation but seem to have received a Family Assessment response. Upon review, this appears to be data entry errors in documentation of relationships, rather than inappropriate assignment of these cases to a Family Assessment response. There were fewer errors in 2017 than in previous years.

Table 2. Number of alleged offenders by relationship to alleged victims, and percent child protection response and determination status in 2017

Offender relationship	Family Assessment	Investigations	Investigations determined	Percent determined
Unmarried partner of parent	1,174	1,257	677	53.9%
Biological parent	16,605	9,810	5,196	53.0%
Unknown or missing	45	48	22	45.8%
Other	164	476	215	45.2%
Legal guardian	286	221	97	43.9%
Step-parent	767	536	232	43.3%
Friends or neighbors	47	84	35	41.7%
Other relative (non-foster parent)	483	766	318	41.5%
Non-caregiver sex trafficker	7	10	4	40.0%
Child daycare provider	15	204	79	38.7%
Sibling	215	680	249	36.6%
Adoptive parent	264	194	59	30.4%
Group home or residential facility staff	3	51	15	29.4%
Other professionals	1	21	6	28.6%
Relative foster parent	10	255	63	24.7%
Non-relative foster parent	3	260	47	18.1%

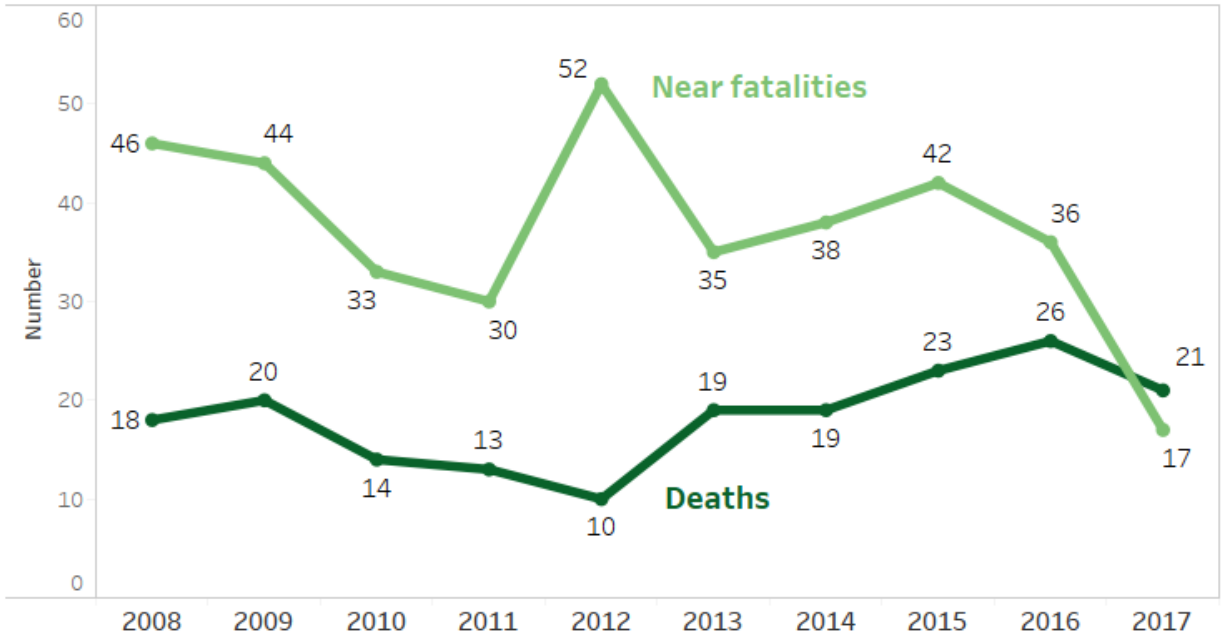
Child fatalities and near fatalities due to maltreatment

Local social service agencies and department staff take the work of protecting children very seriously. In 2016, in response to recommendations from the Governor's Task Force on the Protection of Children and the final report from the National Commission to Eliminate Child Abuse and Neglect Fatalities, department staff began working with Collaborative Safety, LLC, to implement a trauma-informed, robust and scientific systemic critical incident review process for child fatalities and near fatalities due to maltreatment. The review process is designed to systemically analyze the child welfare system to identify opportunities for improvement, as well as address barriers to providing the best possible services to children and families. The model utilizes components from the same science used by other safety-critical industries, including aviation and health care; it moves away from blame and toward a system of accountability that focuses on identifying underlying systemic issues to improve Minnesota's child welfare system.

The Department began utilizing this new review process in 2017 in partnership with local agency staff and community partners. A significant component of the department's work with Collaborative Safety over the past year has involved creating, advancing, and supporting development of a safety culture within Minnesota's child welfare system. This approach has been shown to improve staff engagement and retention, and improve outcomes for children and families. The first step towards building a safety culture in Minnesota that will support learning after critical incidents and prevention of future incidents included training more than 1600 individuals statewide over the past year to provide information about safety science and the critical incident review process. This included training department leadership, county and tribal agency leaders, frontline staff and other child welfare partners.

- Figure 23 provides trend information regarding both near fatalities and deaths that were determined to be a result of maltreatment from 2008 to 2017.
- There were **21** deaths and **17** near fatalities determined to be a result of maltreatment in 2017.
- The reduction in near fatality numbers in 2017 may be attributed to a number of factors. Language used to categorize these types of cases has changed from "Life threatening" to "Near fatality." This change was made to coincide with a Near Fatality Tip Sheet created by the department to assist agencies in determining whether a child's injury met established criteria. In addition, department staff worked with agencies statewide to ensure that coding is accurate and consistent. As a result of this effort, some cases were re-coded from "Near fatality" to something less severe (e.g., serious injury, moderate injury, etc.) as injuries in those cases did not meet criteria for near fatality.

Figure 23. Victims who died or had a near fatality as a result of maltreatment, 2008 – 2017



- Tables 3 and 4 provide detailed information about victims who died as a result of maltreatment in 2017. Table 3 provides information on victims who died as a result of maltreatment and had at least one prior screened in maltreatment report; Table 4 provides information on victims who died and had no known prior involvement in a screened in child maltreatment report.
- There are often a number of months, and sometimes longer, between when a determination is finalized and when a death occurred. The delay often results from needing to wait until criminal investigations are completed before making a determination. The tables provide information about when a death occurred; in all cases, the final determination about whether a death was a result of maltreatment was not made until 2017, which is why it is included in the 2017 report.
- Other information included in the table are age at time of death, gender, and the type of maltreatment that resulted in death.
- Of the **21** children whose deaths were determined to be a result of maltreatment in 2017, **seven children** had been involved in prior screened in child protection reports, and **14** had not.

Table 3. Details regarding deaths that were determined to be a result of maltreatment in 2017, where children had a prior child protection history

Year of death	Age and gender	Type of maltreatment
2015	7 years old, male	Neglect
2016	8 years old, female	Physical abuse
2016	6 years old, male	Neglect
2016	Less than 1 year old, female	Neglect
2017	Less than 1 year old, female	Neglect, physical abuse
2017	Less than 1 year old, male	Neglect
2017	Less than 1 year old, female	Neglect

Table 4. Details regarding deaths determined to be a result of maltreatment in 2017, where children had no prior child protection history

Year of death	Age and gender	Type of maltreatment
2016	13 years old, male	Physical abuse
2016	10 years old, female	Physical abuse
2016	Less than 1 year old, female	Neglect
2016	Less than 1 year old, female	Physical abuse
2016	Less than 1 year old, female	Physical abuse
2016	Less than 1 year old, female	Physical abuse
2017	5 years old, male	Threatened injury
2017	2 years old, male	Neglect, physical abuse
2017	3 years old, male	Physical abuse
2017	1 year old, male	Physical abuse
2017	Less than 1 year old, male	Physical abuse
2017	Less than 1 year old, male	Neglect, physical abuse
2017	1 year old, male	Neglect, physical abuse
2017	Less than 1 year old, female	Neglect, threatened injury

Outcomes after child maltreatment assessments/investigations have concluded

To determine how successful child protection is in assessing the needs of children and families and providing appropriate services to meet those needs, local agency and Child Safety and Permanency Division staff monitor whether children who were alleged or determined victims in child maltreatment reports have another occurrence of being an alleged or determined victim in a screened in maltreatment report within 12 months.

Re-reporting alleged victims

- Table 5 provides information on how many alleged victims in screened in maltreatment reports in 2017 had another screened in maltreatment report within 12 months of the first report by child protection response path.

Table 5. The number and percent of alleged victims with a re-report of maltreatment within 12 months by child protection response path in 2017

Response path	Total number of victims	Victims who had a re-report	Percent of victims with a re-report
Family Assessment	23,571	4,660	19.8%
Family Investigation	15,175	3,227	21.3%
Facility Investigation	1,120	180	16.1%
Total across response path	**39,862**	**8,063**	**20.2%**

Recurrence of maltreatment determinations

- Table 6 provides information on how many children, by race, who were determined victims of maltreatment in 2016 had another maltreatment determination within 12 months of the first determination.
- Maltreatment recurrence is a federal performance measure that is examined annually by the Children's Bureau. It sets a federal performance standard that Minnesota must meet or face the possibility of a performance improvement plan with fiscal penalties. In 2015, the Children's Bureau revised the federal maltreatment performance indicator to follow victims with a determination for 12 months instead of six months following their initial determination. The new federal performance standard for recurrence requires that less than **9.1** percent of children have a maltreatment determination recurrence within 12 months.
- Minnesota met the maltreatment recurrence standard in 2017, with **8.9** percent of all children having a maltreatment determination. This is up from 8.2 in 2016.
- The recurrence rate for African-American/Black, American Indian, and children of two or more races is noticeably higher than recurrence for both white and Asian/Pacific Islander children.

Table 6. The number and percent of victims with a maltreatment determination recurrence within 12 months by race in 2017

Race/ethnicity	Determined victims	Determined victims with maltreatment recurrence within 12 months	Percent with maltreatment recurrence
African-American/Black	1,982	224	11.3%
American Indian	755	92	12.2%
Asian/Pacific Islander	272	14	5.1%
Unknown/declined	230	14	6.1%
Two or more races	1286	157	12.2%
White	3,892	252	6.5%
Total	**8,417**	**753**	**8.9%**
Hispanic (any race)	990	94	9.5%

Child maltreatment appendix

Table 7. Number and percent of child maltreatment reports by screening status and agency, 2017

Agency	Total child maltreatment reports received in 2017	Number of screened in reports	Number of screened out reports	Percent of reports screened in	Percent of reports screened out
Aitkin	210	104	106	49.5	50.5
Anoka	3,609	1,496	2,113	41.5	58.5
Becker	714	300	414	42.0	58.0
Beltrami	938	462	476	49.3	50.7
Benton	689	185	504	26.9	73.1
Big Stone	59	24	35	40.7	59.3
Blue Earth	1,108	369	739	33.3	66.7
Brown	526	205	321	39.0	61.0
Carlton	931	443	488	47.6	52.4
Carver	793	376	417	47.4	52.6
Cass	412	206	206	50.0	50.0
Chippewa	74	50	24	67.6	32.4
Chisago	908	319	589	35.1	64.9
Clay	1,735	498	1,237	28.7	71.3
Clearwater	245	136	109	55.5	44.5
Cook	108	46	62	42.6	57.4
Crow Wing	1,177	244	933	20.7	79.3
Dakota	4,810	1,917	2,893	39.9	60.1
Douglas	774	354	420	45.7	54.3
Fillmore	187	87	100	46.5	53.5
Freeborn	644	223	421	34.6	65.4
Goodhue	724	291	433	40.2	59.8
Grant	217	108	109	49.8	50.2
Hennepin	17,405	10,313	7,092	59.3	40.7
Houston	242	100	142	41.3	58.7
Hubbard	540	319	221	59.1	40.9

Agency	Total child maltreatment reports received in 2017	Number of screened in reports	Number of screened out reports	Percent of reports screened in	Percent of reports screened out
Isanti	857	217	640	25.3	74.7
Itasca	1,117	534	583	47.8	52.2
Kanabec	349	139	210	39.8	60.2
Kandiyohi	793	268	525	33.8	66.2
Kittson	41	14	27	34.1	65.9
Koochiching	330	112	218	33.9	66.1
Lac qui Parle	87	38	49	43.7	56.3
Lake	122	67	55	54.9	45.1
Lake of the Woods	40	24	16	60.0	40.0
Le Sueur	682	267	415	39.1	60.9
McLeod	695	253	442	36.4	63.6
Mahnomen	93	36	57	38.7	61.3
Marshall	121	42	79	34.7	65.3
Meeker	361	128	233	35.5	64.5
Mille Lacs	1,237	360	877	29.1	70.9
Morrison	659	145	514	22.0	78.0
Mower	873	338	535	38.7	61.3
Nicollet	470	191	279	40.6	59.4
Nobles	349	88	261	25.2	74.8
Norman	160	54	106	33.8	66.3
Olmsted	1,527	667	860	43.7	56.3
Otter Tail	843	471	372	55.9	44.1
Pennington	174	98	76	56.3	43.7
Pine	1,251	374	877	29.9	70.1
Polk	636	211	425	33.2	66.8
Pope	214	121	93	56.5	43.5
Ramsey	6,171	2,759	3,412	44.7	55.3
Red Lake	37	20	17	54.1	45.9
Renville	304	108	196	35.5	64.5

Agency	Total child maltreatment reports received in 2017	Number of screened in reports	Number of screened out reports	Percent of reports screened in	Percent of reports screened out
Rice	1,203	322	881	26.8	73.2
Roseau	106	52	54	49.1	50.9
St. Louis	3,773	2,419	1,354	64.1	35.9
Scott	1,838	762	1,076	41.5	58.5
Sherburne	1,403	503	900	35.9	64.1
Sibley	262	156	106	59.5	40.5
Stearns	1,878	809	1,069	43.1	56.9
Stevens	186	97	89	52.2	47.8
Swift	311	93	218	29.9	70.1
Todd	480	113	367	23.5	76.5
Traverse	112	50	62	44.6	55.4
Wabasha	266	116	150	43.6	56.4
Wadena	474	227	247	47.9	52.1
Washington	2,120	847	1,273	40.0	60.0
Watonwan	172	63	109	36.6	63.4
Wilkin	168	65	103	38.7	61.3
Winona	1,126	486	640	43.2	56.8
Wright	2,330	744	1,586	31.9	68.1
Yellow Medicine	223	104	119	46.6	53.4
Southwest HHS	1,697	745	952	43.9	56.1
Des Moines Valley HHS	563	200	363	35.5	64.5
Faribault-Martin	651	320	331	49.2	50.8
Leech Lake Band of Ojibwe	583	247	336	42.4	57.6
White Earth Nation	437	342	95	78.3	21.7
MN Prairie	1,414	535	879	37.8	62.2
Minnesota	**84,148**	**37,736**	**46,412**	**44.8**	**55.2**

Table 8. Number of completed maltreatment assessments/investigations by response path and agency, 2017

Agency	Family Assessment	Family Investigation	Facility Investigation	Total reports
Aitkin	75	17	3	95
Anoka	765	506	26	1,297
Becker	140	144	8	292
Beltrami	139	222	12	373
Benton	99	61	3	163
Big Stone	17	7	0	24
Blue Earth	321	58	11	390
Brown	142	27	2	171
Carlton	169	113	26	308
Carver	257	71	4	332
Cass	56	70	5	131
Chippewa	28	16	1	45
Chisago	142	111	9	262
Clay	264	75	14	353
Clearwater	39	47	3	89
Cook	32	8	2	42
Crow Wing	160	50	13	223
Dakota	1,085	707	25	1,817
Douglas	138	128	11	277
Fillmore	71	4	0	75
Freeborn	115	40	1	156
Goodhue	123	42	7	172
Grant	40	43	2	85
Hennepin	3,566	4,294	297	8,157
Houston	58	11	2	71
Hubbard	214	94	11	319
Isanti	133	42	5	180
Itasca	159	115	25	299

Agency	Family Assessment	Family Investigation	Facility Investigation	Total reports
Kanabec	71	62	3	136
Kandiyohi	89	88	2	179
Kittson	7	5	0	12
Koochiching	71	21	1	93
Lac qui Parle	25	12	1	38
Lake	24	9	2	35
Lake of the Woods	18	3	1	22
Le Sueur	139	41	1	181
McLeod	102	122	2	226
Mahnomen	26	9	0	35
Marshall	27	12	2	41
Meeker	89	32	3	124
Mille Lacs	156	143	17	316
Morrison	87	42	4	133
Mower	210	84	3	297
Nicollet	143	21	1	165
Nobles	62	14	1	77
Norman	27	12	3	42
Olmsted	513	100	6	619
Otter Tail	201	180	3	384
Pennington	47	40	4	91
Pine	154	125	15	294
Polk	117	49	4	170
Pope	40	43	6	89
Ramsey	1,328	947	68	2,343
Red Lake	14	2	1	17
Renville	57	39	7	103
Rice	224	79	3	306
Roseau	39	9	2	50
St. Louis	1,230	643	82	1,955
Scott	479	139	14	632

Agency	Family Assessment	Family Investigation	Facility Investigation	Total reports
Sherburne	307	154	14	475
Sibley	52	64	2	118
Stearns	404	193	25	622
Stevens	76	18	2	96
Swift	36	36	3	75
Todd	70	12	3	85
Traverse	21	21	0	42
Wabasha	80	20	1	101
Wadena	138	49	5	192
Washington	456	206	25	687
Watonwan	49	18	1	68
Wilkin	43	12	2	57
Winona	165	51	10	226
Wright	390	186	15	591
Yellow Medicine	68	25	2	95
Southwest HHS	392	201	23	616
Des Moines Valley HHS	128	42	4	174
Faribault-Martin	174	88	1	263
Leech Lake Band of Ojibwe	237	11	11	259
White Earth Nation	226	22	33	281
MN Prairie	337	58	6	401
Minnesota	**18,212**	**11,737**	**978**	**30,927**

Table 9. Number of alleged victims in completed assessments/investigations by maltreatment type and rate per 1,000 children by agency, 2017

Agency	Medical neglect	Threatened injury	Neglect	Sexual abuse	Mental injury	Physical abuse	Total alleged victims*	Child pop. est. (2016)	Rate per 1,000
Aitkin	1	5	91	17	2	34	127	2,630	48.3
Anoka	3	35	1,038	181	15	567	1,664	83,398	20
Becker	0	17	257	69	20	152	393	8,207	47.9
Beltrami	1	23	456	56	5	120	593	11,651	50.9
Benton	1	20	120	19	9	66	207	9,882	20.9
Big Stone	0	1	12	9	1	12	29	1,042	27.8
Blue Earth	0	18	336	56	4	111	474	13,013	36.4
Brown	0	10	139	23	27	71	216	5,563	38.8
Carlton	4	20	315	49	36	163	428	8,085	52.9
Carver	0	34	228	45	26	186	437	27,384	16
Cass	1	11	101	26	25	60	159	6,190	25.7
Chippewa	0	5	41	12	0	20	73	2,781	26.2
Chisago	1	12	188	48	7	98	317	12,543	25.3
Clay	0	55	291	56	14	177	496	15,053	33
Clearwater	0	8	95	27	16	29	131	2,194	59.7
Cook	0	0	34	3	8	14	52	820	63.4
Crow Wing	0	19	199	59	36	121	324	13,965	23.2
Dakota	2	43	1,435	212	7	605	2,143	102,983	20.8
Douglas	1	13	247	63	34	114	354	7,982	44.3
Fillmore	0	2	28	4	0	51	83	5,095	16.3
Freeborn	0	6	134	33	3	85	220	6,621	33.2
Goodhue	0	11	143	32	0	67	221	10,466	21.1
Grant	1	5	62	8	7	31	87	1,360	64
Hennepin	9	590	5,970	1,588	276	4,737	10,241	273,089	37.5
Houston	0	0	50	11	1	32	82	4,065	20.2
Hubbard	1	21	271	46	27	144	403	4,407	91.4

Agency	Medical neglect	Threatened injury	Neglect	Sexual abuse	Mental injury	Physical abuse	Total alleged victims*	Child pop. est. (2016)	Rate per 1,000
Isanti	0	7	154	35	8	92	249	9,312	26.7
Itasca	1	13	297	74	8	134	424	9,563	44.3
Kanabec	0	15	101	25	15	64	166	3,394	48.9
Kandiyohi	0	11	176	48	6	88	261	10,193	25.6
Kittson	0	0	15	3	2	7	22	925	23.8
Koochiching	0	2	63	7	6	17	88	2,350	37.4
Lac qui Parle	0	5	31	7	3	10	50	1,322	37.8
Lake	0	0	36	6	0	14	50	1,947	25.7
Lake of the Woods	0	0	21	2	0	11	28	687	40.8
Le Sueur	0	12	128	23	10	87	213	6,623	32.2
McLeod	0	9	223	35	10	82	328	8,379	39.1
Mahnomen	0	3	21	8	1	13	35	1,710	20.5
Marshall	0	9	41	20	0	17	64	2,124	30.1
Meeker	2	14	70	27	0	54	146	5,612	26
Mille Lacs	1	9	306	90	16	137	463	6,180	74.9
Morrison	0	4	98	50	4	50	186	7,732	24.1
Mower	0	3	245	66	7	101	361	9,793	36.9
Nicollet	0	8	120	22	29	57	200	7,425	26.9
Nobles	0	2	51	15	3	46	107	5,842	18.3
Norman	0	3	32	10	3	14	57	1,511	37.7
Olmsted	0	11	545	86	13	212	820	37,756	21.7
Otter Tail	1	11	306	44	40	150	436	12,591	34.6
Pennington	0	7	94	13	4	47	137	3,291	41.6
Pine	0	14	259	85	8	132	415	5,799	71.6
Polk	0	10	169	33	3	47	234	7,543	31
Pope	0	9	67	13	8	43	108	2,292	47.1
Ramsey	0	423	1,807	353	25	825	3,106	126,468	24.6
Red Lake	0	0	16	1	0	4	21	983	21.4
Renville	0	5	113	12	9	43	148	3,248	45.6
Rice	0	15	220	48	0	204	428	14,302	29.9

Agency	Medical neglect	Threatened injury	Neglect	Sexual abuse	Mental injury	Physical abuse	Total alleged victims*	Child pop. est. (2016)	Rate per 1,000
Roseau	0	1	54	7	0	10	71	3,792	18.7
St. Louis	1	118	1,492	250	39	877	2,315	38,252	60.5
Scott	0	18	397	113	11	265	729	40,371	18.1
Sherburne	2	20	341	99	49	254	645	25,074	25.7
Sibley	0	1	99	23	1	54	153	3,509	43.6
Stearns	0	36	520	92	14	249	781	35,620	21.9
Stevens	0	10	78	23	4	40	106	2,037	52
Swift	0	2	70	3	4	41	107	2,150	49.8
Todd	0	1	92	14	0	25	127	5,783	22
Traverse	0	6	46	7	3	25	63	686	91.8
Wabasha	0	1	59	16	1	43	116	4,693	24.7
Wadena	1	3	187	46	6	81	253	3,355	75.4
Washington	0	17	456	145	13	396	888	62,865	14.1
Watonwan	0	6	30	11	0	27	70	2,622	26.7
Wilkin	0	6	36	4	2	19	61	1,420	43
Winona	0	11	178	34	46	106	291	9,300	31.3
Wright	2	19	456	73	51	363	789	37,621	21
Yellow Medicine	0	11	85	12	8	32	119	2,289	52
Southwest HHS	2	53	480	107	34	267	759	18,037	42.1
Des Moines Valley HHS	0	13	149	43	8	58	234	4,929	47.5
Faribault-Martin	0	10	255	39	1	99	370	7,349	50.3
Leech Lake Band of Ojibwe†	11	1	295	31	1	43	344	1,975	174.2
White Earth Nation†	1	4	365	12	5	72	411	1,981	207.5
MN Prairie	2	11	309	44	12	174	499	19,213	26
Minnesota	**53**	**1,997**	**24,635**	**5,261**	**1,160**	**14,289**	**39,606**	**1,288,333**	**30.7**

† The data for these two groups are 2010 Census numbers which represent children residing on the Leech Lake and White Earth reservations who indicated American Indian alone or as one of two or more races. There are no intercensal child population estimates for these groups. The Leech Lake reservation overlaps Cass, Itasca, Beltrami and Hubbard counties. The White Earth reservation overlaps Mahnomen, Becker, and Clearwater counties.

* Total unique victims can be less than the sum of victims in all maltreatment types as a child could be represented in multiple maltreatment types.

Table 10. Number of alleged victims by age group and by agency, 2017

Agency	Birth – 2	3 – 5	6 – 8	9 – 11	12 – 14	15 – 17	18 and older
Aitkin	32	25	20	18	27	7	0
Anoka	373	308	375	288	176	154	0
Becker	100	74	65	70	59	34	0
Beltrami	149	117	109	94	74	55	0
Benton	54	37	40	31	23	23	0
Big Stone	6	7	7	4	3	2	0
Blue Earth	118	111	100	96	45	20	0
Brown	36	43	44	35	28	31	0
Carlton	81	79	82	91	60	42	0
Carver	66	76	101	87	61	52	0
Cass	26	25	27	41	30	13	0
Chippewa	16	15	17	15	6	4	0
Chisago	63	60	56	63	48	29	0
Clay	123	105	106	81	67	26	0
Clearwater	24	31	25	24	17	12	0
Cook	14	12	10	9	5	3	0
Crow Wing	101	55	52	48	34	37	1
Dakota	387	349	510	380	292	248	0
Douglas	75	79	68	53	50	38	0
Fillmore	12	16	10	19	17	10	0
Freeborn	59	43	36	31	35	19	0
Goodhue	63	47	42	34	24	12	0
Grant	16	15	22	12	13	9	0
Hennepin	2,312	1,793	2,011	1,775	1,344	1,180	2
Houston	23	20	17	7	10	7	0
Hubbard	75	68	75	84	67	43	0
Isanti	53	53	50	49	27	20	0
Itasca	84	87	80	68	69	44	1

Agency	Birth – 2	3 – 5	6 – 8	9 – 11	12 – 14	15 – 17	18 and older
Kanabec	35	41	27	27	17	19	0
Kandiyohi	77	43	47	34	37	23	0
Kittson	2	2	3	9	2	4	0
Koochiching	17	18	17	18	15	6	0
Lac qui Parle	5	10	13	13	4	5	0
Lake	10	6	9	9	8	8	0
Lake of the Woods	7	5	5	6	3	3	0
Le Sueur	51	39	39	31	32	24	0
McLeod	72	59	70	56	51	22	0
Mahnomen	9	8	6	1	6	6	0
Marshall	17	17	11	9	5	6	0
Meeker	39	16	26	27	21	21	0
Mille Lacs	115	97	84	75	61	38	0
Morrison	45	44	40	28	16	14	0
Mower	72	72	70	80	44	29	0
Nicollet	28	48	33	44	29	18	0
Nobles	12	26	22	18	17	13	0
Norman	14	10	16	8	8	1	0
Olmsted	196	160	154	135	88	95	1
Otter Tail	105	88	88	67	58	40	0
Pennington	41	32	27	20	13	5	0
Pine	89	62	80	82	66	47	0
Polk	60	51	51	45	23	7	0
Pope	12	29	22	25	13	9	0
Ramsey	770	491	636	548	364	319	0
Red Lake	6	6	2	2	4	1	0
Renville	29	34	25	23	27	11	0
Rice	102	71	91	81	45	47	0
Roseau	14	16	15	12	10	4	0
St. Louis	584	446	447	408	287	193	2
Scott	162	137	149	116	95	80	0

Agency	Birth – 2	3 – 5	6 – 8	9 – 11	12 – 14	15 – 17	18 and older
Sherburne	125	85	143	113	110	76	0
Sibley	25	27	25	33	24	21	0
Stearns	171	164	136	126	112	79	0
Stevens	14	20	23	21	19	14	0
Swift	24	25	16	19	14	10	0
Todd	26	32	22	22	18	8	0
Traverse	15	19	10	7	11	3	0
Wabasha	25	27	21	23	14	8	0
Wadena	49	46	43	53	43	22	0
Washington	176	166	174	149	138	92	0
Watonwan	7	14	17	17	5	10	0
Wilkin	11	18	9	9	9	5	0
Winona	66	64	62	44	33	25	0
Wright	126	139	165	151	115	106	0
Yellow Medicine	35	18	22	22	14	11	0
Southwest HHS	151	153	166	124	100	74	0
Des Moines Valley HHS	50	57	53	30	27	20	0
Faribault-Martin	91	67	64	67	39	42	0
Leech Lake Band of Ojibwe	81	62	86	78	37	12	0
White Earth Nation	110	81	82	54	54	37	0
MN Prairie	103	89	107	92	68	47	0
Minnesota	**8,819**	**7,307**	**7,928**	**6,918**	**5,184**	**4,014**	**7**

Note: Some victims may be involved in more than one report during the report period.

