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
FEBRUARY 18, 2020
10:30 A.M.

1. CALL TO ORDER
2. REVIEW AND APPROVE BOARD MEETING AGENDA:
3. REVIEW AND APPROVE PREVIOUS HHS BOARD MEETING MINUTES

   Documents:

   JANUARY 21, 2020 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. Public Health Emergency Preparedness Local Concurrence Letter

      Documents:

      PHEP LOCAL CONCURRENCE LETTER.PDF

   c. SCHA Delegation Agreement

      Documents:

      SCHA DELEGATION AGREEMENT.PDF

5. ACTION ITEMS:
   a. Accounts Payable

      Documents:

      ACCOUNTS PAYABLE.PDF

   b. Personnel Requests
      Nina Arneson

      Documents:

PERSONNEL REQUESTS.PDF
PUBLIC HEALTH NURSE (PHN).PDF
LIVE WELL GOODHUE COUNTY INTERN.PDF

c. Proclamation For GCHHS Staff Appreciation Day- March 11, 2020
Nina Arneson

Documents:

2020 GCHHS APPRECIATION DAY.PDF

6. INFORMATIONAL ITEMS:

a. Southeast Regional Crisis Center (SERCC) Update
Tim Hunter

Documents:

REGIONAL MENTAL HEALTH CRISIS CENTER.PDF

7. FYI-MONTHLY REPORTS:

a. Placement Report

Documents:

PLACEMENT REPORT.PDF

b. Child Protection Report

Documents:

CHILD PROTECTION REPORT.PDF

c. Quarterly Trend Report

Documents:

QUARTERLY TREND REPORT.PDF

d. Minnesota's Child Maltreatment Report-2018

Documents:

MN CHILD MALTREATMENT REPORT 2018.PDF

e. Minnesota's Out-Of-Home Care And Permanency Report- 2018

Documents:

MN OUT-OF-HOME CARE AND PERMANENCY REPORT 2018.PDF

f. Follow Along Program (FAP) Annual Report

Documents:

FOLLOW ALONG PROGRAM (FAP) ANNUAL REPORT 2019.PDF

g. Who Are We Serving- Public Assistance

Documents:

WHO ARE WE SERVING - PUBLIC ASSISTANCE.PDF

8. ANNOUNCEMENTS/COMMENTS:
9. ADJOURN
    a. Next HHS Board Meeting Will Be March 17, 2020 At 10:30 A.M.

PROMOTE, STRENGTHEN, AND PROTECT THE HEALTH OF INDIVIDUALS, FAMILIES, AND COMMUNITIES

GOODHUE COUNTY

HEALTH & HUMAN SERVICES BOARD MEETING

MINUTES OF JANUARY 21, 2020

The Goodhue County Health and Human Services Board convened their regularly scheduled meeting at 10:30 A.M., Tuesday, January 21, 2020, in the Goodhue County Board Room located in Red Wing, Minnesota.

BOARD MEMBERS PRESENT:

Brad Anderson, Paul Drotos, Linda Flanders, Jason Majerus, Barney Nesseth, and Nina Pagel. Susan Johnson was absent with prior notice.

STAFF AND OTHERS PRESENT:

Nina Arneson, Mary Heckman, Mike Zorn, Lisa Woodford, Kris Johnson, Brooke Hawkenson, Katie Bystrom, Katherine Cross, and Andrea Emery.

AGENDA:

On a motion by B. Anderson and seconded by N. Pagel, the Board unanimously approved the January 21, 2020 Agenda.

MEETING MINUTES:

On a motion by J. Majerus and seconded by B. Anderson, the Board unanimously approved the Minutes of the H&HS Board Meeting on December 17, 2019.

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 N. Pagel, the Board unanimously approved payment of all accounts as presented.

On a motion by B. Anderson and seconded by L. Flanders, the Board unanimously approved the request for Sex Trafficking and Exploitation Awareness Month Proclamation for January 2020.

B. Nesseth nominated L. Flanders to participate in the 2020-2025 Strategic Plan Appointment and seconded by B. Anderson, the Board unanimously approved this appointment.

On a motion by B. Nesseth and seconded by J. Majerus, the Board unanimously approved Child Protection On-Call Assignment and Adjustment Request.