Table 11. Number of alleged victims by race, ethnicity, and agency, 2017

Agency	African-American/ Black	American Indian	Asian/ Pacific Islander	Two or more races	Unknown/ declined	White	Total alleged victims	Hispanic (any race)
Aitkin	*	32	*	*	*	85	127	*
Anoka	281	28	39	191	87	1,038	1,664	130
Becker	15	73	*	57	*	240	393	21
Beltrami	12	374	*	41	*	158	593	16
Benton	22	*	*	31	*	145	207	9
Big Stone	*	*	*	*	*	25	29	*
Blue Earth	82	14	*	62	*	288	474	46
Brown	*	*	*	*	13	191	216	31
Carlton	*	134	*	66	*	221	428	*
Carver	57	8	*	46	*	302	437	54
Cass	*	14	*	*	12	126	159	*
Chippewa	*	7	*	7	*	56	73	14
Chisago	*	*	*	34	24	250	317	14
Clay	42	59	*	78	*	314	496	88
Clearwater	*	22	*	11	7	89	131	*
Cook	*	16	*	11	*	24	52	*
Crow Wing	*	20	*	25	*	272	324	*
Dakota	347	42	41	307	276	1,130	2,143	326
Douglas	19	*	*	30	9	290	354	11
Fillmore	*	*	*	*	*	78	83	*
Freeborn	9	*	*	12	10	182	220	51
Goodhue	16	*	*	18	*	175	221	19
Grant	*	*	*	*	*	76	87	8
Hennepin	4,361	544	365	1,761	321	2,889	10,241	1,433
Houston	*	*	*	*	10	64	82	*
Hubbard	8	50	*	45	*	297	403	13
Isanti	*	*	*	24	*	212	249	*
Itasca	7	49	*	53	*	310	424	*

Agency	African-American/ Black	American Indian	Asian/ Pacific Islander	Two or more races	Unknown/ declined	White	Total alleged victims	Hispanic (any race)
Kanabec	*	*	*	8	9	147	166	*
Kandiyohi	15	*	7	9	*	224	261	95
Kittson	*	*	*	*	*	22	22	*
Koochiching	*	*	*	*	*	80	88	*
Lac qui Parle	*	*	*	*	*	40	50	9
Lake	*	*	*	*	*	43	50	*
Lake of the Woods	*	*	*	*	*	21	28	*
Le Sueur	*	*	*	16	10	179	213	37
McLeod	*	*	*	19	*	292	328	62
Mahnomen	*	16	*	*	*	14	35	*
Marshall	*	*	*	*	*	51	64	8
Meeker	*	*	*	*	*	130	146	16
Mille Lacs	10	155	*	37	*	229	463	16
Morrison	*	*	*	32	*	140	186	7
Mower	48	*	17	33	*	254	361	68
Nicollet	25	*	*	17	7	151	200	27
Nobles	9	*	*	*	11	74	107	46
Norman	*	8	*	*	*	42	57	12
Olmsted	114	*	37	130	*	537	820	116
Otter Tail	17	11	*	32	*	346	436	20
Pennington	7	*	*	13	*	114	137	21
Pine	9	69	*	29	*	287	415	9
Polk	7	10	*	19	*	194	234	69
Pope	*	*	*	7	*	97	108	*
Ramsey	1,194	115	362	412	101	922	3,106	366
Red Lake	*	*	*	*	*	18	21	*
Renville	*	*	*	10	*	131	148	25
Rice	44	*	*	31	78	269	428	88
Roseau	7	*	*	11	*	45	71	*
St. Louis	241	298	*	309	*	1,409	2,315	70

Agency	African-American/ Black	American Indian	Asian/ Pacific Islander	Two or more races	Unknown/ declined	White	Total alleged victims	Hispanic (any race)
Scott	72	18	22	85	44	488	729	86
Sherburne	51	*	*	83	85	419	645	24
Sibley	*	*	*	13	8	132	153	46
Stearns	149	9	*	70	*	530	781	46
Stevens	*	10	*	*	*	81	106	16
Swift	14	*	*	15	*	77	107	21
Todd	*	*	*	8	*	114	127	11
Traverse	*	28	*	*	*	32	63	*
Wabasha	16	*	*	*	8	85	116	*
Wadena	12	*	*	23	7	205	253	*
Washington	94	19	31	114	199	431	888	77
Watonwan	*	*	*	*	*	69	70	43
Wilkin	*	9	*	7	*	45	61	*
Winona	28	*	*	27	14	218	291	19
Wright	49	8	7	51	30	644	789	32
Yellow Medicine	*	28	*	23	*	63	119	14
Southwest HHS	19	52	17	86	57	528	759	109
Des Moines Valley HHS	*	*	10	12	11	198	234	30
Faribault-Martin	*	*	*	34	9	319	370	58
Leech Lake Band of Ojibwe	*	330	*	13	*	*	344	7
White Earth Nation	*	380	*	31	*	*	411	10
MN Prairie	51	*	*	45	*	394	499	64
Minnesota	**7,659**	**3,157**	**1,014**	**4,902**	**1,772**	**21,102**	**39,606**	**4,253**

* The number of children is omitted to prevent identification of individuals. Totals include the omitted data.

Table 12. Number of alleged and determined victims in completed assessments/ investigations and rate per 1,000 children by agency, 2017

Agency	Unique alleged victims	Unique determined victims	Child pop. est. (2016)	Determined victims per 1,000
Aitkin	127	24	2,630	9.1
Anoka	1,664	349	83,398	4.2
Becker	393	123	8,207	15.0
Beltrami	593	247	11,651	21.2
Benton	207	56	9,882	5.7
Big Stone	29	5	1,042	4.8
Blue Earth	474	33	13,013	2.5
Brown	216	16	5,563	2.9
Carlton	428	107	8,085	13.2
Carver	437	49	27,384	1.8
Cass	159	38	6,190	6.1
Chippewa	73	20	2,781	7.2
Chisago	317	68	12,543	5.4
Clay	496	30	15,053	2.0
Clearwater	131	39	2,194	17.8
Cook	52	9	820	11.0
Crow Wing	324	32	13,965	2.3
Dakota	2,143	330	102,983	3.2
Douglas	354	135	7,982	16.9
Fillmore	83	2	5,095	0.4
Freeborn	220	50	6,621	7.6
Goodhue	221	59	10,466	5.6
Grant	87	17	1,360	12.5
Hennepin	10,241	3,210	273,089	11.8
Houston	82	1	4,065	0.2
Hubbard	403	37	4,407	8.4
Isanti	249	44	9,312	4.7
Itasca	424	55	9,563	5.8
Kanabec	166	44	3,394	13.0
Kandiyohi	261	77	10,193	7.6
Kittson	22	1	925	1.1
Koochiching	88	17	2,350	7.2
Lac qui Parle	50	6	1,322	4.5
Lake	50	11	1,947	5.6
Lake of the Woods	28	4	687	5.8
Le Sueur	213	23	6,623	3.5
McLeod	328	61	8,379	7.3
Mahnomen	35	5	1,710	2.9
Marshall	64	8	2,124	3.8
Meeker	146	13	5,612	2.3
Mille Lacs	463	69	6,180	11.2
Morrison	186	53	7,732	6.9
Mower	361	63	9,793	6.4
Nicollet	200	15	7,425	2.0

Agency	Unique alleged victims	Unique determined victims	Child pop. est. (2016)	Determined victims per 1,000
Nobles	107	8	5,842	1.4
Norman	57	6	1,511	4.0
Olmsted	820	32	37,756	0.8
Otter Tail	436	87	12,591	6.9
Pennington	137	18	3,291	5.5
Pine	415	70	5,799	12.1
Polk	234	44	7,543	5.8
Pope	108	30	2,292	13.1
Ramsey	3,106	815	126,468	6.4
Red Lake	21	2	983	2.0
Renville	148	28	3,248	8.6
Rice	428	79	14,302	5.5
Roseau	71	3	3,792	0.8
St. Louis	2,315	413	38,252	10.8
Scott	729	80	40,371	2.0
Sherburne	645	131	25,074	5.2
Sibley	153	42	3,509	12.0
Stearns	781	159	35,620	4.5
Stevens	106	19	2,037	9.3
Swift	107	53	2,150	24.7
Todd	127	9	5,783	1.6
Traverse	63	23	686	33.5
Wabasha	116	7	4,693	1.5
Wadena	253	7	3,355	2.1
Washington	888	94	62,865	1.5
Watonwan	70	7	2,622	2.7
Wilkin	61	1	1,420	0.7
Winona	291	55	9,300	5.9
Wright	789	96	37,621	2.6
Yellow Medicine	119	13	2,289	5.7
Southwest HHS	759	203	18,037	11.3
Des Moines Valley HHS	234	19	4,929	3.9
Faribault-Martin	370	72	7,349	9.8
Leech Lake Band of Ojibwe†	344	2	1,975	1.0
White Earth Nation†	411	22	1,981	11.1
MN Prairie	499	43	19,213	2.2
Minnesota	**39,606**	**8,447**	**1,288,333**	6.6

† The data for these two groups are 2010 Census numbers which represent children residing on the Leech Lake and White Earth reservations who indicated American Indian alone or as one of two or more races. There are no intercensal child population estimates for these groups. The Leech Lake reservation overlaps Cass, Itasca, Beltrami and Hubbard counties. The White Earth reservation overlaps Mahnomen, Becker, and Clearwater counties.

Table 13. Number of social service agency referrals to early intervention for infants and toddlers involved in substantiated cases of maltreatment, 2017

Agency	Children with a referral	Children required to be referred	Referral rate
Aitkin	3	4	75.0
Anoka	90	102	88.2
Becker	25	35	71.4
Beltrami	74	80	92.5
Benton	9	11	81.8
Big Stone	0	0	--
Blue Earth	4	7	57.1
Brown	3	4	75.0
Carlton	27	31	87.1
Carver	10	11	90.9
Cass	4	7	57.1
Chippewa	4	4	100.0
Chisago	5	15	33.3
Clay	9	12	75.0
Clearwater	5	13	38.5
Cook	0	3	0.0
Crow Wing	3	5	60.0
Dakota	98	112	87.5
Douglas	32	39	82.1
Fillmore	0	0	--
Freeborn	8	11	72.7
Goodhue	5	14	35.7
Grant	4	5	80.0
Hennepin	793	823	96.4
Houston	0	1	0.0
Hubbard	8	11	72.7
Isanti	8	9	88.9
Itasca	6	8	75.0
Kanabec	10	12	83.3
Kandiyohi	20	24	83.3
Kittson	0	0	--
Koochiching	0	1	0.0
Lac qui Parle	0	0	--
Lake	1	2	50.0
Lake of the Woods	0	1	0.0
Le Sueur	4	5	80.0
McLeod	9	11	81.8
Mahnomen	0	2	0.0
Marshall	0	0	--

Agency	Children with a referral	Children required to be referred	Referral rate
Meeker	3	4	75.0
Mille Lacs	16	23	69.6
Morrison	6	14	42.9
Mower	15	18	83.3
Nicollet	1	1	100.0
Nobles	0	0	--
Norman	2	3	66.7
Olmsted	5	6	83.3
Otter Tail	28	41	68.3
Pennington	4	6	66.7
Pine	13	16	81.3
Polk	9	13	69.2
Pope	0	1	0.0
Ramsey	249	270	92.2
Red Lake	0	0	--
Renville	4	4	100.0
Rice	16	16	100.0
Roseau	0	1	0.0
St. Louis	72	94	76.6
Scott	18	25	72.0
Sherburne	32	35	91.4
Sibley	9	12	75.0
Stearns	28	38	73.7
Stevens	3	4	75.0
Swift	10	17	58.8
Todd	1	2	50.0
Traverse	6	13	46.2
Wabasha	0	0	--
Wadena	0	2	0.0
Washington	23	26	88.5
Watonwan	0	1	0.0
Wilkin	0	0	--
Winona	6	16	37.5
Wright	15	19	78.9
Yellow Medicine	1	2	50.0
Southwest HHS	37	47	78.7
Des Moines Valley HHS	0	0	--
Faribault-Martin	17	18	94.4
Leech Lake Band of Ojibwe	0	0	--
White Earth Nation	2	4	50.0
MN Prairie	5	9	55.6
Minnesota	**1,937**	**2,256**	**85.9**

Table 14. Number of assessments/investigations by SDM risk assessment status and by agency, 2017

Agency	Low risk, no CP services needed	Low risk, CP services needed	Low risk, total	Moderate risk, no CP services needed	Moderate risk, CP services needed	Moderate risk, total	High risk, no CP services needed	High risk, CP services needed	High risk, total
Aitkin	9	0	9	34	13	47	16	20	36
Anoka	341	12	353	540	66	606	199	114	313
Becker	28	3	31	109	15	124	30	103	133
Beltrami	31	9	40	108	81	189	39	93	132
Benton	15	1	16	56	7	63	4	77	81
Big Stone	5	2	7	10	3	13	1	3	4
Blue Earth	72	0	72	175	13	188	87	31	118
Brown	33	2	35	74	14	88	22	24	46
Carlton	46	1	47	131	29	160	24	52	76
Carver	98	6	104	140	26	166	22	36	58
Cass	15	3	18	40	13	53	20	35	55
Chippewa	8	0	8	16	7	23	2	11	13
Chisago	63	1	64	109	18	127	21	41	62
Clay	31	1	32	145	15	160	81	74	155
Clearwater	22	2	24	31	7	38	8	16	24
Cook	2	0	2	9	6	15	13	10	23
Crow Wing	36	3	39	85	22	107	26	38	64
Dakota	494	8	502	914	63	977	132	183	315
Douglas	27	0	27	117	18	135	31	75	106
Fillmore	28	1	29	36	1	37	8	1	9
Freeborn	20	3	23	53	15	68	23	43	66
Goodhue	13	2	15	61	16	77	40	34	74
Grant	19	3	22	20	15	35	9	19	28
Hennepin	1,454	21	1,475	3,055	570	3,625	904	1,836	2,740
Houston	13	0	13	20	1	21	21	14	35
Hubbard	51	3	54	117	32	149	62	43	105
Isanti	38	1	39	65	11	76	17	46	63

Agency	Low risk, no CP services needed	Low risk, CP services needed	Low risk, total	Moderate risk, no CP services needed	Moderate risk, CP services needed	Moderate risk, total	High risk, no CP services needed	High risk, CP services needed	High risk, total
Itasca	65	2	67	111	25	136	22	49	71
Kanabec	19	3	22	36	19	55	23	33	56
Kandiyohi	29	3	32	67	13	80	20	46	66
Kittson	4	0	4	4	2	6	1	1	2
Koochiching	13	1	14	37	5	42	19	17	36
Lac qui Parle	4	0	4	21	2	23	3	7	10
Lake	1	0	1	8	7	15	4	13	17
Lake of the Woods	3	2	5	5	3	8	4	2	6
Le Sueur	38	1	39	76	19	95	19	27	46
McLeod	40	5	45	92	39	131	17	31	48
Mahnomen	8	0	8	14	5	19	2	4	6
Marshall	3	0	3	15	5	20	4	12	16
Meeker	28	5	33	43	10	53	19	16	35
Mille Lacs	70	6	76	124	49	173	18	35	53
Morrison	30	3	33	57	10	67	4	27	31
Mower	88	0	88	147	18	165	23	18	41
Nicollet	29	5	34	61	22	83	12	36	48
Nobles	15	3	18	34	9	43	12	3	15
Norman	8	0	8	16	7	23	3	5	8
Olmsted	106	0	106	298	63	361	48	100	148
Otter Tail	77	4	81	146	36	182	28	90	118
Pennington	12	0	12	32	11	43	21	9	30
Pine	58	3	61	132	30	162	18	38	56
Polk	19	1	20	72	5	77	25	52	77
Pope	14	1	15	36	14	50	11	11	22
Ramsey	596	29	625	1,061	281	1,342	81	231	312
Red Lake	6	0	6	7	1	8	1	1	2
Renville	13	3	16	39	11	50	13	17	30
Rice	58	7	65	120	38	158	39	42	81

Agency	Low risk, no CP services needed	Low risk, CP services needed	Low risk, total	Moderate risk, no CP services needed	Moderate risk, CP services needed	Moderate risk, total	High risk, no CP services needed	High risk, CP services needed	High risk, total
Roseau	10	1	11	14	11	25	3	9	12
St. Louis	329	11	340	826	105	932	259	347	606
Scott	193	4	197	250	62	312	37	63	100
Sherburne	101	5	106	203	38	241	45	68	113
Sibley	14	6	20	36	35	71	1	24	25
Stearns	113	3	116	250	48	298	97	88	185
Stevens	14	5	19	27	17	44	9	23	32
Swift	1	1	2	18	10	28	7	35	42
Todd	14	5	19	26	10	36	11	16	27
Traverse	2	0	2	15	9	24	7	9	16
Wabasha	20	1	21	47	7	54	17	10	27
Wadena	35	4	39	64	41	105	16	27	43
Washington	186	5	191	311	37	348	45	84	129
Watonwan	15	1	16	33	7	40	2	9	11
Wilkin	6	0	6	18	6	24	5	20	25
Winona	33	1	34	117	3	120	33	32	65
Wright	160	3	163	256	49	305	66	41	107
Yellow Medicine	6	0	6	34	19	53	5	29	34
Southwest HHS	122	10	132	233	66	299	48	122	170
Des Moines Valley HHS	41	1	42	54	24	78	19	31	50
Faribault-Martin	60	0	60	111	17	128	39	35	74
Leech Lake Band of Ojibwe	54	10	64	86	25	111	43	30	73
White Earth Nation	39	5	44	81	33	114	28	62	90
MN Prairie	81	0	81	162	25	188	44	82	126
Minnesota	**6,115**	**257**	**6,372**	**12,453**	**2,560**	**15,015**	**3,262**	**5,341**	**8,603**

Note: Across all agencies, there were 1,067 reports excluded from this table because they had no associated SDM Risk Assessment completed.

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DEPARTMENT OF HUMAN SERVICES

Minnesota's Out-of-home Care and Permanency Report, 2017

Children and Family Services

November 2018

Minnesota Department of Human Services
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For accessible formats of this information or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 651-431-4670, or use your preferred relay service. ADA1 (2-18)

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $10,667.30.

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Contents

Out-of-home Care and Permanency report summary, 2017

Purpose

The purpose of this annual report is to provide information on children placed in out-of-home care in Minnesota, and to highlight work across the state to ensure and promote the safety, permanency, and well-being of children who experience out-of-home care. For the purpose of this report, the terms out-of-home care, out-of-home placement, foster care, and in care will be used interchangeably to refer to any instance in which a child is removed from their home of origin and placed in the care of the responsible social service agency. For information about performance on all state and federal performance measures, see the Minnesota Child Welfare Data Dashboard.

Findings

Placement data for out-of-home care in 2017 is as follows:

- There were 16,593 children in 17,241 out-of-home care episodes who experienced one or more days in out-of-home care. (Children could be in multiple episodes of out-of-home care if they achieved permanency and then re-entered care.)
- There was a 10.6 percent increase in children experiencing out-of-home care from 2016.
- There were 7,482 children who entered out-of-home care in 2017, consistent with the previous year.
- The number of children who continued in out-of-home care is on the rise in 2017, with 9,413 children continued in care from 2016, a 21 percent increase from the year prior (that is, their episode began in a prior year and extended into 2017).
- Parental drug abuse continued to be the most common primary reason for new out-of-home care episodes, accounting for 2,260 new episodes or 29 percent of all new episodes, continuing a trend started in 2016.
- White children remain the largest group in care, however, disproportionality remains a significant concern.
- American Indian children were 18.5 times more likely, African-American children were more than 3.0 times, and those identified as two or more races were 4.8 times more likely than white children to experience care, based on Minnesota population estimates from 2016.
- Children under age 2 and those between 15 and 17 years of age were the most likely age groups to experience out-of-home care.

Supervision and case management data is as follows:

- Of all out-of-home care placements, most are supervised by county social services (86.8 percent of enterers and 81.0 percent of continuers). The rest were overseen by corrections (5.9 percent of enterers, 3.4 percent of continuers), and tribal social services (7.3 percent of enterers, 15.6 percent of continuers).

- The most common settings experienced by children who entered care were family foster homes, with just over 80 percent of children spending some time in that type of setting.

Leaving out-of-home care data is as follows:

- There were 6,978 unique children in 7,194 placement episodes that ended in 2017.
- Of placement episodes that ended, 35.4 percent lasted six months or less.
- Most (64.1 percent) placements that ended in 2017 were because children were able to safely return home to their parents or other primary caregivers.
- More than one-in-five (21.7 percent) continuous placement episodes ended with children being adopted, or transfer of permanent legal and physical custody to a relative.
- There were 2,314 children who spent at least one day under guardianship of the commissioner, an increase of 14 percent from 2016.
- Adoptions were finalized for 955 children under guardianship of the commissioner.
- For American Indian children under jurisdiction of tribal court, 70 had a customary tribal adoption, a 63 percent increase from 2016.
- Using the federal performance measure, re-entry into foster care in 2017 was 17.2 percent. Minnesota's re-entry rate is much higher than the federal performance standard of 8.3 percent.

Legislation

This report was prepared by the Minnesota Department of Human Services, Children and Family Services Administration, Child Safety and Permanency Division, for the Minnesota Legislature in response to a legislative directive in Minn. Stat., section 257.0725. This report also fulfills reporting requirements under the Vulnerable Children and Adults Act, [Minn. Stat., section 256M.80, subd. 2] and the Minnesota Indian Family Preservation Act. [Minn. Stat., section 260.775]

Minn. Stat., section 257.0725: The commissioner of human services shall publish an annual report on child maltreatment and on children in out-of-home placement. The commissioner shall confer with county agencies, child welfare organizations, child advocacy organizations, courts, and other groups on how to improve the content and utility of the department's annual report. Regarding child maltreatment, the report shall include the number and kinds of maltreatment reports received, and other data that the commissioner determines appropriate in a child maltreatment report.

Minn. Stat., section 256M.80, subd. 2: Statewide evaluation. Six months after the end of the first full calendar year and annually thereafter, the commissioner shall make public county agency progress in improving outcomes of vulnerable children and adults related to safety, permanency and well-being.

Minn. Stat., section 260.775: The commissioner of human services shall publish annually an inventory of all Indian children in residential facilities. The inventory shall include, by county and statewide, information on legal status, living arrangement, age, sex, tribe in which the child is a member or eligible for membership, accumulated length of time in foster care, and other demographic information deemed appropriate concerning all Indian children in residential facilities. The report must also state the extent to which authorized child-placing agencies comply with the order of preference described in United States Code, title 25, section 1901, et seq.

Introduction

Placement in out-of-home care is sometimes necessary. Foster care, especially family foster care settings, can mitigate the negative effects of maltreatment and/or neglect, providing children with supports that are essential for healthy development. [Annie E. Casey Foundation, 2012] It is imperative that the Minnesota Department of Human Services (department) monitor and assess information on children placed in out-of-home care, ranging from conditions that resulted in a child's removal from their home to how effective the system is at helping children find safe, permanent homes.

Entering out-of-home care can cause significant trauma for many children. Those in out-of-home care have been found more likely to have difficulties in school and exhibit emotional and behavioral problems. [Kortenkamp & Ehrle, 2002] Placement in out-of-home care, especially during particularly important developmental periods, can be problematic for a child's attachment with their primary caregiver(s). Additional negative impacts on emotional development are associated with multiple moves, and with re-entry into foster care. [American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care, 2000]

Minnesota children

According to the National Kids Count Data Book, Minnesota has fewer children entering out-of-home care than many other states relative to the population of children. [Annie E. Casey Foundation, 2016] However, recent increases in children involved in child protection and a growing drug epidemic are contributing to more children entering care and staying in care longer. Minnesota has seen a 10.6 percent increase in children experiencing out-of-home care from 2016 to 2017.

Minnesota has significant racial disparities in out-of-home care; African-American and American Indian children are disproportionately likely to experience out-of-home care. [Minnesota Department of Human Services, 2013 and 2014]

What is out-of-home care?

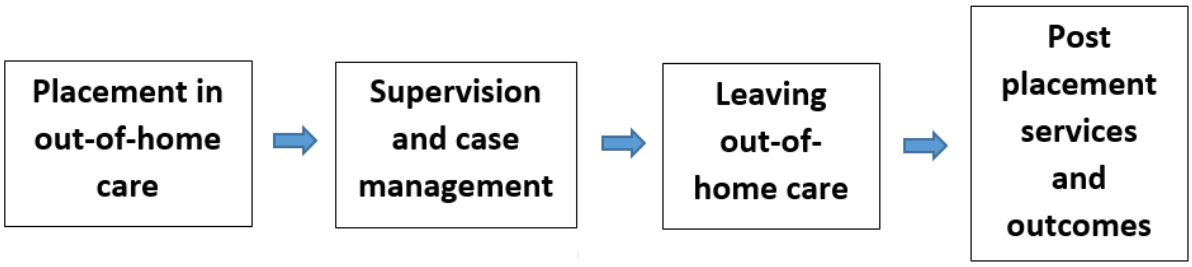
Minnesota Statutes provide a detailed description of what constitutes out-of-home care or foster care. [Minn. Stat., 260C.007, subd. 18] Out-of-home care or foster care is any 24-hour substitute care for children placed away from their parents or guardians and for whom a responsible social services agency has placement and care responsibility. Foster care includes, but is not limited to, placement in foster family homes (relative and non-relative), group homes, emergency shelters, residential facilities, child

care institutions and pre-adoptive homes. In Minnesota, children can enter out-of-home care for a variety of reasons: Child protection, specialized treatment for mental health concerns or developmental disabilities, and juvenile corrections.

Minnesota's out-of-home care system

Minnesota is a state supervised, locally administered child welfare system. This means that local social service agencies (87 counties and two American Indian tribes participating in the American Indian Child Welfare Initiative) are responsible for the care and protection of children in out-of-home placement. The Minnesota Department of Human Services, Child Safety and Permanency Division, provides oversight, guidance, training, technical assistance, and quality assurance monitoring of local agencies in support of that work. The purpose of this annual report is to provide information on children affected, and the work being done across the state to ensure and promote the safety, permanency, and well-being of children who have experienced out-of-home care. There is an additional annual report that provides information on children who may have been maltreated, "Minnesota's Child Maltreatment Report, 2017." For information about performance on all state and federal child welfare performance measures, see the Minnesota Child Welfare Data Dashboard.

Pathway from out-of-home care to permanency



Placement in out-of-home care

Children are placed in out-of-home care for a variety of reasons: Juvenile delinquency, developmental disabilities, access to needed mental health or other specialized treatment, or as a result of child protection involvement. There are three ways children can be placed into care (see Minn. Stat., Chapter 260C and Minn. Stat., Chapter 260D):

1. Voluntary placement agreement
2. Court order of a placement (involuntary), or
3. A 72-hour hold by law enforcement (involuntary)

A voluntary placement occurs when parents or custodians of a child agree to allow the local social service agency to temporarily take responsibility for care of a child. A court-ordered placement occurs

because a family is unable or unwilling to meet the safety or specialized needs of a child in their home. A 72-hour hold occurs when a child is found in surroundings or conditions which endanger their health or welfare; law enforcement has authority to remove a child from the home and place them in foster care. For a child to remain in care longer than 72 hours, the child welfare agency must have court-approved placement, or a parent must sign a voluntary agreement.

When a child enters out-of-home care, one of three different types of agencies assumes, or is delegated by the court, responsibility for supervision of that out-of-home care placement episode: County social services, corrections, or tribal social services.

There were 16,593 children who experienced 17,241 placements during 2017. Of these placement episodes, 11.6 percent began as a voluntary or court-reviewed voluntary hold (N = 1,992), and 88.3 percent began as a court-ordered or protective involuntary hold (N = 15,220). There were 40 episodes that did not have placement authority data entered.

Children and placements: Enterers and continuers

This report distinguishes between two groups of children who experience out-of-home care in a year: Enterers and continuers. Enterers are those children who had a placement episode which began in 2017, and continuers are those who were in a placement episode that began prior to 2017 and continued into 2017. As mentioned earlier, the number of placement episodes is higher than the number of children as a child could have been in multiple episodes.

- Of the 16,593 children who experienced 17,241 episodes of out-of-home care in 2017, there were 7,482 children in 7,828 placement episodes who were enterers, and 9,413 in placement episodes who were continuers.
- There were 302 children who were continuers and, after returning home in 2017, had a new entry into out-of-home care in 2017 and were subsequently categorized as enterers, as well. See Figure 1 for a diagram that shows the overlap in children.

Figure1. Continuers and Enterers

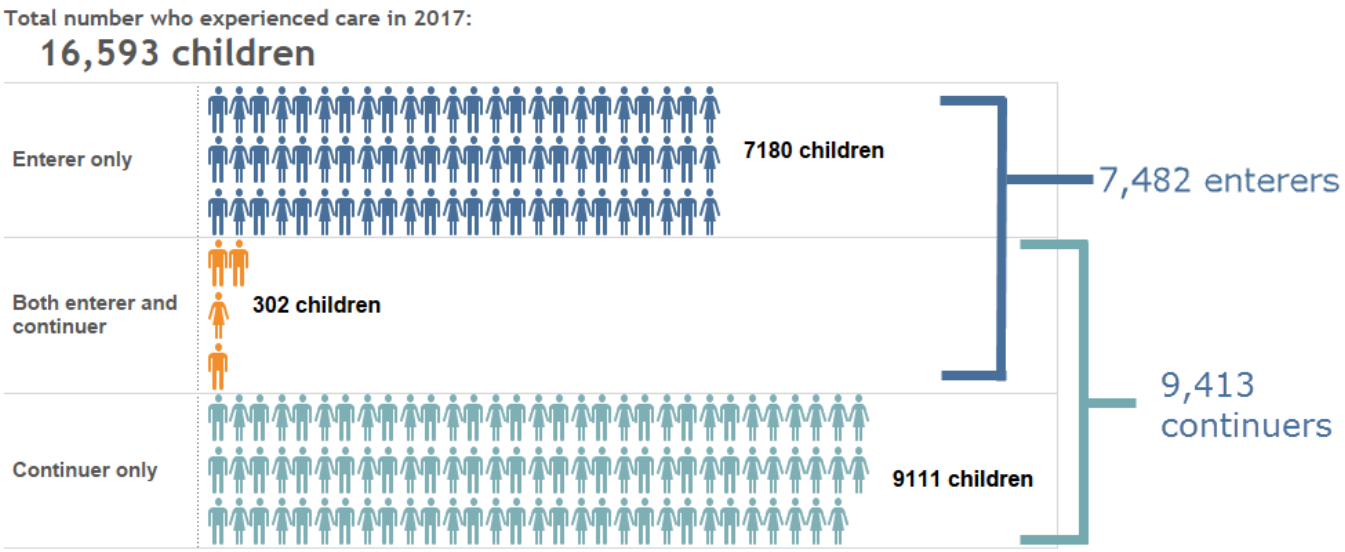
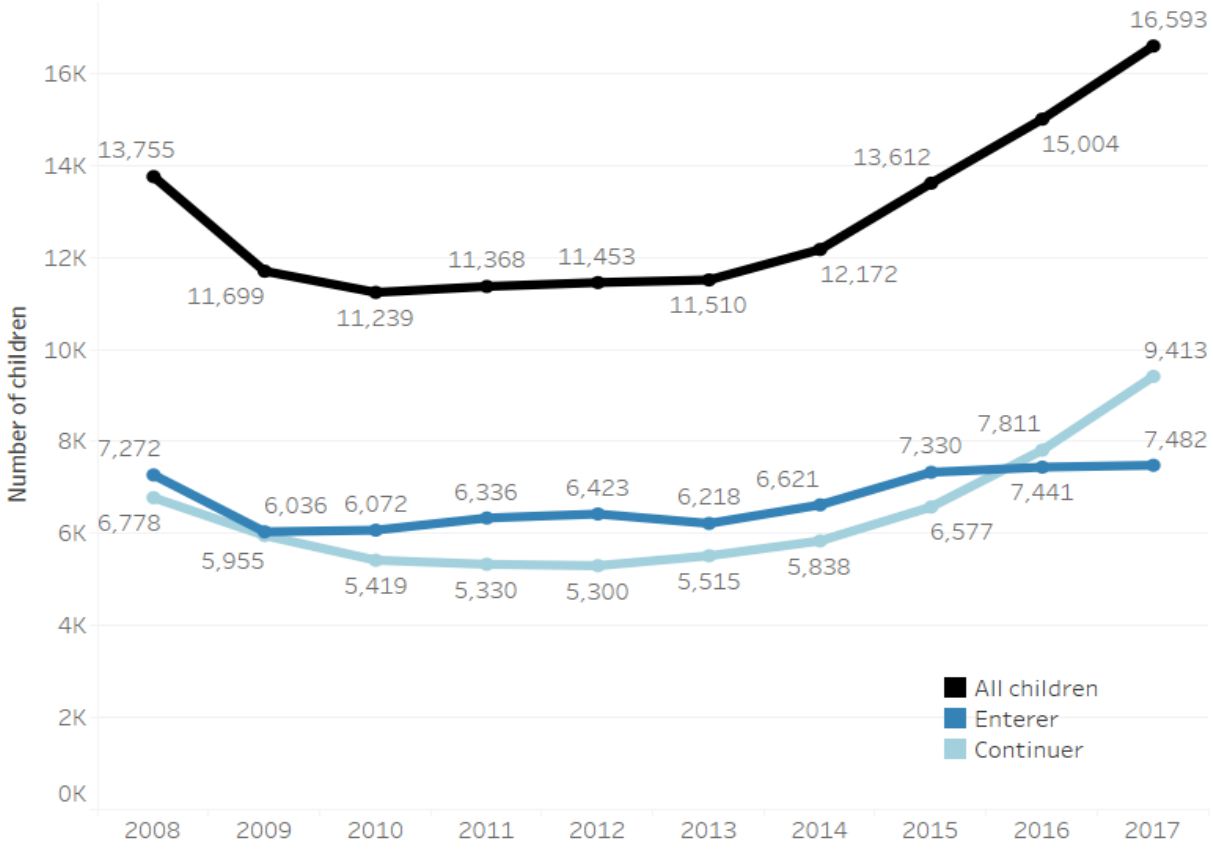


Figure 2. Number of children experiencing care by continuers, enterers and all children, 2008-2017



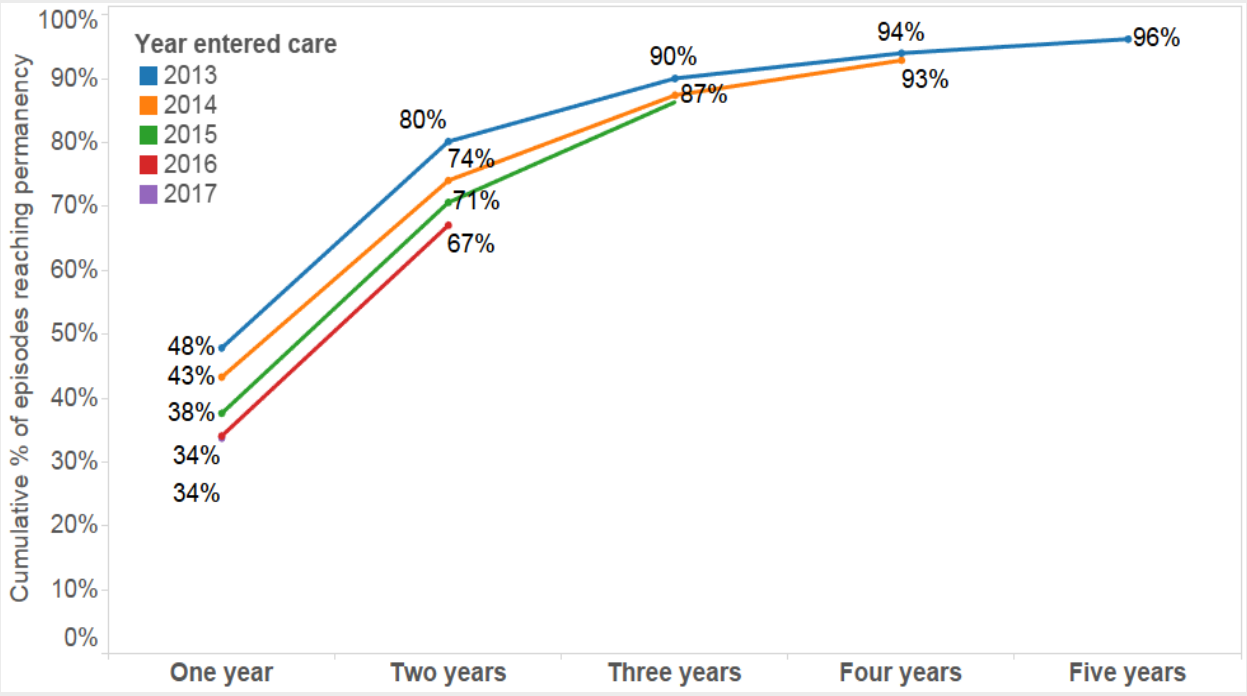
- The figure above shows 10-year trends for the number of children experiencing care, broken down by total number of children, number of enterers, and number of continuers
- In 2017, there was a 10 percent increase in the number of children experiencing care for at least one day of the year from the previous year.
- For the second year, more children were continuers than enterers in care, accounting for approximately 57 percent of children in out-of-home care in 2017.
- Additionally, there has been a 21 percent increase in children who are continuing in care from the previous year.
- The number of children who entered care in 2017 remained nearly the same as the previous year, increasing by 41 children.

Sidebar: Why are more children experiencing out-of-home care in a single year?

Over the last five years Minnesota has seen an increase in the number of children in care across the state. There has been a sharper increase in the number of continuers than enterers, which highlights the fact that children are staying in care for longer periods and not exiting to permanency. The chart below displays the decreases in the percent of children reaching permanency over time, starting with those who entered care in 2013. As shown, the one-year permanency rates dropped from 48 percent to 34 percent from 2013 to 2017, with two-year permanency rates dropping from 80 percent to 67 percent.

The median length of time in care for exiters has increased from 175 days in 2013 to 297 days in 2017. This increase can be partially tied to the reason for removal. There continues to be an increase in the number of children removed for parental substance abuse, and these cases have historically taken longer to reach permanency due to a variety of factors. As county or tribal courts have oversight in the majority of placements, it is important to recognize the vital role the courts play in ensuring that children achieve permanency within legally mandated time frames.

Decreases in number of episodes reaching permanency from 2013 to 2017



Characteristics of children in out-of-home care

This section provides data on the race, age, and disability status of children who entered care and continued in care in 2017. Disproportionality remains a significant concern for children in out-of-home placement.

- White children remain the largest group, both entering and continuing in care in 2017, accounting for 46.3 percent of enterers and 42.4 percent of continuers.
- African-American/Black children comprised the second largest number and percent of enterers, at 18.4 percent and American Indian children comprised the second largest group of continuers, at 24.1 percent.

Figure 3. Number and percentage by race/ethnicity of children in care in 2017

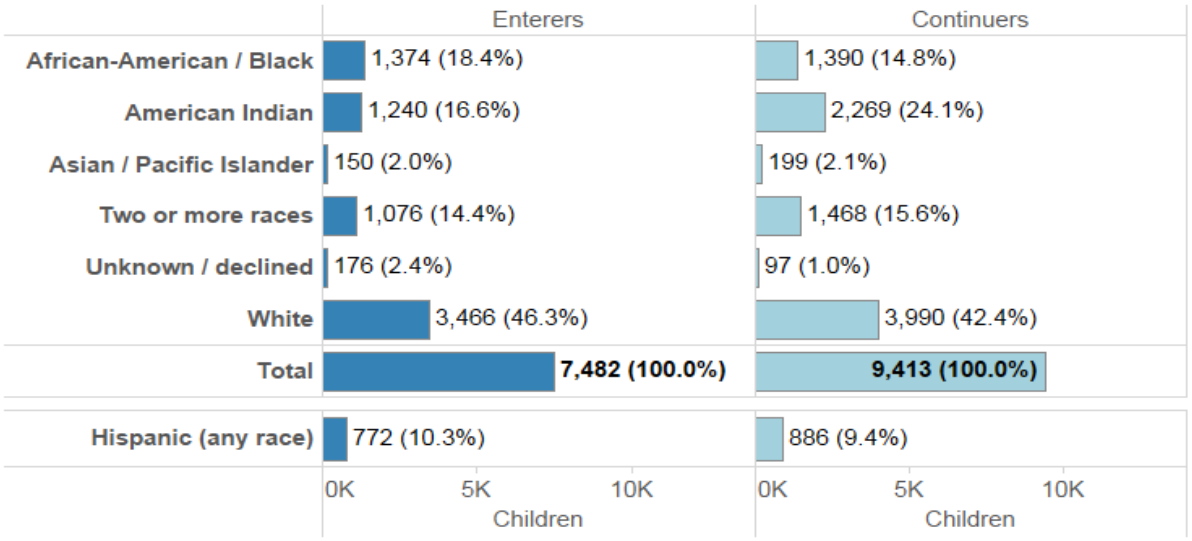
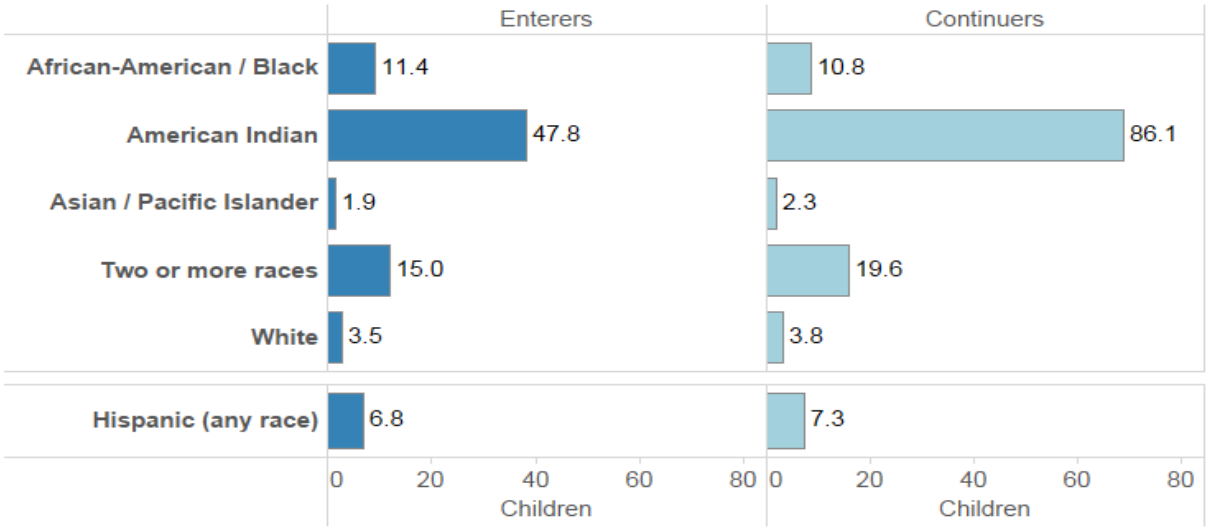


Figure 4. Rate per 1,000 for children in care in 2017



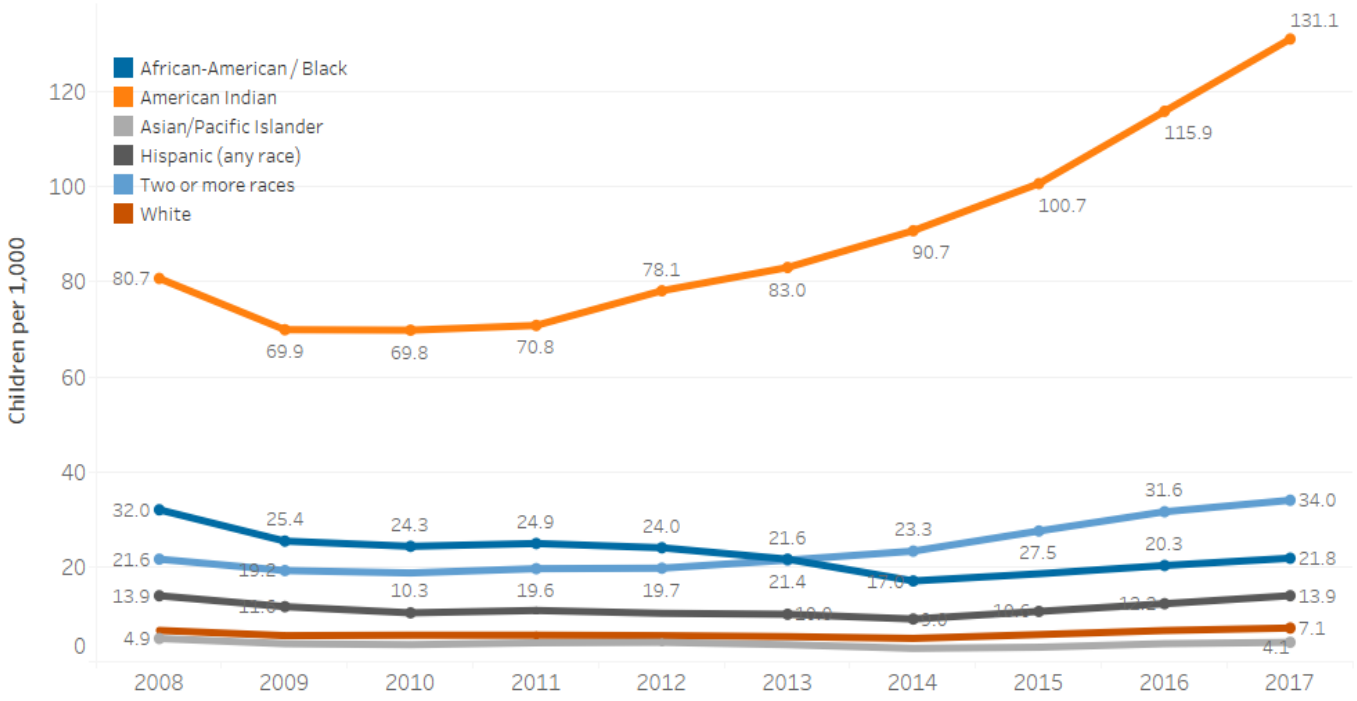
Sidebar: A closer look at the two or more races category

Minnesota is becoming more diverse, with many children and families identifying with more than one race. The rate of children identified as more than one race has been steadily increasing since 2010. Of those children who experienced care in 2017 and identified as more than one race:

- **87.6** percent identified at least one race as White
- **59.9** percent identified at least one race as African-American/Black
- **54.4** percent identified at least one race as American Indian
- **4.6** percent identified at least one race as Asian
- **1.2** percent identified as Pacific Islander.

- As shown in Figure 5 below, the rates of children experiencing out-of-home care have continued to increase for both American Indian children and those who identify as two or more races.
- American Indian children were 18.5 times more likely, African-American children were more than 3.0 times, and those identified as two or more races were 4.8 times more likely than white children to experience care, based on Minnesota population estimates from 2016 (rates of entry per 1,000 children in the population by race are shown in Figure 4).

Figure 5. Rate per 1,000 children in out-of-home care by race/ethnicity, 2008 – 2017



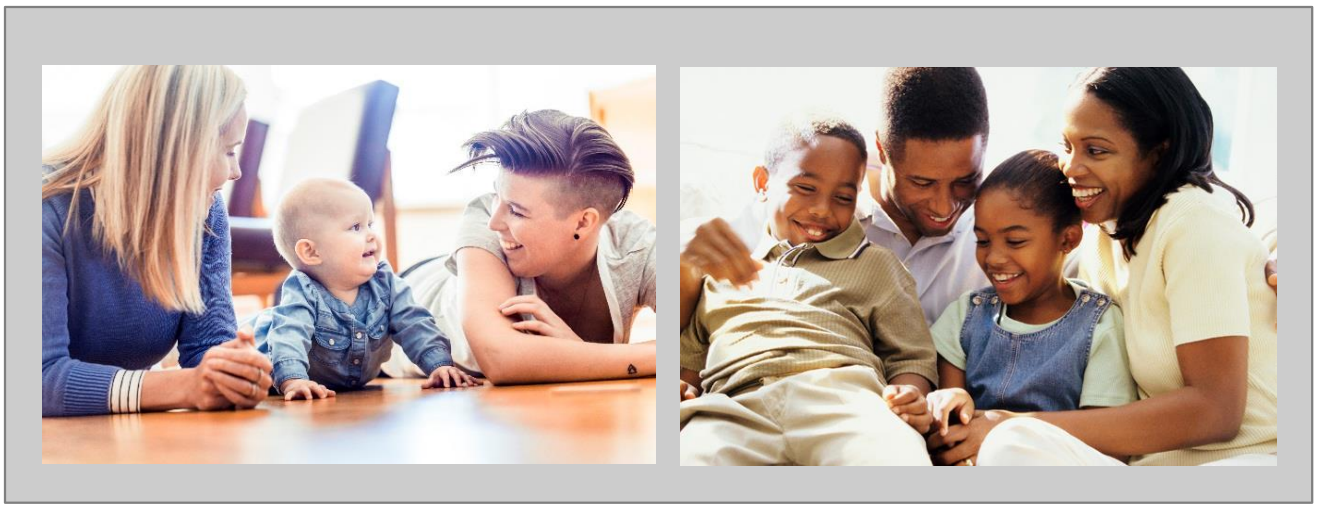
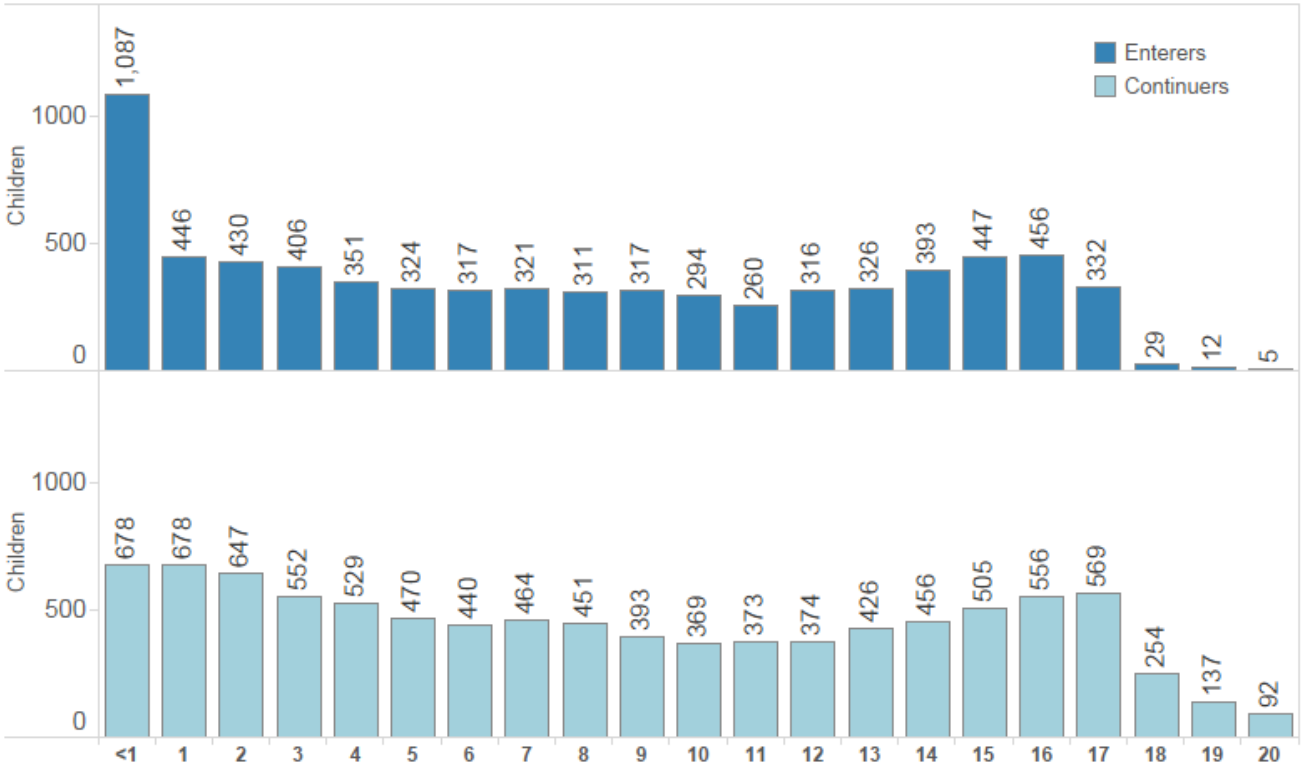


Figure 6. Number of children by age experiencing care in 2017



- Figure 6 shows the distribution of children experiencing out-of-home care by enterers and continuers by age. Age is calculated at either Jan. 1, 2017, for continuers, or the date of entry into care for those whose entered out-of-home care in 2017.
- Children under age 2 and those between 15 and 17 years of age were more likely to experience out-of-home care.