INFORMATIONAL ITEMS:

Child Protection Year End Report by Kris Johnson
2019 Fiscal Year End Report by Mike Zorn

FYI & REPORTS:

Placement Report
Child Protection Report
HHS Staffing Report
2018 HHS Annual Report

ADJOURN:

On a motion by B. Anderson and seconded by N. Pagel, the Board unanimously approved adjournment of this session of the Health & Human Services Board Meeting at or around 12:17 pm.

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (HHS)

REQUEST FOR BOARD ACTION

Requested Board Date:	February 18, 2020	**Staff Lead:**	Kris Johnson
Consent Agenda:	☒ Yes ☐ No	**Attachments:**	☐ Yes ☒ No
Action Requested:	Approve Child Care Licensure Actions		

BACKGROUND:

Child Care Re-licensures:

Carrie Peterson	Goodhue
Catherine Swanson	Goodhue

Child Care Licensures:

Tonia Smith	Zumbrota

Number of Licensed Family Child Care Homes: 82

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

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (GCHHS)

REQUEST FOR BOARD ACTION

Requested Board Date:	February 18, 2020	**Staff Lead:**	Ruth Greenslade
Consent Agenda:	☒ Yes ☐ No	**Attachments:**	☒ Yes ☐ No
Action Requested:	Approval Public Health Emergency Preparedness (PHEP) Local Concurrence Letter		

BACKGROUND:

The Minnesota Department of Health (MDH) is required to obtain annual concurrence from local health departments and tribal officials regarding the general approach of the activities MDH is using to make sustainable progress in achieving public health preparedness through the use of federal Public Health Emergency Preparedness (PHEP) funds. These strategies for moving forward in 2020-2021 (Budget Period 2) were developed using the strategic programmatic plan, local and tribal health department mid-year and end of year PHEP reports, ongoing feedback from local and tribal health departments, and direction provided in the grant guidance from the Centers for Disease Control and Prevention (CDC). The State Community Health Services Advisory Committee (SCHSAC) PHEP Oversight Work Group also reviewed the activities and agreed with the proposed direction and focus.

CDC requires the concurrence be sent on agency letterhead and signed by an authorized agency representative. Goodhue County Health and Human Services is a recipient of the PHEP funds and attached please find our county letter to meet this concurrent requirement. MDH requested the letter on 2/6/20 with a due date of 2/26/20.

RECOMMENDATION: HHS Department recommends approval as requested.

Goodhue County
Health and Human Services

426 West Avenue
Red Wing, MN 55066
(651) 385-3200 ● Fax (651) 267-4877

February , 2020

To Whom It May Concern:

Minnesota Department of Health (MDH) priorities for the second budget period of the five year project period (2020-2021 Budget Period 2) will focus on engaging with community partners serving populations with access or functional needs, promoting personal preparedness, practicing shift/operational period change briefings, pandemic influenza planning, and maintaining foundational preparedness activities. As in past years, there will be recurring, base, and funding level-based elective duties. The set of recurring and base grant-related activities will be completed by all CHBs. Based on funding levels, CHBs will select from a list of elective duties (similar to previous years) to meet jurisdictional priorities and threats.

The duties were developed using input from local and tribal health departments, direction provided in the grant guidance from the Centers for Disease Control and Prevention (CDC), and MDH's programmatic strategic planning. The SCHSAC PHEP Oversight Work Group and the PHEP Grant Duty Development Work Group reviewed the activities and agreed with the proposed direction and focus.

The Recurring duties focus on those activities that occur every year, such as reports, work plans, multi-year exercise and training plans (MYTEP), updating contact and POD information, attending MDH-sponsored preparedness trainings, responding to HANs, conducting volunteer call down drills, and forwarding and monitoring responses from local HAN networks.

The Base duties include engaging with key community sectors, conducting / reviewing jurisdictional risk assessments (every five years) for threats and their public health impacts, practicing shift changes within an ICS structure, sending HANs to local networks and monitoring responses, continuing to communicate with volunteers, and maintaining active membership with the regional Health Care Coalitions. There are duties related to gaps identified in the June 2020 full-scale exercise that will help CHBs continue to operationalize plans.

Based on funding levels, the Elective duties allow CHBs to select duties that advance work on their jurisdictional priorities. Elective duties include work on climate change and disasters, developing, revising, or exercising plans for mass care, family reunification and assistance centers, emergency operations coordination (e.g., writing Incident Action Plans, department operations center activation), responder safety and health planning, testing/retesting identified gaps, and developing CPOD plans and agreements.