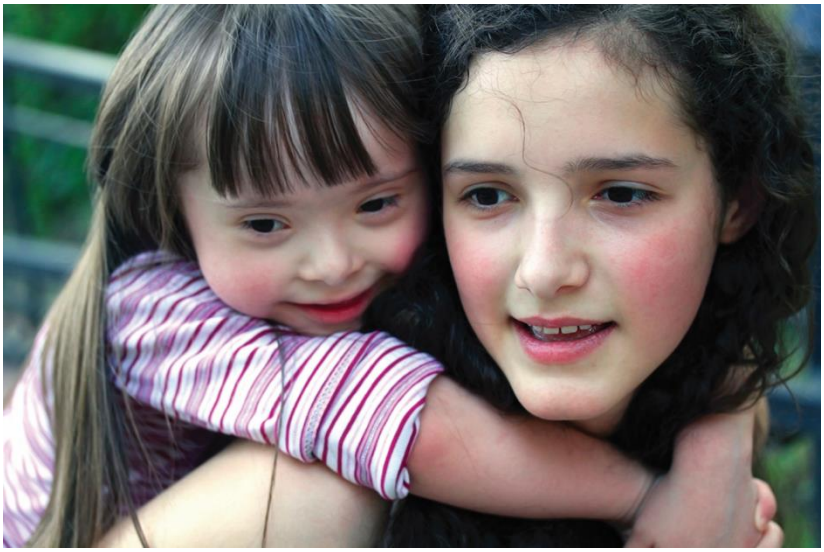
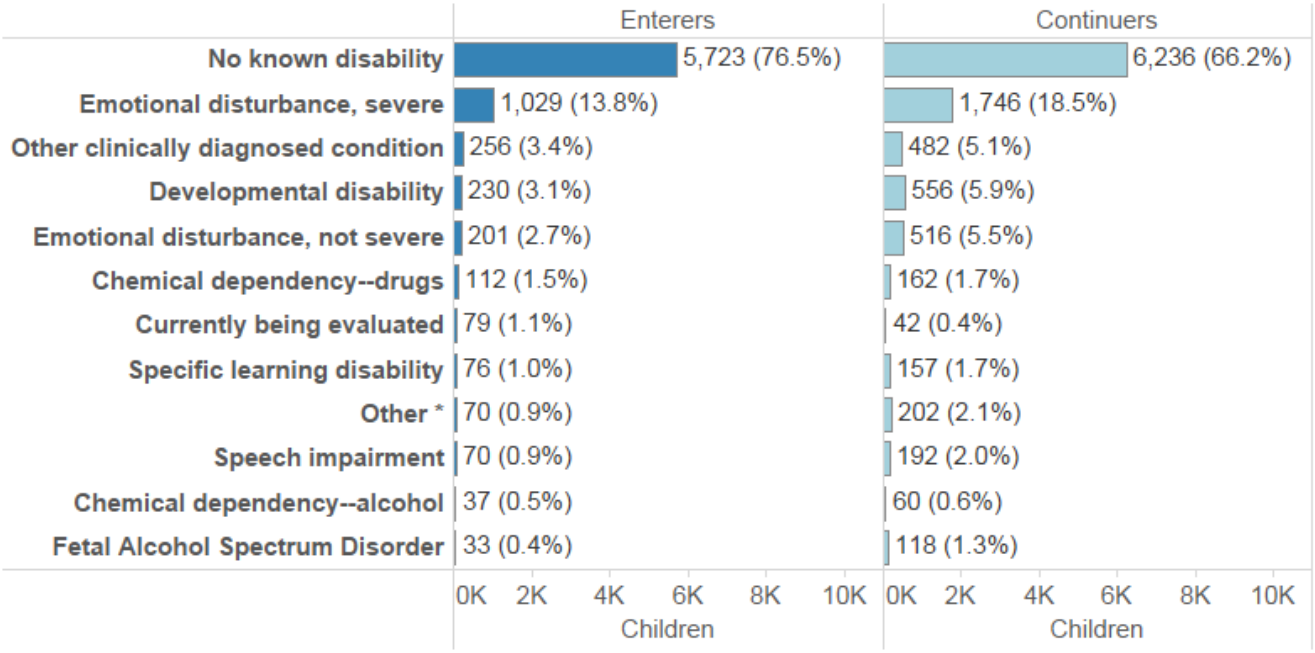


Figure 7. Number and percentage of children by disability status in 2017



Note: The "Other" category includes hearing or visual impairment, physical disability, brain injury, HIV/AIDS.

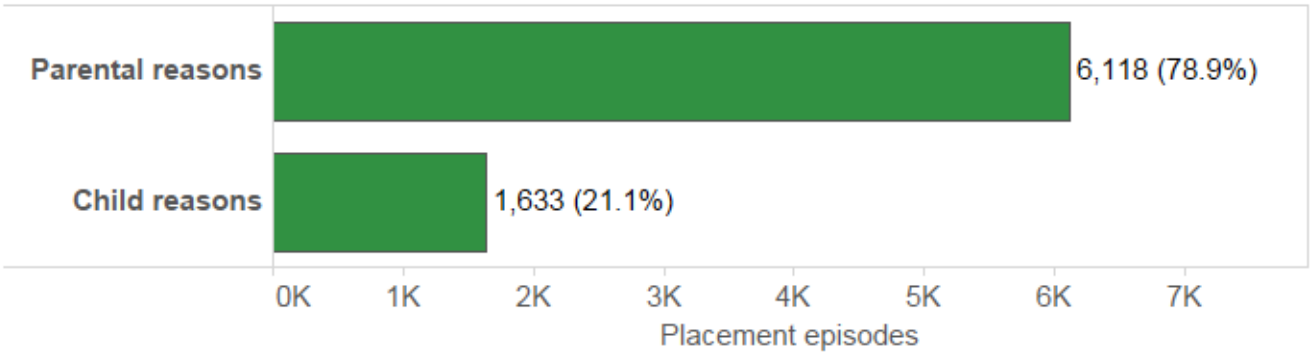
- Some children who experienced out-of-home care have disabilities and may need additional support while in out-of-home placement. These range from learning and physical disabilities, emotional disturbances to Fetal Alcohol Spectrum Disorders. Data show that 23.5 percent of children who entered care in 2017 had an identified disability, while 33.8 percent who continued in care into 2017 did (see Figure 7).

- For those children who entered or continued in care in 2017 with an identified disability, the most common was severe emotional disturbance (13.8 percent for enterers and 18.5 percent for continuers, a reduction of 2.8 percent from 2016 for continuers).
- Despite the difficulty in defining disability across disciplines, a review of relevant research suggests children with disabilities experience out-of-home care at higher rates than those without identified disabilities. There are several reasons why this may be true. Research has shown that there are higher rates of child maltreatment for this population. [Lightfoot & LaLiberte, 2013] Alternatively, children in out-of-home care may have higher rates of disability because they are more likely to come into contact with more child-serving professionals who often have training and experience in identifying red flags for developmental delays.

Reasons for entering care

Children enter out-of-home care for many different reasons. Most are related to the behavior of a parent or caregiver; a few are related to the behavior and needs of a child. Generally, removal due to a parental reason is a result of some factor that compromises the ability of that parent or caregiver to provide safety for a child. This may include parental drug use, alleged abuse or neglect of a child, incarceration, or parental mental health needs. Alternatively, a removal due to a child reason is typically a result of factors that affect the ability of a child to remain safe while in their home, or jeopardizes the safety of community members. Usually, a child has special needs, such as mental health and/or substance abuse that require specialized treatment. Although children may enter care for multiple reasons, more than three of every four placements (78.9 percent) had an indicated *primary* removal reason attributed to parents.

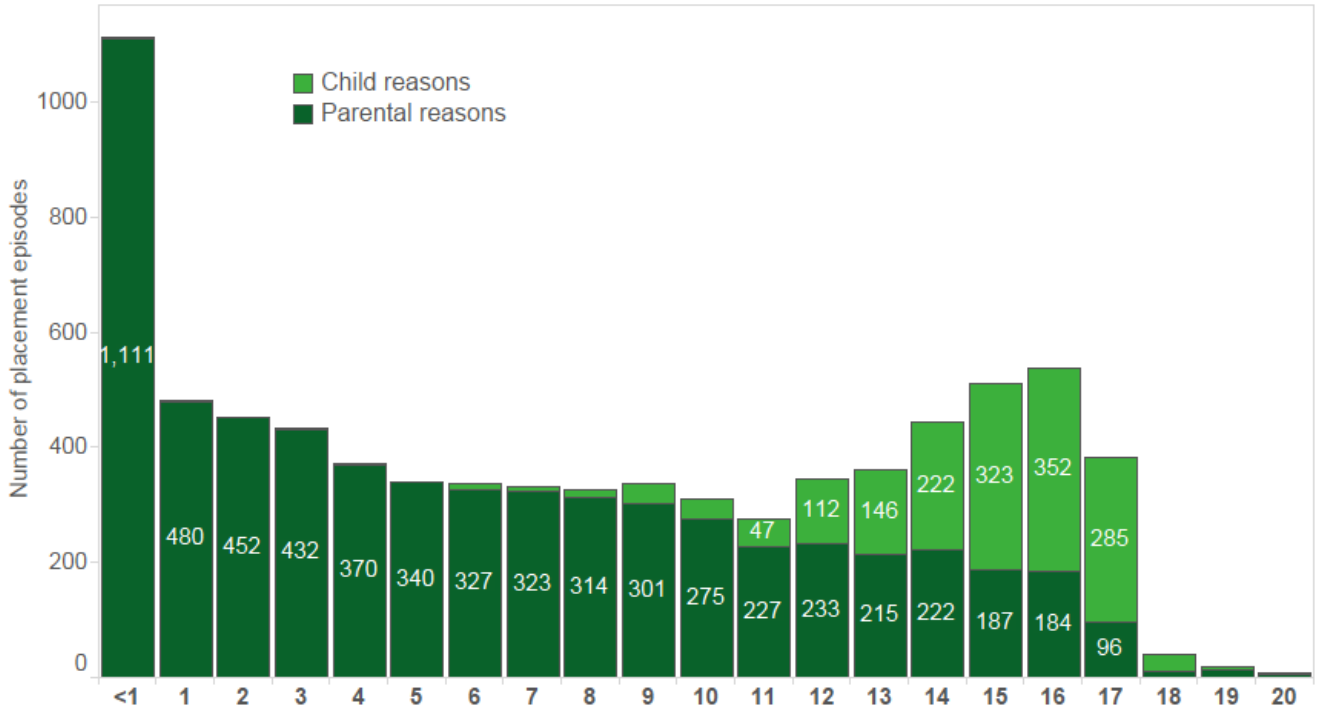
Figure 8: Number and percent of placement episodes with parental and child reasons beginning in 2017



Note: At the time of data analysis, there were 72 continuous placement episodes in which a local agency had not selected a primary reason for removal from the home.

- Although most placement episodes that began in 2017 were supported by at least one parental reason, child reasons were substantially more common in placements with older children. Figure 9 shows the number of placement episodes beginning in 2017 by parent and child reasons for each age group. Generally, children age 11 and younger were removed from their home due to parental reasons. For older children, increasingly higher proportions of new placement episodes began due to child reasons.

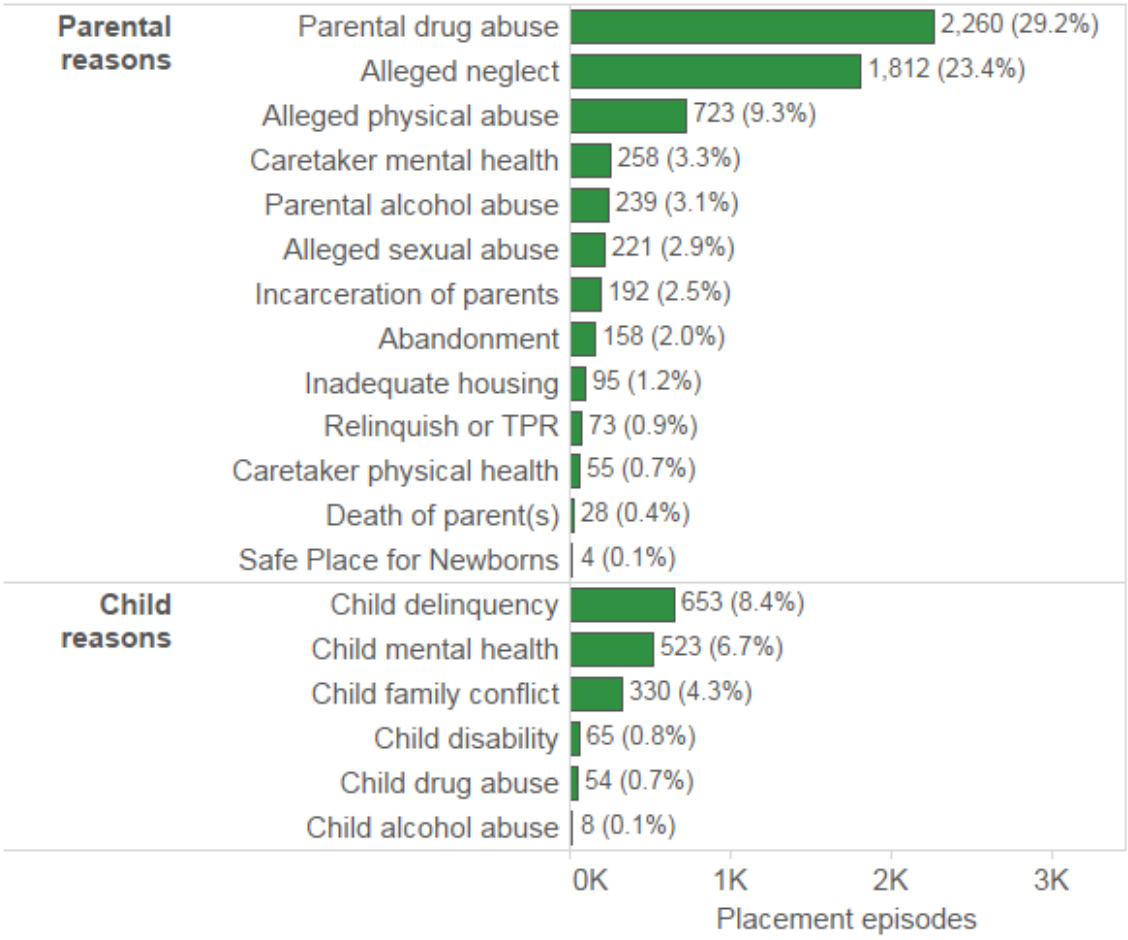
Figure 9: Number of placement episodes by age and primary removal reason beginning in 2017



Note: Age here is calculated at either Jan. 1, 2017, (for continuers) or the date of entry into care for those whose out-of-home care episode began in 2017.

- There are several reasons that may explain why older children are removed for child reasons more often. For example:
    - Older children may be more likely to become involved in delinquent activity and be placed in a juvenile detention facility. Some child welfare agencies in Minnesota have an agreement with juvenile corrections to provide funding for placement of these children.
    - Older children are more likely to have diagnosed mental health needs. Previous research has shown a relationship between children with complex mental health/behavioral needs and an increased likelihood of out-of-home placement. [Bhatti-Sinclair & Sutcliffe, 2012]

Figure 10: Number and percent of placement episodes by primary removal reason beginning in 2017



- More than one-quarter (29.2 percent) of placement episodes had a primary removal reason of parental drug abuse, whereas just less than one-quarter (23.5 percent) had a primary removal reason of alleged neglect. See Figure 10.
- There were 99 fewer children removed in 2017 due to a child reason (1,633 compared to 1,732 in 2016).
- Compared to parental reasons, removal from the home due to child reasons tended to occur at lower rates. Of the placement episodes where a child reason was identified as the primary reason for removal, almost all (1,504 of 1,732 or 92.2 percent) had either child delinquency, child mental health, or child family conflict listed as the primary removal reason.

Supervision and case management

The next section of the report provides information about what happens to children once they are placed in out-of-home care. It includes information on supervising agencies, placement locations where children are during their episode, and other information regarding what happens when children are in out-of-home care.

Supervising agency

There are three different agencies that assume, or are delegated by a county or tribal court, responsibility for placement of a child into out-of-home care: County social services, tribal social services, or corrections. These agencies ensure that state and federal laws are appropriately followed.

- A high proportion of American Indian children who entered care in 2017 were placed under supervision of tribal social services (42.8 percent), and an even higher proportion of American Indian children who continued in care in 2017 (61.3 percent) were under supervision of tribal social services.
- The proportion of children under supervision of corrections also varies by race, with African-American/Black children entering and continuing in care at a higher rate than other racial groups (14.0 percent for enterers and 9.2 percent for continuers). These numbers were reduced by more than 20 percent from 2016 data.

Table 1. Number and percent of placement episodes by race/ethnicity for three types of supervising agencies in 2017

	Enterers			Continuers			
	County social services	Corrections	Tribal social services	County social services	Corrections	Tribal social services	
African-American / Black	1,264 (86.0%)	206 (14.0%)		1,262 (90.8%)	128 (9.2%)		**2,860** (100.0%)
American Indian	690 (53.7%)	46 (3.6%)	550 (42.8%)	844 (37.2%)	34 (1.5%)	1,391 (61.3%)	**3,555** (100.0%)
Asian / Pacific Islander	145 (94.2%)	9 (5.8%)		190 (95.5%)	9 (4.5%)		**353** (100.0%)
Two or more races	1,051 (93.8%)	49 (4.4%)	21 (1.9%)	1,343 (91.5%)	46 (3.1%)	79 (5.4%)	**2,589** (100.0%)
Unknown / declined	176 (96.7%)	5 (2.7%)	1 (0.5%)	95 (97.9%)	2 (2.1%)		**279** (100.0%)
White	3,468 (95.9%)	147 (4.1%)		3,890 (97.5%)	100 (2.5%)		**7,605** (100.0%)
All races	**6,794** (86.8%)	**462** (5.9%)	**572** (7.3%)	**7,624** (81.0%)	**319** (3.4%)	**1,470** (15.6%)	**17,241** (100.0%)
Hispanic (any race)	762 (93.2%)	45 (5.5%)	11 (1.3%)	794 (89.6%)	32 (3.6%)	60 (6.8%)	**1,704** (100.0%)

Case management services

Case management services are provided for families with children in out-of-home care for more than 30 days. Services are customized based on the reasons for placement, including: Child protection, specialized treatment for mental health concerns or developmental disabilities, and juvenile corrections.

While children are in care, county and tribal agency staff work with the child, their family, and providers to develop a comprehensive Out-of-home Placement Plan (OHPP). The OHPP is the case plan that drives the services that a child and family receive; it outlines all specific provisions that must be met for a child to safely return home. Often, there are certain safety requirements that a family must meet or exceed for a child to return home.

Out-of-home Placement Plans are completed:

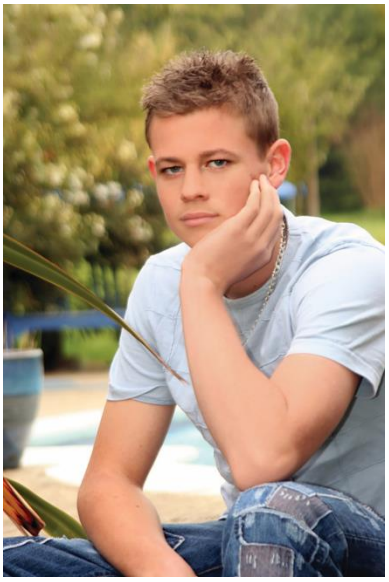
- Within 30 days of a child's initial placement
- Jointly with parents
- Jointly with a child, when of appropriate age, and
- In consultation with guardian ad litem, foster parent, and tribe, if a child is American Indian.

For placements that have court involvement, OHPPs receive court approval and are reviewed every 90 days while a child remains in care to ensure that adequate and appropriate services are being provided.

An independent living skills (ILS) plan for children age 14 or older is also required. This plan is developed with youth, caseworker, caretaker(s), and other supportive adults in a youth's life to encourage continued development of independent living skills, and life-long connections with family, community and tribe. Specific independent living skills include, but are not limited to, the following areas: Educational, vocational or employment planning; transportation; money management; health care and medical coverage; housing; and social and/or recreation. It does not conflict with, or replace the goal of, achieving permanency for youth. [See Minn. Stat., section 260C.212, subd. 1(c)(11)]

Additional services available to youth in out-of-home care, based on eligibility, include:

- Support for Emancipation and Living Functionally (SELF) program: Helps youth working with a county or tribal caseworker prepare for a successful transition to adulthood, including independent living skills training, housing, transportation, permanent connections, education, and employment services to youth ages 14 - 20
- Minnesota Education and Training Voucher (ETV) program: Current and former foster youth can get up to $5,000 per school year for post-secondary education at college, university, vocational, technical or trade schools



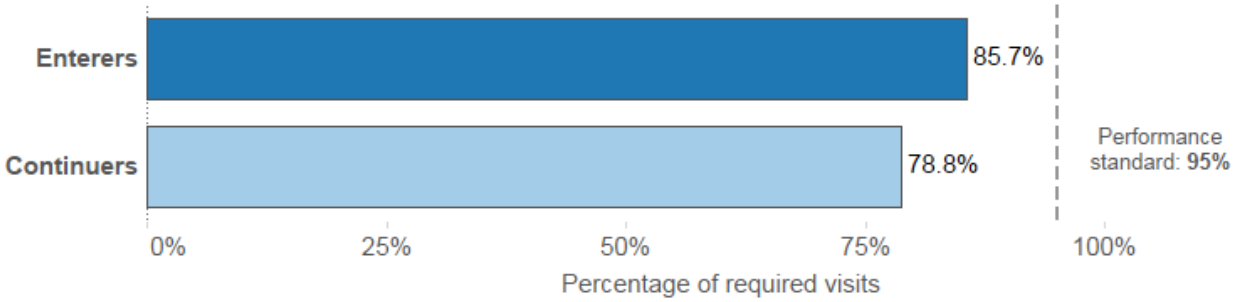
- Extended foster care (EFC) services and payments: Youth can stay in their foster care setting longer, live on their own with additional support, or request to return to foster care through age 20
- Healthy Transition and Homeless Prevention program: Partnership with nonprofit agencies statewide to provide independent living skills services to youth currently or previously experiencing out-of-home care through age 21.

Caseworker visits with children in out-of-home care

Caseworkers are required to meet monthly with children in out-of-home placement. Monthly visits are critical to a child remaining safe, achieving successful and timely reunification, or reaching alternative means of permanency. Visits provide an opportunity for caseworkers to monitor a child's safety, stability of placement, progress on services provided to a child and family, and well-being while in care. Often, children are seen more frequently than monthly, depending on the needs of a child, family, or placement provider.

- Of enterers in 2017, for the months where face-to-face visits were required, caseworkers saw children monthly 85.7 percent of the time; for continuers, caseworkers saw children monthly 78.8 percent of the time (see Figure 11).
- Minnesota's child welfare agencies continue to work on improving the frequency with which children are seen by examining the barriers to monthly case worker visits. There was a small increase in the case worker visits in 2017, following the appropriation of additional funds by the Minnesota Legislature to increase the number of child welfare workers.

Figure 11: Percent of months in which children received a required monthly caseworker visit (enterers vs. continuers) in 2017



Note: Caseworker visit calculations include only children under 18 years old.

Placement experiences

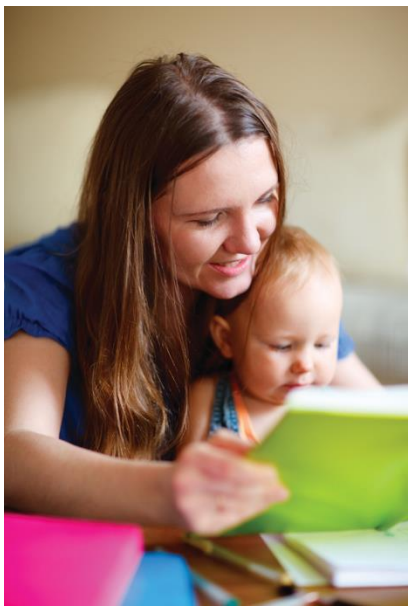
Once a child has been removed from the home or even prior to their removal, whenever possible, child welfare agencies work diligently to locate a safe and stable placement. There are a variety of out-of-home care settings that vary on overall level of restrictiveness, as well as the types of services provided. These settings range from family-type settings, including foster homes to more intensive settings like residential treatment centers. Children may experience multiple placement setting types during a single placement episode, depending on their unique needs.

Minnesota Statutes dictate that when placing a child, an agency must first consider placing them with a suitable individual who is related to them, then consider any individuals who a child may have significant contact with (see Minn. Stat., 260C.212, subd. 2 (a) for details). Numerous factors related to a child's overall well-being, such as their educational, medical, developmental, religious, and cultural needs, as well as their personal preference if old enough, are considered.

- Table 2 provides information about the racial diversity of individuals who provided family foster care for at least one day to a child in placement in Minnesota.

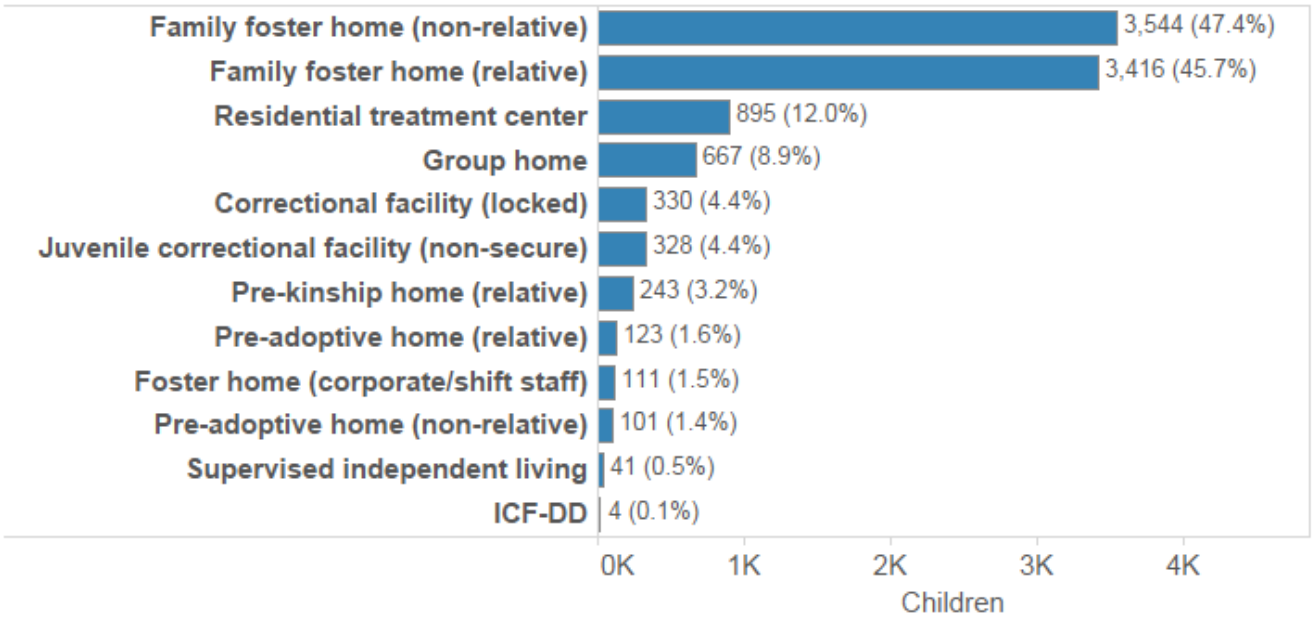
Table 2: Number and percent of foster care homes where at least one caregiver identifies as a specified race/ethnicity in 2017

	Number	Percent
African-American / Black	1,248	14.5%
American Indian	1,079	12.5%
Asian or Pacific Islander	147	1.7%
Two or more races	421	4.9%
Unknown / declined	351	4.1%
White	6,046	70.0%
Hispanic	402	4.7%



- Placement in the least restrictive, most home-like environment is preferred whenever possible. Children were most often placed in home-like settings (see Figure 12). Of the 7,482 children who entered care in 2017, about three-quarters (77.6 percent) spent some time in either a relative or non-relative foster home setting. Just under half of all children in care (45.7 percent) spent at least some time in relative family foster care more specifically. (Children can spend time in multiple location settings during an episode of out-of-home care, and could therefore be counted multiple times across different setting types.)
- Other types of settings such as group homes, residential treatment centers and correctional facilities are more restrictive for a child and are less common than family foster care.
- The remaining settings prepare a child for adoption or other permanent placement, i.e., pre-adoptive or pre-kinship homes and independent living centers.

Figure 12: Number and percent of children by location setting in 2017



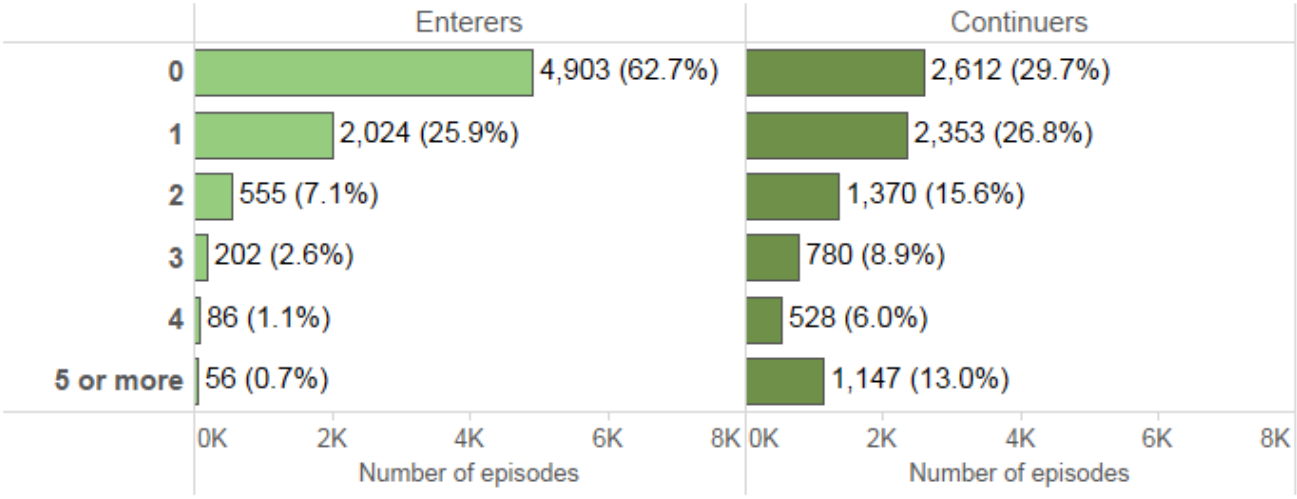
Note: This graph shows only children who entered out-of-home care in 2017. ICF-DD stands for Intermediate Care Facilities for persons with developmental disabilities.

Placement moves

During a placement episode, children may move from one location to another to better meet their particular needs. Although moves can create further trauma for a child in out-of-home care, some moves are necessary to better ensure safety of a child, provide needed services and/or a less restrictive environment, or achieve permanency.

- When taking into account the entire length of an out-of-home care episode for all episodes occurring in 2017 (both enterers and continuers), the vast majority of placement episodes had between zero and three moves (89.1 percent). Children who were in care for longer periods of time experience more moves. See Figure 13.
- The majority of children who entered care in 2017 only experienced one placement location (62.7 percent).
- The majority of continuers experienced one placement location (29.7 percent).

Figure 13: Number of total moves children experienced while in a placement episode (through 2017)



Leaving out-of-home care

This section focuses on children who left out-of-home care in 2017. The designation of exiters will be used for children who were in out-of-home placement and exited during 2017.

Length of time in care

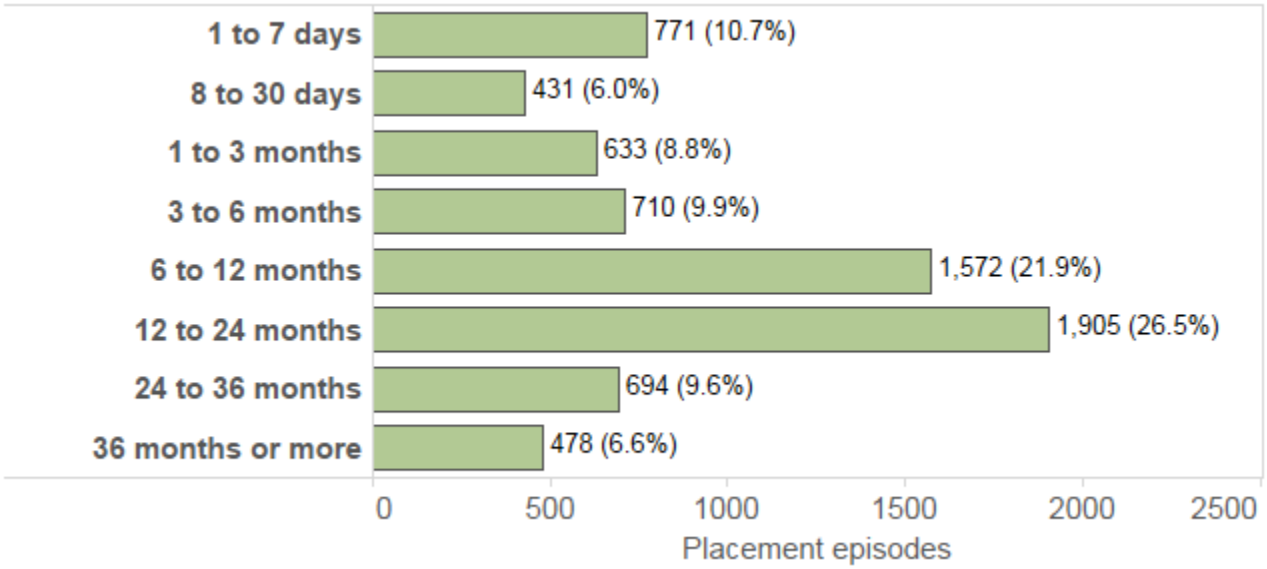
There were 6,978 unique children in 7,194 placement episodes that ended in 2017 (e.g., some children experienced more than one placement episode that ended during the year). Some children were in care for only a few days while others had been in care for multiple years. Approximately 35.4 percent of placements were for six months or less (see Figure 14).

The length of time that a child spends in care is highly variable and may be influenced by the following, among many other factors:

- Needs of child and family
- Safety concerns
- Availability of resources to help families reach goals in their case plan
- Overall permanency goal(s)
- Administrative requirements/barriers, and
- Legal responsibilities/court decisions.

Although most children discharge prior to their 18th birthday, Minnesota law allows youth in foster care on their 18th birthday to receive extended foster care services through age 20, if they meet certain criteria. There were 902 children/youth who experienced extended foster care during 2016. The most common criteria were: Completing high school/GED (58.6 percent), employed at least 80 hours per month (29.5 percent), and enrolled in post-secondary or vocational education (21.6 percent).

Figure 14: Length of stay for placement episodes ending in 2017



- Length of time in care also varies by race and ethnicity. Table 3 shows the number and percentage of placement episodes broken down by length of stay and race and ethnicity.
- American Indian children have high proportions who stay in care for two years or longer compared to other racial and ethnic groups.

Table 3: Number and percent of placement episodes ending in 2017 by length of time in care and race/ethnicity

	African-American / Black	American Indian	Asian / Pacific Islander	Two or more races	Unknown / declined	White	All races	Hispanic (any race)
1 to 7 days	**260** (21.2%)	**58** (5.1%)	**29** (19.5%)	**88** (8.6%)	**39** (31.0%)	**297** (8.4%)	**771** (10.7%)	**84** (11.5%)
8 to 30 days	**114** (9.3%)	**39** (3.4%)	**10** (6.7%)	**53** (5.2%)	**10** (7.9%)	**205** (5.8%)	**431** (6.0%)	**64** (8.8%)
1 to 3 months	**97** (7.9%)	**78** (6.8%)	**10** (6.7%)	**97** (9.5%)	**13** (10.3%)	**338** (9.6%)	**633** (8.8%)	**72** (9.9%)
3 to 6 months	**108** (8.8%)	**102** (8.9%)	**16** (10.7%)	**103** (10.1%)	**11** (8.7%)	**370** (10.5%)	**710** (9.9%)	**72** (9.9%)
6 to 12 months	**254** (20.7%)	**213** (18.6%)	**31** (20.8%)	**192** (18.8%)	**31** (24.6%)	**851** (24.1%)	**1,572** (21.9%)	**159** (21.8%)
12 to 24 months	**205** (16.7%)	**322** (28.1%)	**35** (23.5%)	**298** (29.1%)	**18** (14.3%)	**1,027** (29.1%)	**1,905** (26.5%)	**167** (22.9%)
24 to 36 months	**107** (8.7%)	**177** (15.5%)	**12** (8.1%)	**120** (11.7%)	**4** (3.2%)	**274** (7.8%)	**694** (9.6%)	**70** (9.6%)
36 months or more	**82** (6.7%)	**155** (13.5%)	**6** (4.0%)	**73** (7.1%)		**162** (4.6%)	**478** (6.6%)	**42** (5.8%)
Total	**1,227** (100.0%)	**1,144** (100.0%)	**149** (100.0%)	**1,024** (100.0%)	**126** (100.0%)	**3,524** (100.0%)	**7,194** (100.0%)	**730** (100.0%)

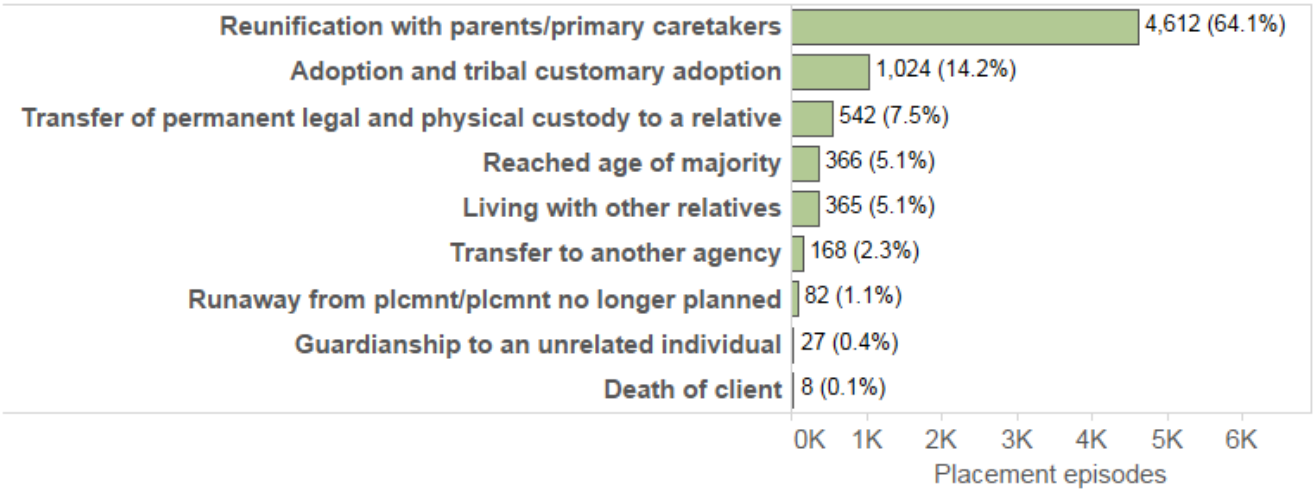
Reasons for leaving out-of-home care

The following section provides information about the reasons why children were discharged from their out-of-home placement episode.

- For placement episodes that ended in 2017 (see Figure 15), the majority (64.1 percent) ended because children were able to safely return home to their parents or other primary caregivers.
- More than one-quarter (26.8 percent) of placement episodes ended with children being adopted, living with relatives (including a non-custodial father), or a transfer of permanent legal and physical custody to a relative.
- A small proportion of placements ended because children turned 18, ran away, or transferred to a different agency, such as a correctional facility.
- Tragically, there were eight cases where continuous placement episodes ended because the child died while in care. Five instances were due to accidental or natural causes, two were undetermined, and one was due to child maltreatment.
- In 2017, the department began using a trauma-informed, robust and scientific systemic critical incident review process for child fatalities that occur in foster care settings. The review process is designed to systemically analyze the child welfare system to identify opportunities for improvement, as well as address barriers to providing the best possible services to children and families. The model utilizes components from the same science used by other safety-critical industries, including aviation and health

care; it moves away from blame and toward a system of accountability that focuses on identifying underlying systemic issues to improve Minnesota's child welfare system.

Figure 15: Number and percent of placement episodes ending by discharge reason in 2017



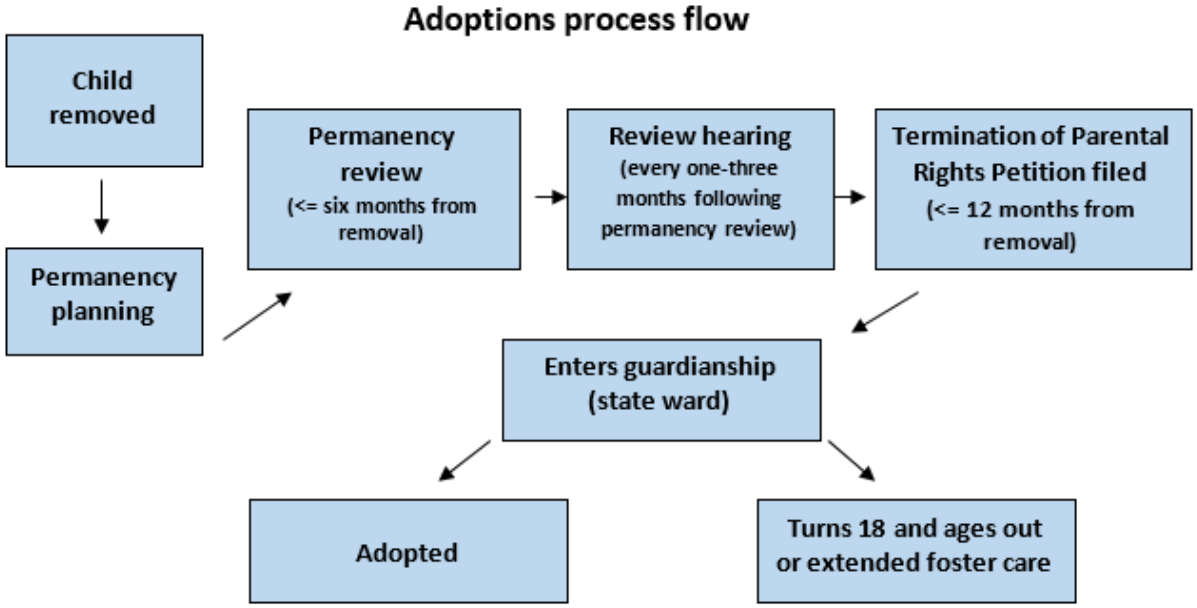
Adoptions

Some children exited out-of-home care in 2017 due to adoption. The following section provides details about children who exited to adoption, as well as the process through which a child goes from being in out-of-home care to being adopted. Adoption is the preferred permanency option if reunification with parents or primary caregivers cannot be achieved in a safe and/or timely fashion. Children may ultimately be adopted by their foster parents, relatives, or other individuals who have developed a relationship with a child; all pre-adoptive parents must meet the necessary state requirements for adoption. When reunification is not possible, and adoption is determined to be the appropriate permanency option for a child, the court must order a termination of parental rights (TPR), which severs the legal parent-child relationship, or accept parents' consent to adoption. The court must also order guardianship of a child to the department's commissioner.

Children under guardianship of the commissioner are referred to as "state wards" in this section. The commissioner is the temporary guardian of these children until they are adopted. Adoption is the only permanency option for children under guardianship of the commissioner.[1] As designated agents of the

[1] The exception is when a court determines that re-establishing parental rights is the most appropriate permanency option. There are specific eligibility criteria that must be met prior to making this determination, including age of a child, length of time in care post-termination of parental rights, and whether a parent has corrected conditions that led to the termination of parental rights. See Minn. Stat., 260C.329 for more information.

commissioner, county and tribal social service agencies are responsible for safety, placement, and well-being of these children, including identifying appropriate adoptive parents and working with adoptive parents, courts, and others to facilitate the adoption process. This process may be lengthy. Children may remain under guardianship of the commissioner for months, years, or until they turn age 18 and either age out of the foster care system or continue in extended foster care. Once a child turns 18, they are no longer under guardianship of the commissioner.



Children and state guardianship: Enterers and continuers

The remainder of this report uses county data from the department's Adoption Information System, and includes data from court, county, and tribal social services documents entered at the department. As was done in the section about children who experienced out-of-home placement, this section will distinguish between two groups of children who are under guardianship of the commissioner in a year: Enterers and continuers.

Enterers are those children where the commissioner became their legal guardian in 2017 due to termination of parental rights or court's acceptance of parents' consent to

adoption. Continuers are those who became wards of the state prior to 2017 and remained under state guardianship into 2017. During 2017, there were 2,314 children who spent at least one day under guardianship of the commissioner. There were 965 children who entered guardianship and 1,349 who continued in guardianship.

Characteristics of children under state guardianship

This section focuses on the age and race of children who entered guardianship and continued to be under state guardianship in 2017. White children remain the largest group, both entering and continuing in guardianship in 2017 (see Figure 16). Although white children comprised the greatest number of children under guardianship, American Indian children and those with two or more races have the highest rate per 1,000 for children continuing in care under guardianship (see Figure 17).

Figure 16: Number and percent of children under guardianship by race/ethnicity in 2017

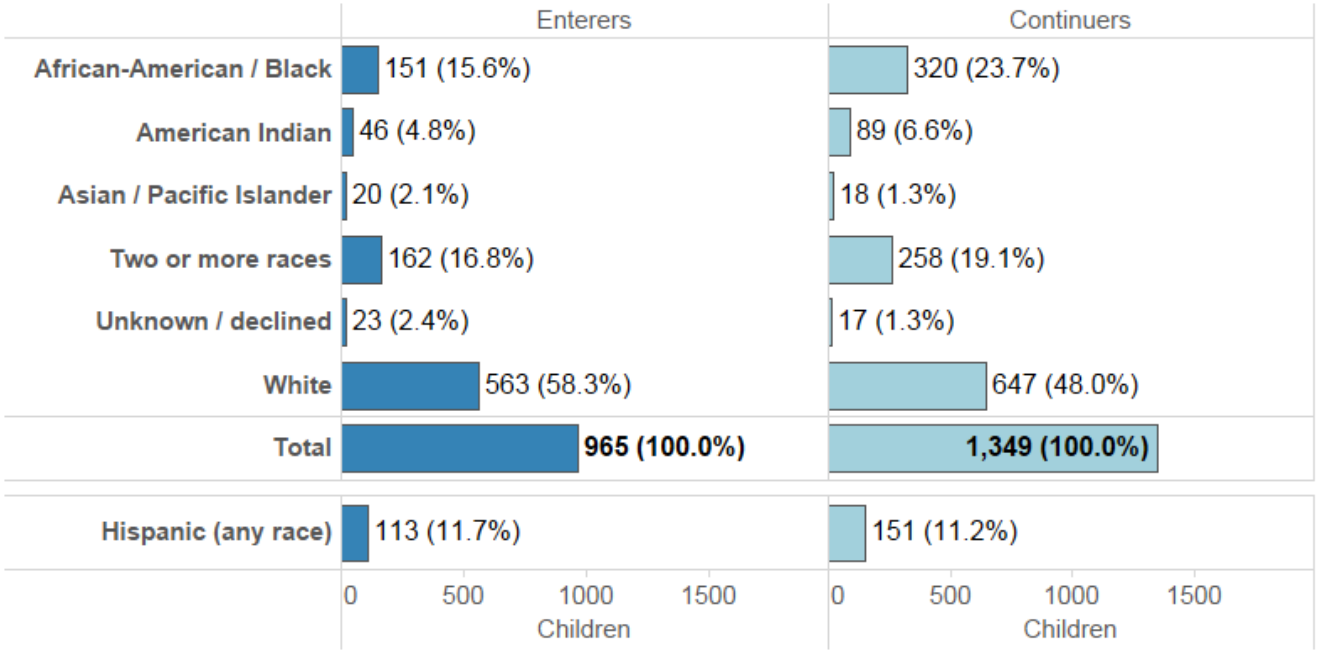


Figure 17: Rate per 1,000 for children under guardianship in 2017

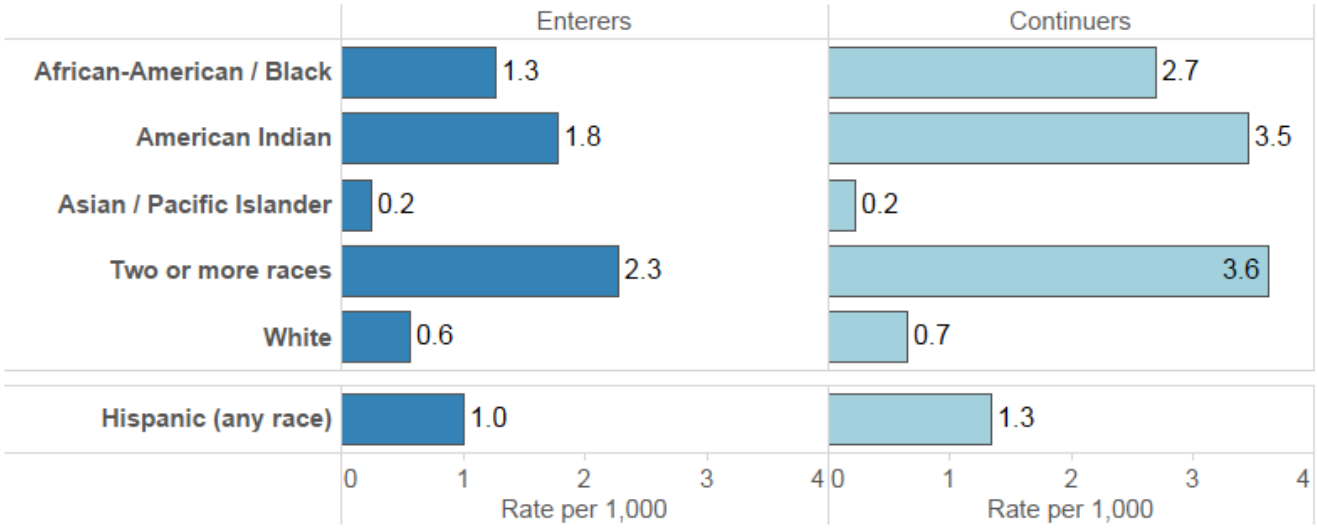
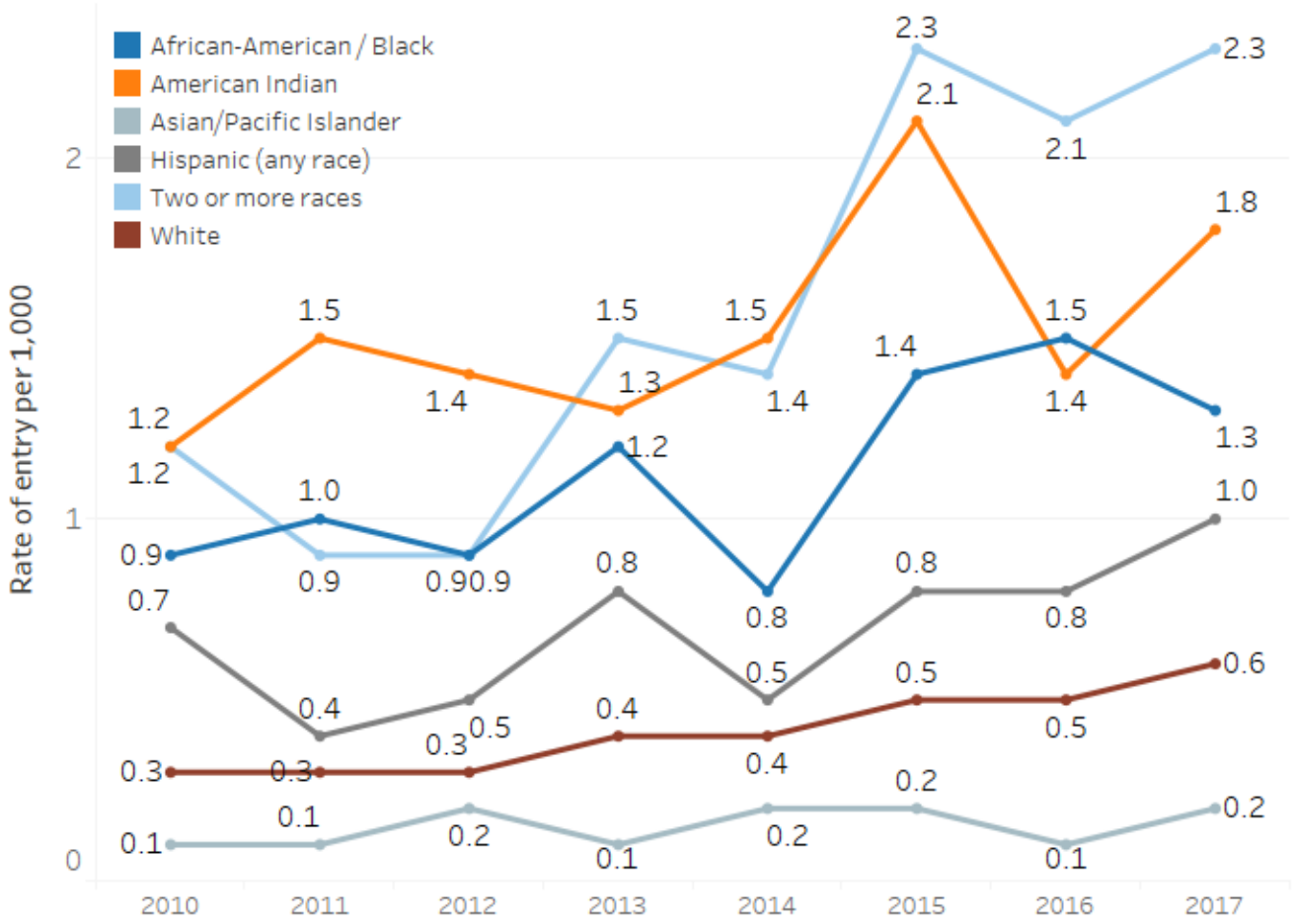
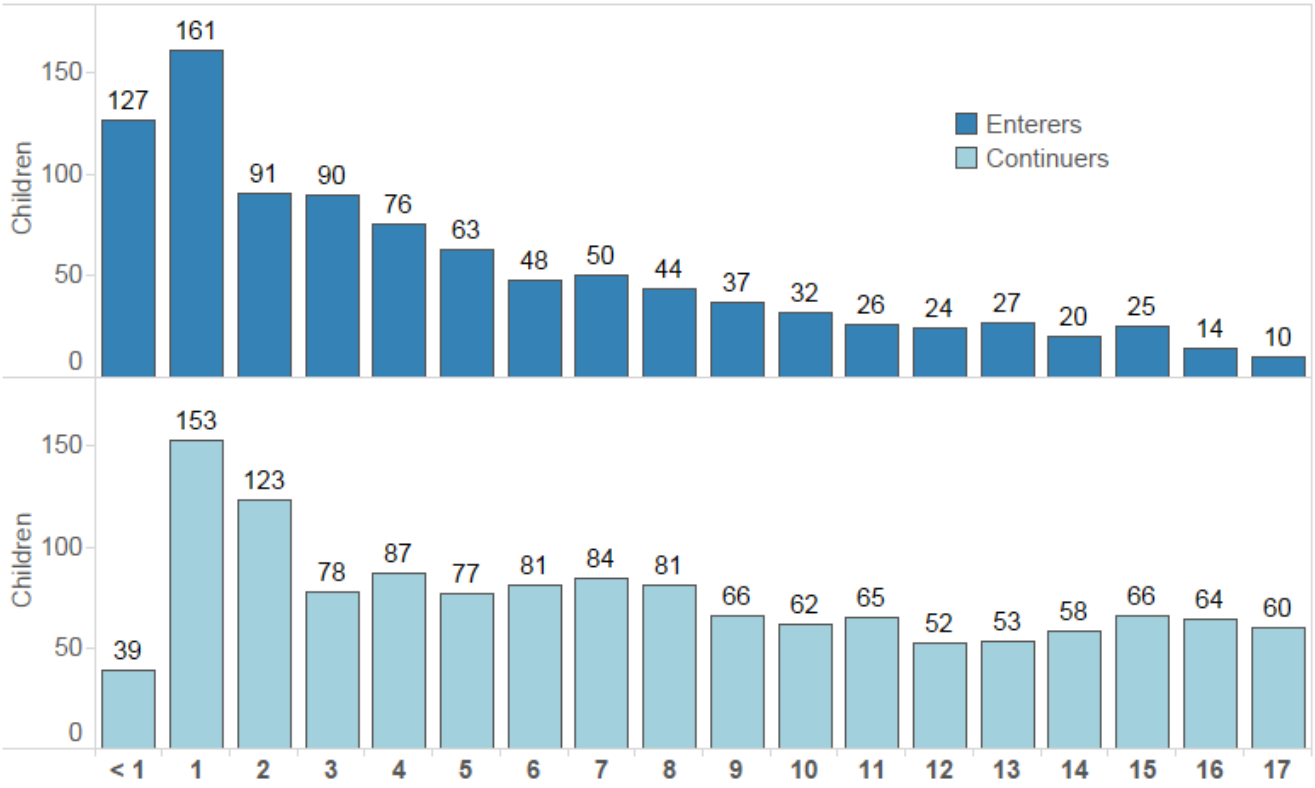


Figure 18: Rate per 1,000 of children entering guardianship by race/ethnicity, 2010 – 2017



- Figure 19 shows the distribution of children entering and continuing guardianship by age
- Children entering guardianship tended to be younger, with approximately half being age 4 or younger
- Children continuing under guardianship were more evenly distributed across age groups, although approximately 35.5 percent of these children were also age 4 or younger.

Figure 19. Number of children by age experiencing state guardianship in 2017

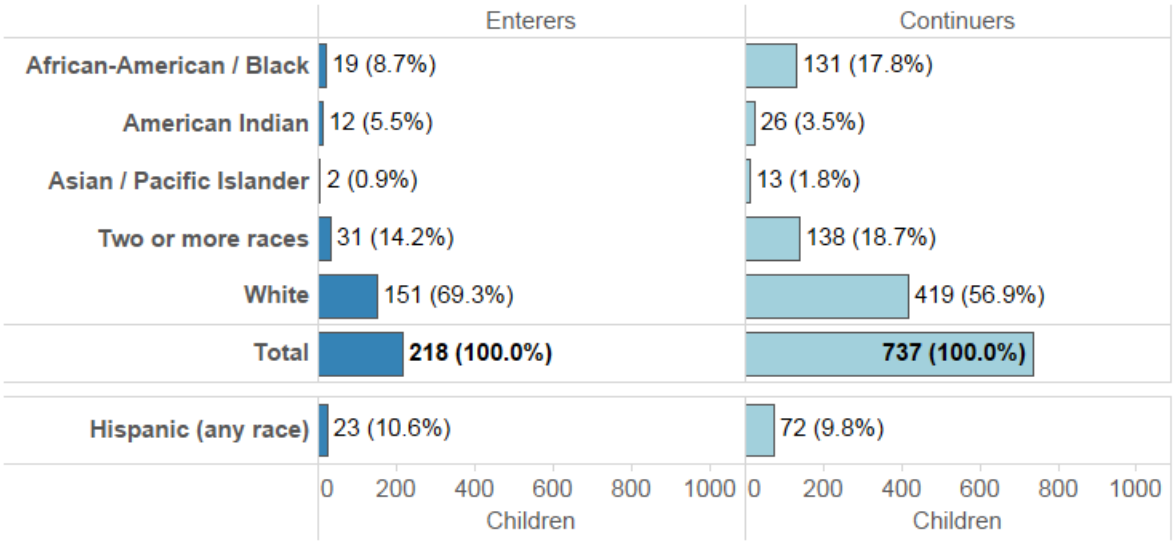


Characteristics of children who were adopted

The following section provides information on the characteristics of children who had been state wards in 2017 and who had finalized adoptions during the year.

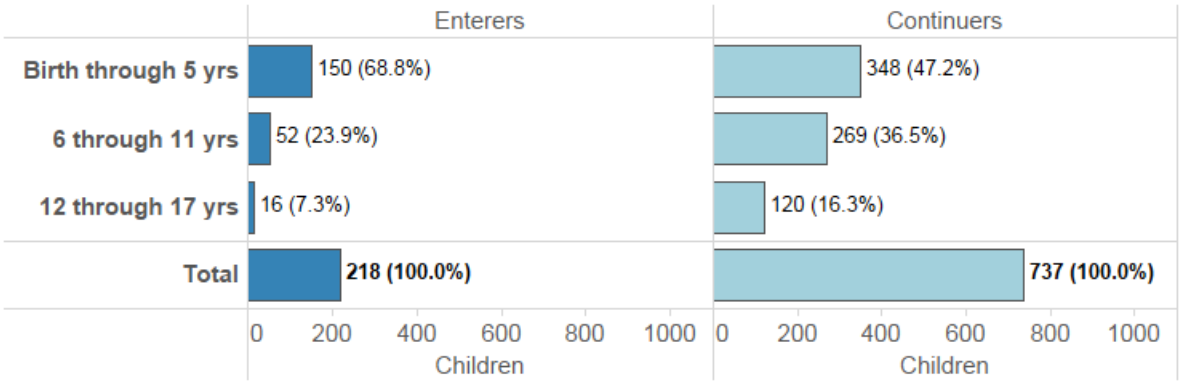
- During 2017, 955 children had finalized adoptions. Of these, 218 became state wards during the same year, and 737 were state wards prior to the beginning of 2017.
- In total, approximately 41.8 percent of all children under state guardianship in 2017 were adopted.
- White children comprised the largest proportion who were adopted. The racial and ethnic breakdown of all children adopted during 2017 is shown in Figure 20.

Figure 20. Number and percent of children adopted by race/ethnicity in 2017



- Children birth to age 5 comprise the largest proportion of adopted children. This pattern is more pronounced for children who entered guardianship in 2017 than for those who were already under guardianship on the first of the year, (Figure 21).

Figure 21. Number and percent of children adopted by age group in 2017



The number of children adopted in all age categories increased in 2017 from 2016.

- As displayed in the next two graphs (Figures 22 and 23), white children continue to comprise the largest group of adopted children; white children comprised 52.6 percent of children under guardianship in 2017, and 77.7 percent of Minnesota's child population.
- The number adopted increased for all races, excluding Asian/Pacific Islander and Hispanic children of any race, (Figures 22 and 23).

Figure 22. Number of children adopted by age group, 2010 – 2017

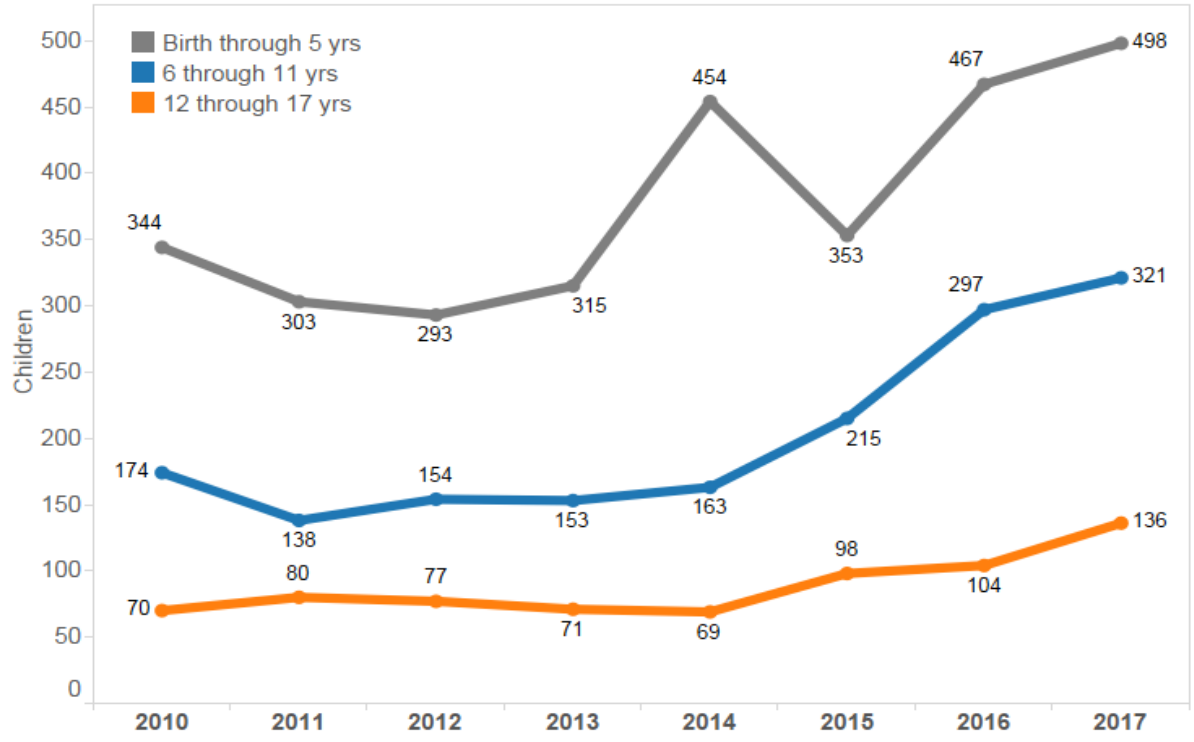
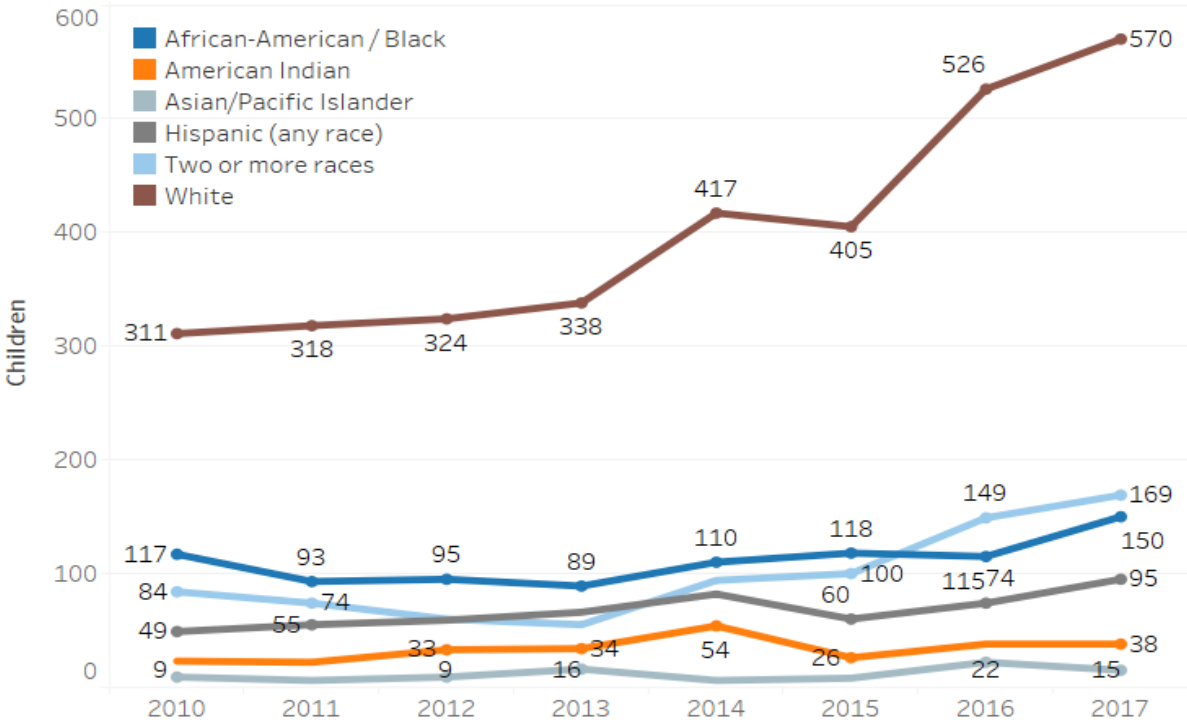


Figure 23. Number of children adopted by race/ethnicity, 2010 – 2017



Children who aged out of guardianship

Not all children who become state wards eventually get adopted. Some children turn age 18 and "age out" of the foster care system. Children may still be adopted after turning 18, although this information is not monitored by the department.

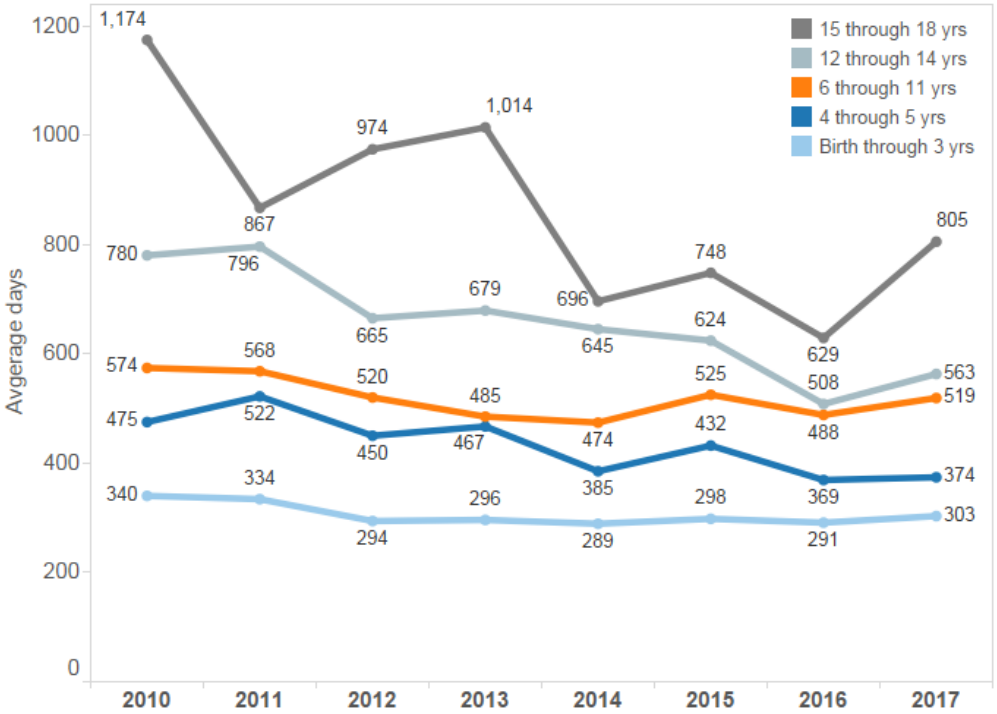
- During 2017, 55 children who had been state wards aged out before being adopted
- Eleven of the 55 children (20 percent) continued in care after turning 18 through the extended foster care program.

Time to adoption

The average time from being placed under state guardianship to adoption has overall improved over the last eight years. The following figure (Figure 24) provides information about how long it takes from the date of entering state guardianship to adoption for children who were adopted between 2010 and 2017.

- Younger children are typically adopted faster than older children, with those birth - 3 remaining in care for 303 days, on average.
- Children age 15 - 18 increased by an average of 176 days in 2017 as compared with their length of time in guardianship in 2016.
- Every age group saw an increase in the time to adoption from 2015 to 2017.

Figure 24. Days from entering guardianship to adoption by age, 2010 – 2017



Adoption of siblings[2]

Keeping siblings together contributes to maintaining family relationships and cultural connections. Separating siblings in foster care and adoption may add to the trauma experienced by separation from birth parents and other family members. Both state and federal laws require siblings to be placed together for foster care and adoption at the earliest possible time, unless it is determined not to be in the best interest of a child, or is not possible after reasonable efforts by an agency.

- Table 4 shows the number and percentages of sibling groups that were adopted fully intact, and either partially or fully intact for the years 2010–2017.
- In 2017, 65.8 percent of sibling groups were adopted together.
- About 81 percent of sibling groups were adopted either partially or fully intact in 2017. These percentages have had only minor fluctuations between 2010 and 2017.

Table 4. Sibling group preservation in adoptions, 2010 – 2017

	2010	2011	2012	2013	2014	2015	2016	2017
Sibling groups available for adoption with at least one child adopted	153	133	135	135	184	169	237	234
Sibling groups adopted fully intact	111	90	97	97	130	118	172	154
Sibling groups adopted partially intact	18	14	13	16	22	23	27	36
Percent of sibling groups adopted fully intact	72.5%	67.7%	71.9%	71.9%	70.7%	69.8%	72.6%	65.8%
Percent of sibling groups adopted partially or fully intact	84.3%	78.2%	81.5%	83.7%	82.6%	83.4%	84.0%	81.1%

[2] Currently, the Social Service Information System categorizes siblings based on the biological mother, so siblings placed with, or separated from paternal siblings, are not included in the data. In addition, siblings who are 18 years or older, who were previously adopted, or who were never under guardianship of the commissioner, are also not counted as part of a sibling group in this data table. Because percentages of sibling groups preserved are calculated for adoption within a calendar year, some intact adoptions may not be counted if adoptions of individual children took place over the span of more than one year. Note that the percentages for sibling group preservation are smaller than those reported in previous years due to increased accuracy in determining sibling groups. The current method includes all sibling groups available for adoption during a given year in which one or more siblings were adopted.

Tribal customary adoptions

Most tribes in Minnesota offer culturally appropriate permanency options through tribal court. Some tribes utilize customary adoption as a permanency option, which occurs after suspension of parental rights rather than a termination of parental rights.

- Table 5 includes American Indian children who were under tribal court jurisdiction and were adopted through customary adoption from 2010 – 2017 by age group. Although there are minor fluctuations in numbers by age group across years, the relatively small number of tribal court children within each group limits interpretation of these trends.

Table 5. Number and percentage of American Indian children adopted through customary adoption by age group, 2010 - 2017

	Birth through 5 yrs.		6 yrs. or older		
	Number	Percent	Number	Percent	Total Number
2010	14	60.9%	9	39.1%	23
2011	23	60.5%	15	39.5%	38
2012	22	73.3%	8	26.7%	30
2013	10	47.6%	11	52.4%	21
2014	20	90.9%	2	9.1%	22
2015	37	43.5%	48	56.5%	85
2016	24	55.8%	19	44.2%	43
2017	28	40.0%	42	60.0%	70

Post placement services and outcomes

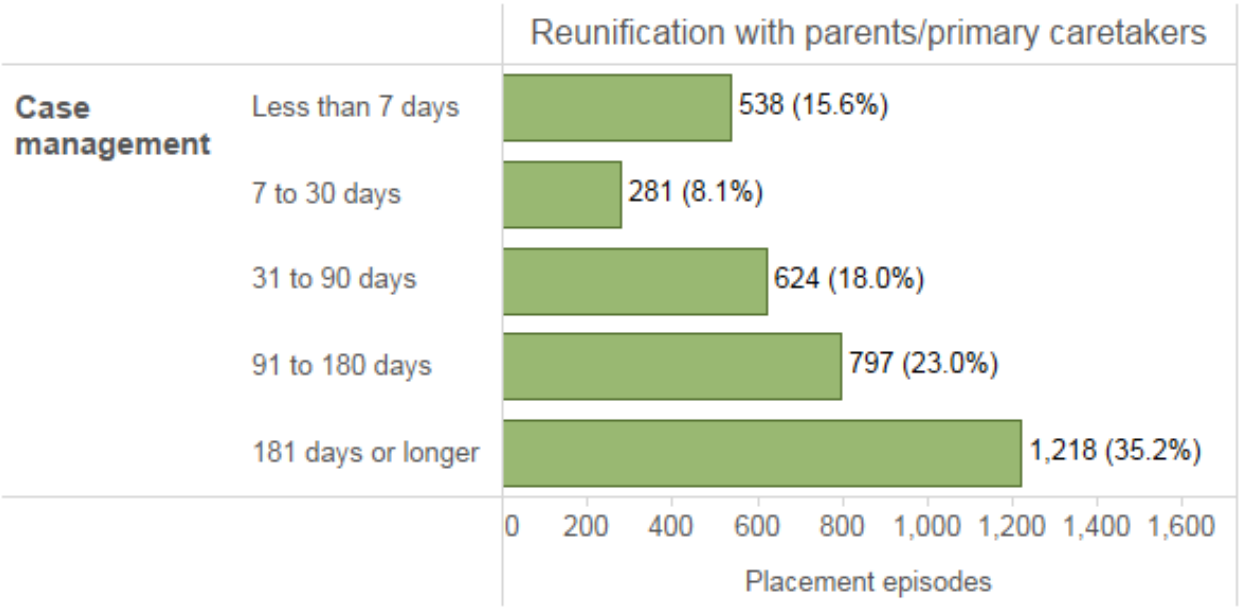
After achieving permanency, either through reunification, adoption, or transfer of permanent legal and physical custody to a relative, the local social services agency or the department may provide services to support families. Some children who have achieved permanency may continue to have challenges and re-enter out-of-home care. The following section provides information about the services received post placement and on re-entry into out-of-home care.

Post reunification services

Children and their families may continue receiving support after their out-of-home placement has ended through provision of case management services by the local social services agency. The following section provides information about how many children received this type of service and for how long.

- For episodes that ended in reunification with parents/caretakers and children/families receiving case management, nearly 60 percent of episodes remained open for three months or more after a child was reunified.
- See Figure 25 for information on episodes that ended with reunification and ongoing case management services.

Figure 25. Number and percent of episodes that closed to reunification where ongoing services were provided by length of time in 2017



Adoption and kinship assistance

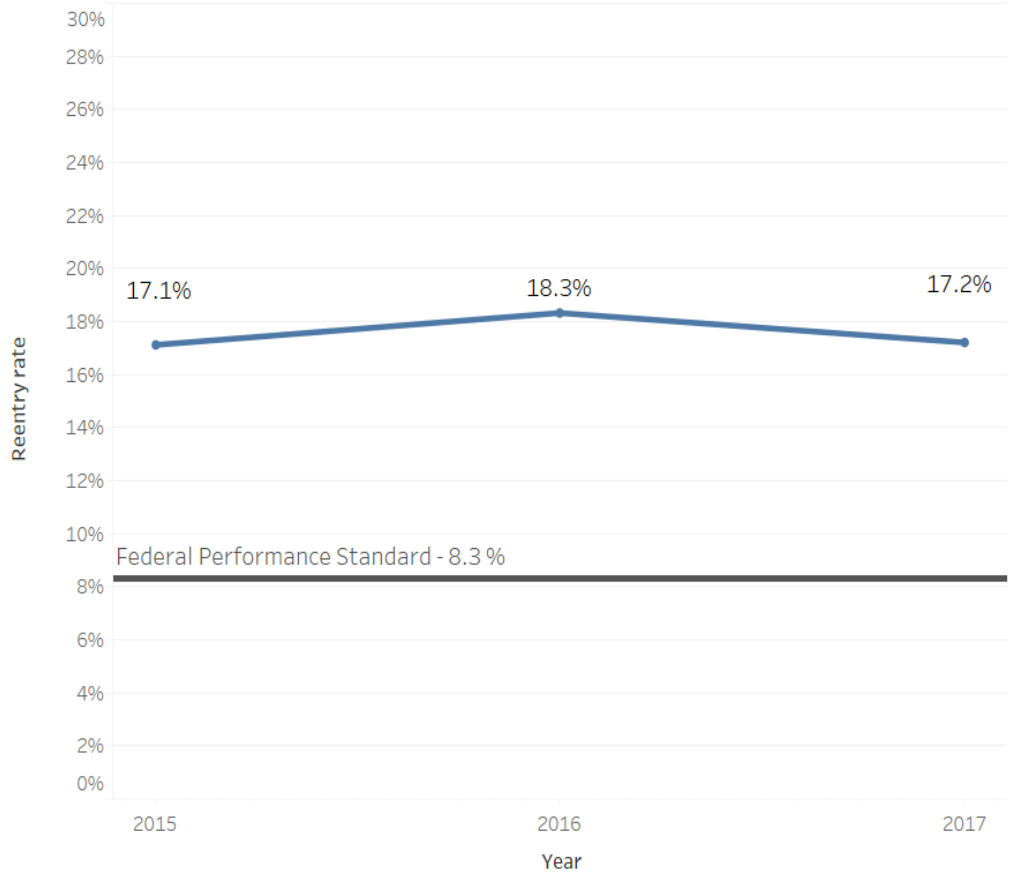
A child and family may receive ongoing support in the form of adoption assistance, available to many adoptive families or kinship assistance if they meet eligibility criteria. For more information about eligibility criteria and the process, see Northstar Adoption Assistance Program. While adoption assistance has been available for the past few decades, Northstar kinship assistance is a new program that began in 2015 to support relatives who assume permanent legal and physical custody of a related child.

- There were 7,832 children who received payments for adoption assistance in 2017.
- Of the 7,832 children, 731 were adopted or had a customary tribal adoption finalized in 2017.
- There were 1,898 children who received payments for Northstar kinship assistance in 2017.

Re-entry

Despite the best efforts of county and tribal agency staff, some children who experience out-of-home care and achieve permanency will re-enter the foster care system due to either safety concerns or the need for specialized treatment. Using the CFSR Round 3 performance measure for re-entry into foster care, Minnesota's re-entry rate is much higher than the federal performance standard of 8.3 percent.

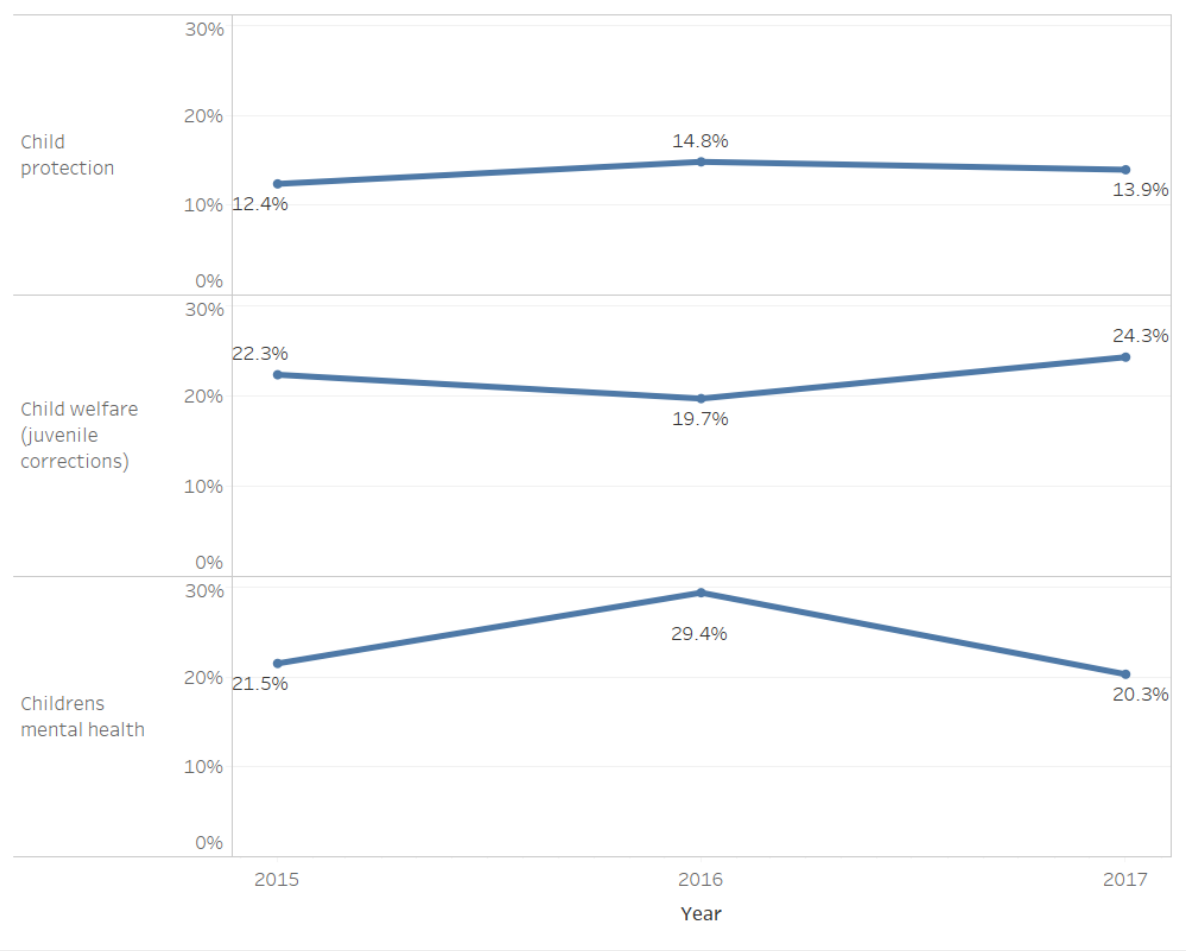
Figure 26. Re-entry into foster care in 2017



Sidebar: A closer look at out-of-home care re-entry and program of services

When foster care re-entry is further explored by program area in which a child is being served by social services, the majority of children who re-entered according to this performance measure received services from one of the following programs: Child protection, child welfare (frequently juvenile correctional placements), or children's mental health. Child protection consistently has the lowest re-entry rate of the three (13.9 percent in 2017), although it is still above the federal performance standard.

Re-entry rates by program area



The out-of-home care and permanency appendix

Table 6. Number of children in out-of-home care by sex and agency with U.S. Census child population estimate and rate per 1,000, 2017

Agency	Under 18 (female)	Under 18 (male)	18 or older (female)	18 or older (male)	Total children / young adults	2016 child population estimate	Child rate per 1,000
Aitkin	31	34	1	0	66	2,630	24.7
Anoka	251	258	11	14	534	83,398	6.1
Becker	101	108	6	0	215	8,207	25.5
Beltrami	563	565	10	5	1,143	11,651	96.8
Benton	53	60	1	1	115	9,882	11.4
Big Stone	10	5	0	0	15	1,042	14.4
Blue Earth	82	84	0	0	166	13,013	12.8
Brown	26	30	0	0	56	5,563	10.1
Carlton	64	82	3	2	151	8,085	18.1
Carver	95	66	6	6	173	27,384	5.9
Cass	69	60	4	0	133	6,190	20.8
Chippewa	3	5	0	0	8	2,781	2.9
Chisago	68	70	1	1	140	12,543	11.0
Clay	95	129	2	5	231	15,053	14.9
Clearwater	9	15	0	0	24	2,194	10.9
Cook	10	14	0	1	25	820	29.3
Crow Wing	125	119	2	3	249	13,965	17.5
Dakota	228	234	3	2	467	102,983	4.5
Douglas	51	44	3	1	99	7,982	11.9
Fillmore	12	13	0	0	25	5,095	4.9
Freeborn	48	50	1	0	99	6,621	14.8
Goodhue	51	55	4	0	110	10,466	10.1
Grant	5	5	0	1	11	1,360	7.4
Hennepin	1,463	1,580	65	79	3,187	273,089	11.1
Houston	17	24	0	0	41	4,065	10.1
Hubbard	39	51	1	1	92	4,407	20.4
Isanti	51	67	1	4	123	9,312	12.7
Itasca	125	149	7	10	291	9,563	28.7
Kanabec	22	28	1	1	52	3,394	14.7
Kandiyohi	52	56	3	1	112	10,193	10.6

Agency	Under 18 (female)	Under 18 (male)	18 or older (female)	18 or older (male)	Total children / young adults	2016 child population estimate	Child rate per 1,000
Kittson	5	3	1	1	10	925	8.6
Koochiching	25	37	1	1	64	2,350	26.4
Lac qui Parle	9	6	0	0	15	1,322	11.3
Lake	11	16	1	0	28	1,947	13.9
Lake of the Woods	3	8	0	0	11	687	16.0
Le Sueur	29	28	1	0	58	6,623	8.6
McLeod	67	68	2	0	137	8,379	16.1
Mahnomen	10	15	2	0	27	1,710	14.6
Marshall	7	4	1	0	12	2,124	5.2
Meeker	20	14	0	3	37	5,612	6.1
Mille Lacs	120	139	3	0	262	6,180	41.9
Morrison	48	48	1	1	98	7,732	12.4
Mower	47	52	0	1	100	9,793	10.1
Nicollet	41	39	3	1	84	7,425	10.8
Nobles	31	39	3	1	74	5,842	12.0
Norman	12	11	0	0	23	1,511	15.2
Olmsted	93	105	10	7	215	37,756	5.2
Otter Tail	75	95	1	2	173	12,591	13.5
Pennington	24	29	1	0	54	3,291	16.1
Pine	78	75	0	1	154	5,799	26.4
Polk	46	47	1	1	95	7,543	12.3
Pope	14	15	0	4	33	2,292	12.7
Ramsey	815	906	34	30	1,785	126,468	13.6
Red Lake	5	5	0	0	10	983	10.2
Renville	18	33	0	0	51	3,248	15.7
Rice	88	97	5	3	193	14,302	12.9
Roseau	15	10	0	0	25	3,792	6.6
St. Louis	602	624	20	19	1,265	38,252	32.1
Scott	92	65	1	2	160	40,371	3.9
Sherburne	67	80	1	2	150	25,074	5.9
Sibley	19	20	0	0	39	3,509	11.1
Stearns	191	230	7	11	439	35,620	11.8
Stevens	13	18	1	1	33	2,037	15.2

Agency	Under 18 (female)	Under 18 (male)	18 or older (female)	18 or older (male)	Total children / young adults	2016 child population estimate	Child rate per 1,000
Swift	22	28	0	1	51	2,150	23.3
Todd	47	55	1	4	107	5,783	17.6
Traverse	8	9	0	1	18	686	24.8
Wabasha	19	29	2	1	51	4,693	10.2
Wadena	33	49	1	1	84	3,355	24.4
Washington	124	129	10	6	269	62,865	4.0
Watonwan	7	11	2	2	22	2,622	6.9
Wilkin	4	9	0	1	14	1,420	9.2
Winona	69	67	2	0	138	9,300	14.6
Wright	114	137	3	1	255	37,621	6.7
Yellow Medicine	20	23	0	0	43	2,289	18.8
Southwest HHS	143	140	4	6	293	18,037	15.7
Des Moines Valley HHS	27	43	3	0	73	4,929	14.2
Faribault-Martin	78	78	1	3	160	7,349	21.2
Leech Lake Band of Ojibwe	121	130	1	1	253	1,975	127.1
White Earth Nation	248	249	3	0	500	1,981	250.9
MN Prairie	103	91	0	1	195	19,213	10.1
Minnesota	7,746	8,318	270	259	16,593	1,288,333	12.5

†Note: The data for these two groups are 2010 Census numbers which represent children residing on the Leech Lake and White Earth reservations who indicated American Indian alone or as one of two or more races. There are no intercensal child population estimates for these groups. The Leech Lake reservation overlaps Cass, Itasca, Beltrami and Hubbard counties. The White Earth reservation overlaps Mahnomen, Becker and Clearwater counties.

Note: Child rate per 1,000 only includes children under 18. Age was calculated either on the first of the year for those who were in care on Jan. 1, 2017 or on the day an out-of-home care placement episode began in 2017 for all others.

Table 7. Number of children in out-of-home care by age and agency, 2017

Agency	Birth - 2 years	3 - 5 years	6 - 8 years	9 - 11 years	12 - 14 years	15 - 17 years	18 or older	Total children
Aitkin	12	7	9	13	12	12	1	66
Anoka	115	86	75	68	78	87	25	534
Becker	56	34	35	26	27	31	6	215
Beltrami	296	214	186	164	140	128	15	1,143
Benton	26	18	10	17	12	30	2	115
Big Stone	4	3	0	2	1	5	0	15
Blue Earth	35	41	30	31	19	10	0	166
Brown	12	10	6	5	12	11	0	56
Carlton	28	26	14	23	33	22	5	151
Carver	26	14	23	21	30	47	12	173
Cass	20	19	19	23	18	30	4	133
Chippewa	2	3	1	1	1	0	0	8
Chisago	38	29	19	18	14	20	2	140
Clay	39	27	29	20	46	63	7	231
Clearwater	6	4	2	4	2	6	0	24
Cook	4	3	1	6	6	4	1	25
Crow Wing	71	47	39	25	35	27	5	249
Dakota	131	79	79	48	53	72	5	467
Douglas	18	20	14	10	18	15	4	99
Fillmore	4	3	4	1	4	9	0	25
Freeborn	26	21	11	10	8	22	1	99
Goodhue	21	16	17	15	17	20	4	110
Grant	2	2	0	2	2	2	1	11
Hennepin	877	458	417	378	386	527	144	3,187
Houston	12	8	6	2	7	6	0	41
Hubbard	21	19	8	12	17	13	2	92
Isanti	22	19	19	22	16	20	5	123
Itasca	45	45	27	30	57	70	17	291
Kanabec	14	7	5	4	8	12	2	52
Kandiyohi	25	13	14	11	22	23	4	112
Kittson	0	1	1	2	2	2	2	10

Agency	Birth - 2 years	3 - 5 years	6 - 8 years	9 - 11 years	12 - 14 years	15 - 17 years	18 or older	Total children
Koochiching	7	10	3	12	13	17	2	64
Lac qui Parle	2	1	2	3	2	5	0	15
Lake	4	3	5	5	4	6	1	28
Lake of the Woods	3	4	1	0	1	2	0	11
Le Sueur	11	13	8	7	6	12	1	58
McLeod	27	25	24	19	18	22	2	137
Mahnomen	4	4	3	0	3	11	2	27
Marshall	2	3	0	0	1	5	1	12
Meeker	4	2	3	4	11	10	3	37
Mille Lacs	86	41	37	28	37	30	3	262
Morrison	22	22	7	14	17	14	2	98
Mower	24	11	22	21	13	8	1	100
Nicollet	22	4	12	12	18	12	4	84
Nobles	3	8	12	10	16	21	4	74
Norman	6	3	1	2	3	8	0	23
Olmsted	55	19	21	21	30	52	17	215
Otter Tail	50	19	25	19	30	27	3	173
Pennington	21	8	9	2	5	8	1	54
Pine	41	26	23	18	19	26	1	154
Polk	16	14	11	6	21	25	2	95
Pope	5	8	4	5	3	4	4	33
Ramsey	419	249	231	181	245	396	64	1,785
Red Lake	1	5	2	0	2	0	0	10
Renville	8	10	7	6	12	8	0	51
Rice	48	32	22	27	21	35	8	193
Roseau	2	3	3	2	5	10	0	25
St. Louis	327	217	208	147	178	149	39	1,265
Scott	42	23	25	18	21	28	3	160
Sherburne	32	24	21	15	25	30	3	150
Sibley	10	8	8	2	3	8	0	39
Stearns	95	75	50	41	61	99	18	439
Stevens	5	4	5	3	4	10	2	33
Swift	15	11	9	4	6	5	1	51

Agency	Birth - 2 years	3 - 5 years	6 - 8 years	9 - 11 years	12 - 14 years	15 - 17 years	18 or older	Total children
Todd	21	24	20	20	10	7	5	107
Traverse	3	4	2	1	3	4	1	18
Wabasha	9	6	4	6	9	14	3	51
Wadena	15	14	11	14	16	12	2	84
Washington	59	30	23	28	35	78	16	269
Watonwan	5	2	0	3	1	7	4	22
Wilkin	2	1	2	2	1	5	1	14
Winona	32	21	19	13	23	28	2	138
Wright	50	36	36	42	33	54	4	255
Yellow Medicine	8	6	8	12	4	5	0	43
Southwest HHS	57	48	40	44	48	46	10	293
Des Moines Valley HHS	10	11	6	13	14	16	3	73
Faribault-Martin	33	28	20	19	23	33	4	160
Leech Lake Band of Ojibwe	49	73	47	37	27	18	2	253
White Earth Nation	144	92	78	54	70	59	3	500
MN Prairie	42	31	44	30	17	30	1	195
Minnesota	3,966	2,632	2,304	2,006	2,291	2,865	529	16,593

Table 8. Number of children in out-of-home care by race, ethnicity and by agency, 2017

Agency	African-American / Black	American Indian	Asian or Pacific Islander	Two or more races	Unknown/ declined	White	Grand total	Hispanic (any race)
Aitkin	*	16	*	9	*	36	66	*
Anoka	77	21	8	94	*	324	534	44
Becker	*	74	*	39	*	99	215	14
Beltrami	*	995	*	44	*	93	1,143	24
Benton	13	*	*	23	*	73	115	*
Big Stone	*	*	*	*	*	14	15	*
Blue Earth	25	*	*	24	*	100	166	11
Brown	*	*	*	*	*	54	56	12
Carlton	*	65	*	29	*	54	151	*
Carver	17	*	*	18	*	129	173	13
Cass	*	34	*	*	*	86	133	*
Chippewa	*	*	*	*	*	7	8	*
Chisago	*	*	*	17	*	109	140	7
Clay	18	35	*	58	*	120	231	50
Clearwater	*	12	*	*	*	7	24	*
Cook	*	*	*	*	*	15	25	*
Crow Wing	20	24	*	18	*	186	249	*
Dakota	86	11	8	84	*	253	467	65
Douglas	13	*	*	19	*	59	99	*
Fillmore	*	*	*	*	*	24	25	*
Freeborn	*	*	*	12	*	84	99	23
Goodhue	*	*	*	9	*	92	110	17
Grant	*	*	*	*	*	8	11	*
Hennepin	1,274	448	91	731	*	598	3,187	413
Houston	*	*	*	*	*	30	41	*
Hubbard	8	22	*	12	*	49	92	10
Isanti	*	*	*	23	*	90	123	*
Itasca	*	44	*	30	*	211	291	*
Kanabec	*	*	*	*	*	48	52	*
Kandiyohi	9	*	*	*	*	93	112	54
Kittson	*	*	*	*	*	8	10	*

Agency	African-American / Black	American Indian	Asian or Pacific Islander	Two or more races	Unknown/ declined	White	Grand total	Hispanic (any race)
Koochiching	*	9	*	*	*	50	64	*
Lac qui Parle	*	*	*	*	*	13	15	*
Lake	*	*	*	*	*	24	28	*
Lake of the Woods	*	*	*	*	*	*	11	*
Le Sueur	*	*	*	*	*	50	58	13
McLeod	*	*	*	10	*	120	137	18
Mahnomen	*	20	*	*	*	*	27	*
Marshall	*	*	*	*	*	10	12	*
Meeker	*	*	*	*	*	28	37	*
Mille Lacs	*	178	*	17	*	62	262	*
Morrison	*	*	*	23	*	72	98	*
Mower	11	*	11	15	*	63	100	16
Nicollet	*	*	*	16	*	61	84	19
Nobles	*	*	*	*	*	53	74	33
Norman	*	*	*	*	*	21	23	*
Olmsted	28	*	*	41	*	139	215	17
Otter Tail	8	13	*	19	*	127	173	9
Pennington	*	*	*	*	*	46	54	15
Pine	*	58	*	13	*	80	154	*
Polk	*	*	*	15	*	70	95	30
Pope	*	*	*	*	*	26	33	*
Ramsey	669	143	173	312	*	466	1,785	201
Red Lake	*	*	*	*	*	7	10	*
Renville	*	*	*	*	*	40	51	9
Rice	40	*	*	17	*	122	193	26
Roseau	*	*	*	*	*	17	25	*
St. Louis	105	316	*	224	*	602	1,265	36
Scott	11	*	*	30	*	105	160	18
Sherburne	18	*	*	34	*	88	150	*
Sibley	*	*	*	*	*	35	39	16
Stearns	84	12	*	69	*	265	439	56
Stevens	*	*	*	*	*	29	33	8
Swift	*	*	*	*	*	41	51	15

Agency	African-American / Black	American Indian	Asian or Pacific Islander	Two or more races	Unknown/ declined	White	Grand total	Hispanic (any race)
Todd	*	*	*	19	*	83	107	*
Traverse	*	*	*	*	*	10	18	*
Wabasha	*	*	*	*	*	45	51	11
Wadena	*	*	*	17	*	60	84	*
Washington	33	15	*	46	*	146	269	47
Watonwan	*	*	*	*	*	21	22	13
Wilkin	*	*	*	*	*	12	14	*
Winona	15	*	*	17	*	101	138	12
Wright	20	*	*	29	*	201	255	20
Yellow Medicine	*	12	*	11	*	19	43	*
Southwest HHS	8	50	*	46	*	179	293	37
Des Moines Valley HHS	*	*	*	*	*	70	73	12
Faribault-Martin	*	*	*	15	*	137	160	22
Leech Lake Band of Ojibwe	*	247	*	*	*	*	253	8
White Earth Nation	*	469	*	31	*	*	500	12
MN Prairie	12	*	*	20	*	162	195	37
Minnesota	2,710	3,434	346	2,499	*	7,337	16,593	1,629

* If the number of children is less than seven it is omitted to prevent identification of individuals. Totals include the omitted data.

Table 9. Number of new placement episodes by primary reason for removal from the home and by agency, 2017

Agency	Parental drug abuse	Alleged neglect	Child delinquency	Alleged physical abuse	Child mental health	Child family conflict	Caretaker mental health	Parental alcohol abuse	Alleged sexual abuse	Incarceration of parents	Abandonment	Inadequate housing	Child drug abuse	Relinquish or TPR	Child disability	Caretaker physical abuse health	Death of parent(s)	Child alcohol abuse	Safe Place for Newborns	Total children
Aitkin	15	7	0	0	2	7	2	1	0	0	0	0	1	0	0	0	0	0	0	35
Anoka	92	45	42	6	18	23	7	12	7	21	5	3	0	6	3	1	1	0	0	292
Becker	27	34	11	18	2	1	0	1	4	0	5	0	3	0	0	0	0	0	0	106
Beltrami	90	258	3	12	11	1	3	8	0	3	6	0	1	0	1	0	0	0	0	397
Benton	16	8	11	8	7	2	3	0	1	0	0	4	1	1	0	1	0	0	0	63
Big Stone	0	3	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	4
Blue Earth	27	17	3	1	4	1	4	4	4	3	0	0	0	0	0	0	0	0	0	68
Brown	12	4	2	1	0	4	1	1	0	0	0	1	0	2	0	1	0	0	0	29
Carlton	19	22	8	5	18	3	2	2	4	0	0	0	0	0	1	0	0	0	0	84
Carver	9	15	2	4	1	12	4	8	0	5	2	1	0	1	0	1	0	0	0	65
Cass	12	6	5	0	7	2	0	4	2	0	2	0	1	0	0	0	0	1	0	42
Chippewa	1	4	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	6
Chisago	21	22	0	2	2	2	4	1	1	2	4	3	1	10	0	1	0	0	0	76
Clay	3	7	1	57	5	16	2	0	2	0	2	0	0	1	0	0	0	0	0	96
Clearwater	2	4	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	10
Cook	6	0	6	0	3	1	2	0	0	1	0	0	0	1	0	0	0	0	0	20
Crow Wing	38	35	1	2	0	5	3	1	0	1	4	1	1	1	0	1	1	0	0	95
Dakota	79	75	41	1	1	19	1	7	7	6	9	2	2	8	14	0	0	1	0	273
Douglas	11	10	5	5	5	6	0	3	1	7	0	3	0	0	0	0	0	0	0	56
Fillmore	2	0	0	5	0	2	0	0	1	0	0	0	0	0	1	0	0	0	0	11
Freeborn	13	1	4	2	4	1	8	3	0	1	0	0	0	2	1	1	0	0	0	41
Goodhue	5	18	9	4	3	4	3	0	3	7	2	1	0	1	0	0	0	0	0	60
Grant	0	1	1	0	3	0	2	0	1	0	0	0	0	0	0	0	0	0	0	8
Hennepin	388	317	207	121	70	23	49	78	75	29	34	10	21	5	14	0	17	0	1	1,459
Houston	4	0	2	3	1	1	1	3	1	5	1	0	1	0	0	0	0	0	0	23
Hubbard	6	17	2	2	3	0	0	1	0	0	0	0	0	1	0	0	0	0	0	32
Isanti	26	11	8	0	5	1	1	2	0	2	0	3	0	0	0	0	1	0	0	60
Itasca	27	24	6	23	22	10	8	3	3	11	0	1	0	0	0	3	0	2	0	143
Kanabec	10	1	1	5	4	0	2	3	3	0	3	1	0	0	0	0	0	0	0	33
Kandiyohi	11	21	1	4	7	10	0	0	1	0	1	1	2	0	2	0	0	1	0	62
Kittson	0	0	0	1	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	4
Koochiching	14	6	2	4	5	0	1	0	0	0	0	0	0	0	0	0	0	0	0	32
Lac qui Parle	1	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	3

Agency	Parental drug abuse	Alleged neglect	Child delinquency	Alleged physical abuse	Child mental health	Child family conflict	Caretaker mental health	Parental alcohol abuse	Alleged sexual abuse	Incarceration of parents	Abandonment	Inadequate housing	Child drug abuse	Relinquish or TPR	Child disability	Caretaker physical abuse health	Death of parent(s)	Child alcohol abuse	Safe Place for Newborns	Total children
Lake	9	0	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12
Lake of the Woods	0	6	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	9
Le Sueur	9	11	2	0	5	1	0	2	0	1	0	0	0	0	0	0	0	0	0	31
McLeod	40	9	6	1	2	0	4	4	2	0	1	1	0	1	0	0	0	0	0	71
Mahnomen	7	0	0	4	2	0	0	0	0	0	0	0	1	1	0	0	0	0	0	15
Marshall	1	0	0	1	0	0	0	0	2	2	0	0	0	0	0	1	0	0	0	7
Meeker	5	3	0	0	2	2	0	0	0	2	0	0	0	0	0	1	0	0	0	15
Mille Lacs	41	20	1	5	9	0	0	2	0	1	0	6	0	0	0	1	0	0	0	86
Morrison	14	9	5	1	7	1	2	0	2	0	0	0	4	0	0	0	0	0	0	45
Mower	14	7	5	0	0	1	5	1	1	8	2	0	0	0	2	0	0	0	0	46
Nicollet	9	14	4	0	6	2	6	0	1	0	0	0	1	2	0	0	0	1	0	46
Nobles	10	0	0	4	10	2	1	1	0	2	1	0	0	0	0	1	0	0	0	32
Norman	0	3	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	6
Olmsted	21	25	3	10	12	7	5	1	1	0	0	0	0	1	2	0	0	0	0	88
Otter Tail	17	24	7	1	8	0	2	1	1	7	2	5	1	1	2	0	0	0	0	79
Pennington	17	11	1	2	0	0	0	1	0	1	0	3	1	0	0	0	0	0	0	37
Pine	35	10	4	2	5	1	4	2	0	5	1	0	0	0	0	1	0	0	0	70
Polk	13	7	1	9	5	6	0	0	1	3	0	0	0	0	3	2	0	0	0	50
Pope	3	6	0	0	0	1	2	0	0	2	0	0	0	0	0	0	0	0	0	14
Ramsey	139	263	82	217	27	30	37	6	38	5	8	2	7	2	3	2	5	0	1	874
Red Lake	6	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Renville	6	0	1	2	7	0	1	0	0	0	1	1	0	0	0	1	0	0	0	20
Rice	39	24	24	0	6	3	4	3	1	0	4	2	1	0	0	0	0	0	0	111
Roseau	4	3	0	3	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	12
St. Louis	270	42	19	9	72	21	26	18	8	13	16	4	5	6	0	5	1	0	0	535
Scott	23	17	2	8	4	6	5	9	2	6	2	0	0	3	0	0	0	0	0	87
Sherburne	22	5	10	13	11	3	1	0	0	0	1	0	3	1	0	0	0	0	0	70
Sibley	10	4	4	0	1	0	0	0	1	1	0	0	0	0	0	0	0	0	1	22
Stearns	43	69	55	15	19	12	1	7	5	3	7	0	3	0	1	0	0	0	0	240
Stevens	1	0	11	0	4	1	0	0	2	0	0	0	0	0	0	0	0	0	0	19
Swift	27	3	5	0	1	4	0	0	0	1	0	0	0	0	0	0	0	0	0	41
Todd	23	1	0	0	1	3	2	3	1	2	0	6	1	0	0	0	1	0	0	44
Traverse	4	2	0	0	2	0	2	2	2	0	0	0	0	0	0	0	0	0	0	14
Wabasha	5	11	1	1	1	3	0	0	0	0	0	1	0	0	0	0	0	0	0	23
Wadena	17	5	9	2	2	1	1	0	1	0	0	8	1	0	0	0	1	0	0	48
Washington	30	23	5	13	25	10	7	3	4	4	2	2	0	2	1	5	0	0	0	136

Agency	Parental drug abuse	Alleged neglect	Child delinquency	Alleged physical abuse	Child mental health	Child family conflict	Caretaker mental health	Parental alcohol abuse	Alleged sexual abuse	Incarceration of parents	Abandonment	Inadequate housing	Child drug abuse	Relinquish or TPR	Child disability	Caretaker physical abuse health	Death of parent(s)	Child alcohol abuse	Safe Place for Newborns	Total children
Watonwan	1	4	2	2	0	2	0	0	0	0	0	0	0	0	0	1	0	0	0	12
Wilkin	0	0	3	2	2	1	0	0	0	0	1	0	0	0	0	0	0	0	0	9
Winona	27	21	2	6	3	18	3	0	2	0	3	0	0	0	0	3	0	0	0	88
Wright	36	41	13	3	15	5	0	4	0	0	4	4	1	0	0	5	0	0	1	132
Yellow Medicine	11	3	0	0	3	3	2	1	0	0	2	0	0	0	0	0	0	0	0	25
Southwest HHS	42	25	17	4	4	11	4	0	4	12	5	7	1	4	0	2	0	0	0	142
Des Moines Valley HHS	11	9	5	2	7	3	1	0	0	1	1	0	0	0	0	0	0	0	0	40
Faribault-Martin	40	6	3	2	5	1	2	0	3	1	4	1	4	0	0	11	0	1	0	84
Leech Lake Band of Ojibwe	36	27	8	1	0	0	3	0	2	4	4	0	0	0	0	1	0	1	0	87
White Earth Nation	98	31	6	2	2	2	3	7	2	1	4	5	1	0	3	1	0	0	0	168
MN Prairie	37	15	12	4	8	2	8	14	8	0	2	2	1	1	0	0	0	0	0	114
Minnesota	2,260	1,812	723	653	523	330	258	239	221	192	158	95	73	65	55	54	28	8	4	7,751

Note: This table counts unique continuous placement episodes; children may have been placed in care on multiple occasions during the year.

Table 10. Number of children who experienced out-of-home care by location setting type and by agency, 2017

Agency	Foster family home – non-relative	Foster family home – relative	Residential treatment center	Pre-kinship home – relative	Group home	Pre-adoptive home – non-relative	Pre-adoptive home – relative	Correctional facility (locked)	Foster home– corporate/shift staff	Supervised independent living	Juvenile correctional facility (non-secure, 13 or more children)	Juvenile correctional facility (non-secure, 12 or fewer children)	ICF-DD	Total children
Aitkin	22	25	9	13	1	1	6	0	0	1	6	0	0	66
Anoka	272	152	41	49	15	36	53	3	14	12	40	4	2	534
Becker	98	68	14	31	2	7	23	10	4	4	0	18	0	215
Beltrami	555	545	63	118	78	30	11	22	11	14	25	7	0	1,143
Benton	47	28	14	2	11	15	15	1	3	1	8	2	0	115
Big Stone	6	2	5	0	1	5	2	0	1	0	0	0	0	15
Blue Earth	66	54	8	18	0	12	15	0	2	0	1	1	1	166
Brown	20	12	10	4	4	11	5	1	5	0	1	1	1	56
Carlton	56	53	40	23	26	7	4	5	6	3	2	0	0	151
Carver	57	44	21	32	7	4	10	3	5	15	20	1	0	173
Cass	42	22	16	21	16	12	6	2	5	3	5	3	0	133
Chippewa	1	6	0	0	1	1	1	1	0	0	0	1	0	8
Chisago	73	50	8	1	4	12	9	2	4	3	5	1	0	140
Clay	73	26	14	13	22	49	13	1	3	3	79	1	0	231
Clearwater	10	8	3	4	2	2	0	0	3	1	3	0	0	24
Cook	9	11	7	2	1	0	0	1	1	0	0	0	0	25
Crow Wing	117	84	16	16	12	33	21	0	5	1	4	0	0	249
Dakota	209	167	34	29	9	39	29	4	15	5	3	0	2	467
Douglas	56	27	8	6	5	3	2	1	1	2	3	4	0	99
Fillmore	4	0	3	0	7	5	0	1	3	0	0	1	0	25
Freeborn	42	30	8	4	7	13	17	2	1	2	0	0	0	99
Goodhue	54	34	22	8	3	4	4	1	3	5	0	0	0	110
Grant	5	1	3	0	0	1	0	1	1	0	0	1	0	11
Hennepin	1,275	1,256	496	213	241	204	190	131	62	118	11	1	2	3,187
Houston	19	7	4	4	0	8	0	2	1	0	1	0	0	41
Hubbard	34	22	6	22	1	11	5	0	2	2	2	0	1	92

Agency	Foster family home – non-relative	Foster family home – relative	Residential treatment center	Pre-kinship home – relative	Group home	Pre-adoptive home – non-relative	Pre-adoptive home – relative	Correctional facility (locked)	Foster home– corporate/shift staff	Supervised independent living	Juvenile correctional facility (non-secure, 13 or more children)	Juvenile correctional facility (non-secure, 12 or fewer children)	ICF-DD	Total children
Isanti	50	43	18	15	9	9	8	1	5	2	3	0	0	123
Itasca	127	63	77	19	6	18	22	12	11	7	12	13	0	291
Kanabec	22	15	7	2	6	2	8	2	0	1	0	2	0	52
Kandiyohi	33	45	10	5	8	11	13	3	4	5	6	8	0	112
Kittson	2	1	1	1	1	0	0	0	0	2	1	0	0	10
Koochiching	11	27	13	7	2	8	2	1	0	4	1	2	0	64
Lac qui Parle	3	5	1	0	1	4	1	0	1	0	0	0	0	15
Lake	7	7	4	5	3	2	0	2	1	2	0	0	0	28
Lake of the Woods	0	6	0	3	0	0	0	0	0	0	2	0	0	11
Le Sueur	28	15	10	10	0	5	1	1	0	1	1	1	0	58
McLeod	46	70	7	3	3	4	14	0	2	3	0	0	0	137
Mahnomen	8	9	4	2	1	1	1	4	0	2	1	3	0	27
Marshall	1	7	3	0	0	0	2	2	1	0	1	1	0	12
Meeker	10	5	5	7	8	0	0	0	6	1	1	0	0	37
Mille Lacs	104	94	13	60	16	21	2	9	4	4	9	3	0	262
Morrison	38	29	8	2	1	16	20	0	7	2	0	0	0	98
Mower	37	25	10	8	6	20	17	2	1	1	0	0	0	100
Nicollet	38	17	11	4	6	9	4	0	6	3	1	0	1	84
Nobles	21	8	15	2	4	8	5	1	7	3	6	0	0	74
Norman	6	3	4	2	2	0	4	2	3	0	0	4	0	23
Olmsted	65	49	18	21	10	22	35	3	6	9	9	10	1	215
Otter Tail	61	53	27	36	6	10	5	3	12	1	1	5	0	173
Pennington	23	23	8	3	1	2	4	3	1	0	0	1	0	54
Pine	81	34	14	18	3	15	8	5	2	2	5	1	0	154
Polk	44	15	24	1	3	9	1	3	3	1	5	15	0	95
Pope	6	5	3	4	1	6	5	0	1	3	0	0	0	33
Ramsey	642	683	189	78	163	64	151	182	45	59	1	1	0	1,785
Red Lake	0	6	2	0	0	0	2	0	0	0	0	0	0	10

Agency	Foster family home – non-relative	Foster family home – relative	Residential treatment center	Pre-kinship home – relative	Group home	Pre-adoptive home – non-relative	Pre-adoptive home – relative	Correctional facility (locked)	Foster home– corporate/shift staff	Supervised independent living	Juvenile correctional facility (non-secure, 13 or more children)	Juvenile correctional facility (non-secure, 12 or fewer children)	ICF-DD	Total children
Renville	13	2	9	13	12	5	6	0	1	0	0	0	0	51
Rice	79	73	14	13	13	12	19	0	4	3	4	2	0	193
Roseau	4	7	4	1	2	2	0	1	0	0	5	6	0	25
St. Louis	457	410	142	204	208	92	75	25	27	26	2	0	0	1,265
Scott	48	51	10	12	5	22	15	2	6	3	8	16	0	160
Sherburne	48	32	18	22	13	17	15	2	13	3	5	6	0	150
Sibley	10	18	4	3	0	4	2	0	2	0	0	0	0	39
Stearns	187	130	28	24	48	45	36	25	15	11	7	7	0	439
Stevens	3	10	7	2	5	0	2	0	1	1	3	0	0	33
Swift	30	16	2	3	3	7	0	1	1	1	0	0	0	51
Todd	52	34	8	2	3	11	7	0	1	4	2	0	0	107
Traverse	14	0	1	0	0	2	0	0	2	1	1	0	0	18
Wabasha	29	13	7	0	6	9	3	0	0	0	0	0	1	51
Wadena	27	38	13	10	4	5	0	9	1	0	2	0	0	84
Washington	67	92	50	12	24	13	18	2	13	12	14	11	0	269
Watonwan	8	2	9	0	3	2	1	2	1	4	1	0	0	22
Wilkin	12	1	2	0	1	2	0	0	0	1	0	3	0	14
Winona	55	52	15	10	27	7	6	5	3	2	4	1	1	138
Wright	114	77	24	23	10	10	28	1	6	1	1	2	0	255
Yellow Medicine	2	22	2	5	7	0	6	0	0	0	0	0	0	43
Southwest HHS	84	106	21	23	25	25	21	4	11	15	7	0	2	293
Des Moines Valley HHS	21	15	11	5	5	3	4	0	7	3	5	0	0	73
Faribault-Martin	49	58	23	12	8	13	17	1	1	3	0	1	2	160
Leech Lake Band of Ojibwe	131	101	10	26	5	15	5	0	0	0	7	1	0	253
White Earth Nation	239	171	29	45	16	20	46	5	2	1	21	14	0	500
MN Prairie	69	75	17	7	2	19	34	4	4	0	0	1	0	195

Agency	Foster family home – non-relative	Foster family home – relative	Residential treatment center	Pre-kinship home – relative	Group home	Pre-adoptive home – non-relative	Pre-adoptive home – relative	Correctional facility (locked)	Foster home– corporate/shift staff	Supervised independent living	Juvenile correctional facility (non-secure, 13 or more children)	Juvenile correctional facility (non-secure, 12 or fewer children)	ICF-DD	Total children
Minnesota	6,588	5,702	1,859	1,428	1,201	1,153	1,142	525	412	408	384	188	17	16,593

*ICF-DD: Intermediate Care Facilities for Persons with Developmental Disabilities

Note: Children may have spent time in multiple settings during their time in out-of-home care. Subsequently, adding the numbers up within a county will not equal the "Total children" column on the right of this table.

Table 11. Number of foster care families who cared for children by race/ethnicity and by agency, 2017

Agency	African- American / Black	American Indian	Asian or Pacific Islander	Two or more races	Unknown/ declined	White	Total families	Hispanic (any race)
Aitkin	*	*	*	*	*	34	40	*
Anoka	29	8	*	*	*	236	274	7
Becker	*	18	*	8	*	104	116	7
Beltrami	*	335	*	19	*	209	534	*
Benton	*	*	*	*	*	53	55	*
Big Stone	*	*	*	*	*	13	13	*
Blue Earth	7	*	*	*	*	75	85	*
Brown	*	*	*	*	*	33	33	*
Carlton	*	19	*	8	*	32	50	*
Carver	10	*	*	*	*	87	101	8
Cass	*	11	*	*	15	57	74	*
Chippewa	*	*	*	*	*	9	9	*
Chisago	*	*	*	*	*	77	79	*
Clay	*	*	*	*	*	97	101	*
Clearwater	*	*	*	*	*	14	16	*
Cook	*	*	*	*	*	10	14	*
Crow Wing	*	*	*	*	*	165	173	*
Dakota	25	*	*	13	19	226	271	10
Douglas	*	*	*	*	*	54	58	*
Fillmore	*	*	*	*	*	*	*	*
Freeborn	*	*	*	*	*	56	56	*
Goodhue	*	*	*	*	*	56	62	*
Grant	*	*	*	*	*	7	7	*
Hennepin	713	194	52	102	33	841	1,791	113
Houston	*	*	*	*	*	21	22	*
Hubbard	*	*	*	*	*	43	48	*
Isanti	*	*	*	*	*	71	72	*
Itasca	*	10	*	9	*	96	109	*
Kanabec	*	*	*	*	*	29	30	*
Kandiyohi	*	*	*	*	*	62	66	18
Kittson	*	*	*	*	*	*	*	*

Agency	African- American / Black	American Indian	Asian or Pacific Islander	Two or more races	Unknown/ declined	White	Total families	Hispanic (any race)
Koochiching	*	*	*	*	*	28	32	*
Lac qui Parle	*	*	*	*	*	*	*	*
Lake	*	*	*	*	*	12	12	*
Lake of the Woods	*	*	*	*	*	*	*	*
Le Sueur	*	*	*	*	*	36	37	*
McLeod	*	*	*	*	*	69	75	*
Mahnomen	*	*	*	*	*	9	14	*
Marshall	*	*	*	*	*	*	*	*
Meeker	*	*	*	*	*	21	21	*
Mille Lacs	*	60	*	22	*	87	142	*
Morrison	*	*	*	*	*	72	73	*
Mower	*	*	*	*	*	51	56	*
Nicollet	*	*	*	*	*	36	38	*
Nobles	*	*	*	*	*	21	21	*
Norman	*	*	*	*	*	10	11	*
Olmsted	10	*	*	*	*	130	138	9
Otter Tail	*	*	*	*	*	95	97	*
Pennington	*	*	*	*	*	27	27	*
Pine	*	15	*	*	*	69	86	*
Polk	*	*	*	*	*	36	39	*
Pope	*	*	*	*	*	15	16	*
Ramsey	326	34	64	63	44	458	924	74
Red Lake	*	*	*	*	*	*	*	*
Renville	*	*	*	*	*	22	23	*
Rice	11	*	*	*	*	104	117	14
Roseau	*	*	*	*	*	8	9	*
St. Louis	46	107	*	53	66	528	728	15
Scott	*	*	*	*	12	73	91	*
Sherburne	8	*	*	*	16	55	76	*
Sibley	*	*	*	*	*	27	28	*
Stearns	13	*	*	9	*	197	218	7
Stevens	*	*	*	*	*	10	10	*

Agency	African- American / Black	American Indian	Asian or Pacific Islander	Two or more races	Unknown/ declined	White	Total families	Hispanic (any race)
Swift	*	*	*	*	*	31	37	*
Todd	*	*	*	*	*	61	63	*
Traverse	*	*	*	*	*	15	15	*
Wabasha	*	*	*	*	*	27	28	*
Wadena	*	*	*	*	*	50	51	*
Washington	13	*	*	*	29	106	141	7
Watonwan	*	*	*	*	*	11	12	*
Wilkin	*	*	*	*	*	7	8	*
Winona	*	*	*	*	*	72	81	*
Wright	*	*	*	*	*	133	141	*
Yellow Medicine	*	*	*	*	*	16	20	*
Southwest HHS	*	19	*	*	*	123	141	*
Des Moines Valley HHS	*	*	*	*	*	33	33	*
Faribault-Martin	*	*	*	*	*	89	92	*
Leech Lake Band of Ojibwe	*	61	*	12	22	50	129	*
White Earth Nation	*	137	*	42	7	77	203	*
MN Prairie	*	*	*	*	*	115	118	8
Minnesota	1,248	1,079	147	421	351	6,046	8,632	402

*The number of families is less than seven and is not shown to prevent identification of individuals. Totals include omitted data.

Note: This table shows the number of foster care families who provided a home for children who experienced care during 2017. Note: Cells will not sum to the column or row totals, as provider homes will be counted across both race/ethnicity groupings and child welfare agencies. Row and column totals show unduplicated counts of individual homes.

Table 12. American Indian children in out-of-home care by tribe, 2017

State where the Tribe is primarily located	Tribe	American Indian children
Minnesota	Bois Forte Band of Chippewa	209
	Fond du Lac Band of Lake Superior Chippewa	276
	Grand Portage Band of Lake Superior Chippewa	31
	Leech Lake Band of Ojibwe	778
	Lower Sioux Indian Community of Minnesota	79
	Mille Lacs Band of Ojibwe	416
	Minnesota Chippewa tribe (cannot identify specific band)	9
	Prairie Island Indian Community	11
	Red Lake Nation	1,138
	Shakopee Mdewakanton Sioux Community	8
	Upper Sioux Community of Minnesota	22
	White Earth Nation	1,022
Iowa	Meskwaki Nation	1
Michigan	Grand Traverse Band of Ottawa and Chippewa Indians	1
	Hannahville Indian Community of Michigan	10
	Keweenaw Bay Indian Community	5
	Little Traverse Bay Bands of Odawa Indians	2
	Saginaw Chippewa Tribe of Michigan	1
	Sault Ste. Marie Tribe of Chippewa Indians of Michigan	2
Nebraska	Fort Peck Assiniboine and Sioux tribes	1
	Omaha Tribe of Nebraska	12
	Santee Sioux Nation	8
	Winnebago Tribe of Nebraska	14
North Dakota	Eastern Band of Cherokee Indians	4
	Mandan, Hidatsa and Arikara Nation	18
	Spirit Lake Tribe	48
	Standing Rock Sioux Tribe	96
	Turtle Mountain Band of Chippewa Indians	86

State where the Tribe is primarily located	Tribe	American Indian children
South Dakota	Cheyenne River Sioux Tribe	26
	Crow Creek Sioux Tribe	14
	Flandreau Santee Sioux Tribe	1
	Lower Brule Sioux Tribe	7
	Oglala Sioux Tribe	80
	Rosebud Sioux Tribe	48
	Sisseton Wahpeton Oyate	109
	Yankton Sioux Tribe of South Dakota	46
Wisconsin	Bad River Band of Lake Superior Tribe of Chippewa Indians	26
	Forest County Potawatomi Community	12
	Ho-Chunk Nation	14
	Lac Courte Oreilles Band (LCO)	39
	Lac du Flambeau Band of Lake Superior Chippewa Indians	14
	Menominee Indian Tribe of Wisconsin	21
	Oneida Nation of Wisconsin	25
	Red Cliff Band of Lake Superior Chippewa	24
	Sokaogon Chippewa Community	3
	St. Croix Chippewa Indians of Wisconsin	24
Other unknown	Canadian tribe	15
	Other foreign tribe	7
	Other U.S. tribe	176
	Unknown Dakota, Lakota or Nakota (Sioux)	17
	Unknown Ojibwe, Ojibwa or Chippewa	26
	Unknown tribe	327
	Canadian tribe	15
Total American Indian children		**4,769**

Note: Numbers include children identified as American Indian alone or as one of two or more races. More than one tribal affiliation may be indicated for a child. Indication of a tribe does not necessarily mean a child is an enrolled member.

Table 13. Number of placement episodes ending by length of stay in care and by agency, 2017

Agency	1 to 7 days	8 to 30 days	1 to 3 months	3 to 6 months	6 to 12 months	12 to 24 months	24 to 36 months	36 months or more	Total
Aitkin	5	2	3	2	9	17	0	2	40
Anoka	63	13	20	24	56	62	11	19	268
Becker	1	2	8	12	33	31	5	11	103
Beltrami	8	15	8	39	97	108	61	41	377
Benton	2	0	6	9	15	8	2	3	45
Big Stone	1	0	0	1	2	6	0	0	10
Blue Earth	10	2	3	2	22	25	7	0	71
Brown	0	5	3	4	7	12	3	0	34
Carlton	0	2	8	4	14	27	1	2	58
Carver	2	1	5	9	17	32	10	1	77
Cass	3	1	5	11	11	24	12	5	72
Chippewa	0	0	0	0	0	1	0	0	1
Chisago	5	3	11	6	13	9	4	1	52
Clay	48	8	8	3	16	28	21	5	137
Clearwater	0	0	0	1	2	0	0	1	4
Cook	1	3	2	1	2	1	0	0	10
Crow Wing	5	0	5	8	21	21	15	2	77
Dakota	42	20	19	36	50	50	21	3	241
Douglas	1	7	9	8	12	12	6	1	56
Fillmore	0	3	4	7	3	2	0	1	20
Freeborn	1	4	0	3	12	9	1	2	32
Goodhue	4	3	10	13	8	14	0	4	56
Grant	0	0	0	1	3	1	0	1	6
Hennepin	165	55	82	116	274	305	161	113	1,271
Houston	0	0	4	5	8	4	1	1	23
Hubbard	2	4	1	2	14	11	6	3	43
Isanti	11	2	4	4	2	16	8	3	50
Itasca	6	5	26	16	33	54	10	6	156
Kanabec	0	3	5	7	3	3	0	1	22

Agency	1 to 7 days	8 to 30 days	1 to 3 months	3 to 6 months	6 to 12 months	12 to 24 months	24 to 36 months	36 months or more	Total
Kandiyohi	6	3	9	2	8	27	1	4	60
Kittson	1	0	1	0	1	1	0	1	5
Koochiching	0	0	6	2	9	9	3	5	34
Lac qui Parle	0	0	0	4	2	0	0	4	10
Lake	0	0	1	1	3	2	2	0	9
Lake of the Woods	0	0	1	0	3	3	0	0	7
Le Sueur	0	5	2	3	4	4	5	2	25
McLeod	8	5	1	5	29	11	2	3	64
Mahnomen	0	2	4	0	1	3	0	4	14
Marshall	0	0	0	0	3	1	0	0	4
Meeker	0	0	1	2	1	9	0	0	13
Mille Lacs	10	1	8	2	13	33	12	17	96
Morrison	1	0	3	3	14	20	1	3	45
Mower	15	2	0	3	10	17	8	2	57
Nicollet	4	1	2	5	19	3	4	1	39
Nobles	3	3	10	5	11	7	11	5	55
Norman	1	3	2	2	2	4	1	0	15
Olmsted	2	5	9	8	18	41	12	6	101
Otter Tail	4	1	5	4	5	34	5	2	60
Pennington	3	0	4	1	7	4	2	3	24
Pine	11	2	7	5	19	15	3	7	69
Polk	0	1	9	15	15	3	4	1	48
Pope	2	0	1	4	1	9	5	2	24
Ramsey	130	64	65	63	167	178	59	35	761
Red Lake	0	0	2	0	0	1	0	1	4
Renville	0	1	5	3	3	13	4	0	29
Rice	14	13	8	14	23	23	9	5	109
Roseau	0	1	6	0	3	8	0	0	18
St. Louis	17	38	73	41	91	153	55	36	504
Scott	12	15	10	13	15	25	3	0	93
Sherburne	14	5	9	7	15	29	3	2	84

Agency	1 to 7 days	8 to 30 days	1 to 3 months	3 to 6 months	6 to 12 months	12 to 24 months	24 to 36 months	36 months or more	Total
Sibley	1	1	0	9	4	4	0	0	19
Stearns	32	25	20	31	42	62	17	13	242
Stevens	0	0	1	0	6	5	0	1	13
Swift	2	2	8	7	4	3	2	0	28
Todd	0	1	1	12	17	16	0	6	53
Traverse	1	0	0	1	0	0	1	0	3
Wabasha	0	4	4	0	16	4	3	2	33
Wadena	2	4	9	1	4	15	2	1	38
Washington	21	14	10	13	42	36	5	5	146
Watonwan	1	1	1	4	2	1	0	2	12
Wilkin	3	0	1	0	3	0	0	1	8
Winona	9	17	3	3	4	9	3	1	49
Wright	17	3	12	16	17	25	3	1	94
Yellow Medicine	0	0	5	10	2	4	0	0	21
Southwest HHS	27	6	10	8	39	22	17	7	136
Des Moines Valley HHS	1	1	1	1	3	16	2	2	27
Faribault-Martin	7	10	7	11	13	19	8	5	80
Leech Lake Band of Ojibwe	2	0	1	4	6	3	5	8	29
White Earth Nation	1	6	7	3	50	57	36	39	199
MN Prairie	0	2	9	5	24	21	10	1	72
Minnesota	771	431	633	710	1,572	1,905	694	478	7,194

Table 14. Number of children under state guardianship by agency, 2017

Agency	Entered guardianship prior to 2017	Entered guardianship in 2017	Total children
Aitkin	2	4	6
Anoka	23	38	61
Becker	12	19	31
Beltrami	23	17	40
Benton	11	14	25
Big Stone	5	2	7
Blue Earth	15	11	26
Brown	9	7	16
Carlton	7	5	12
Carver	9	4	13
Cass	13	3	16
Chippewa	2	0	2
Chisago	7	12	19
Clay	41	27	68
Clearwater	0	0	0
Cook	1	0	1
Crow Wing	21	35	56
Dakota	47	23	70
Douglas	3	2	5
Fillmore	2	4	6
Freeborn	12	15	27
Goodhue	3	5	8
Grant	0	1	1
Hennepin	373	230	603
Houston	3	2	5
Hubbard	7	12	19
Isanti	12	6	18
Itasca	20	19	39
Kanabec	7	4	11
Kandiyohi	5	17	22
Kittson	0	0	0
Koochiching	8	3	11

Agency	Entered guardianship prior to 2017	Entered guardianship in 2017	Total children
Lac qui Parle	5	1	6
Lake	0	2	2
Lake of the Woods	0	0	0
Le Sueur	5	1	6
McLeod	8	7	15
Mahnomen	0	1	1
Marshall	1	1	2
Meeker	0	0	0
Mille Lacs	9	12	21
Morrison	20	13	33
Mower	22	13	35
Nicollet	6	3	9
Nobles	12	1	13
Norman	1	3	4
Olmsted	29	32	61
Otter Tail	3	9	12
Pennington	1	6	7
Pine	10	12	22
Polk	4	7	11
Pope	4	5	9
Ramsey	155	65	220
Red Lake	1	1	2
Renville	4	5	9
Rice	17	11	28
Roseau	2	0	2
St. Louis	91	42	133
Scott	2	27	29
Sherburne	17	8	25
Sibley	0	6	6
Stearns	55	42	97
Stevens	0	2	2
Swift	5	2	7
Todd	6	7	13
Traverse	1	3	4

Agency	Entered guardianship prior to 2017	Entered guardianship in 2017	Total children
Wabasha	12	1	13
Wadena	6	0	6
Washington	17	14	31
Watonwan	1	2	3
Wilkin	2	0	2
Winona	9	1	10
Wright	24	10	34
Yellow Medicine	2	4	6
Southwest HHS	25	13	38
Des Moines Valley HHS	6	3	9
Faribault-Martin	19	10	29
MN Prairie	27	16	43
Minnesota	1,349	965	2,314

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