I certify that my community health board concurs with the general approach to public health emergency preparedness as outlined by MDH.

Sincerely,

Nina Arneson, M.S.
GCHHS Director
nina.arneson@co.goodhue.mn.us
651-385-6115

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (GCHHS)

REQUEST FOR BOARD ACTION

Requested Board Date:	February 18, 2020	**Staff Lead:**	Nina Arneson
Consent Agenda:	☒ Yes ☐ No	**Attachments:**	☒ Yes ☐ No
Action Requested:	Approve 2020 South County Health Alliance (SCHA) Delegation Agreement		

BACKGROUND:

South Country Health Alliance (SCHA) and Goodhue County Health and Human Services (GCHHS) Delegation Agreement Amendment covers all the services SCHA entrusts to GCHHS to execute for the Goodhue County SCHA members.

This agreement continues to be an excellent integrated partnership between SCHA and GCHHS.

RECOMMENDATION: The Department recommends approval as requested.

2020 DELEGATION AGREEMENT

THIS DELEGATION AGREEMENT effective January 1, 2020 by and between Goodhue County ("Delegated Entity") and South Country Health Alliance ("SCHA").

WHEREAS, South Country Health Alliance desires to delegate the provision of certain services described herein to Delegated Entity; and

WHEREAS, Delegated Entity desires to provide the delegated services described herein in accordance with SCHA policies and procedures and in compliance with applicable federal and state laws, regulations, and National Committee for Quality Assurance (NCQA) accreditation standards;

NOW THEREFORE, in consideration of the terms and conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

SECTION 1
DEFINITIONS

The following terms as used in this Agreement shall have the meanings ascribed to them below unless the context clearly requires a different meaning:

1.1 **Action**: 1) the denial or limited authorization of a requested service, including the type or level of service; 2) the reduction, suspension, or termination of a previously authorized service; 3) the denial, in whole or in part of payment for a service; 4) the failure to provide services in a timely manner; 5) the failure of the MCO to act within the timeframes identified; 6) for a resident of a rural area with only one MCO , the denial of a member's request to exercise his or her right to obtain services outside the network**.**

1.2 **Agreement:** This Agreement, including any schedules or other attachments hereto, all as presently in effect or as hereafter amended.

1.3 **Appeal:** The oral or written request from the member, or the Provider acting on behalf of the member with the member's written consent to the MCO for review of an Action. An appeal may be expedited if the member's medical condition requires a decision within 3 days.

1.4 **Care Coordination:** The assignment of an individual who coordinates the provision of all Medicare and Medicaid health and long-term care services for members, and who coordinates services to a member among different health and human service professionals and across settings of care. The individual must be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner or physician.

1.5 **Case Management:** The coordination of care and services provided to members to facilitate appropriate delivery of care and services. It involves comprehensive assessment

of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

1.6 **Care Transition:** The movement of a member from one care setting to another as the member's health status changes; for example, moving from home to a hospital as the result of an exacerbation or a chronic condition or moving from the hospital to a rehabilitation facility after surgery.

1.7 **Care Transition, Planned:** Include elective surgery or a decision to enter a long-term care facility.

1.8 **Care Transition Process:** The period from identifying a member who is at risk for a care transition through the completion of a transition. This process goes beyond the actual movement from one setting to another; it includes planning and preparation for transitions and the follow-up care after transitions are completed.

1.9 **CMS:** The federal Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration**.**

1.10 **CMS Contract:** The contract between SCHA and CMS for the provision of Medicare services.

1.11 **Complex Case Management:** The systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

1.12 **Disclosing Entity:** A Medicaid Provider (other than an individual practitioner or group of practitioners), or a fiscal agent as stated in 42 CFR §455.101

1.13 **Elderly Waiver:** The Elderly Waiver (EW) program funds home and community-based services for people age 65 or older who require the level of medical care provided in a nursing home, but choose to reside in the community. To receive EW services a person must choose community care and be eligible for Medical Assistance (MA) payment of long-term (LTC) services; assessed through a Long-Term Care Consultation (LTCC) and determined to need the level of care provided in a nursing facility (NF-I or NF-II); be in need supports and services beyond those available through the standard MA benefit set according to the LTCC screening or MNChoices; and incurring a cost to MA for community-based services that is less than the cost of institutional care.

1.15 **Grievance:** An expression of dissatisfaction about any matter other than an Action, including but not limited to, the quality of care or services provided or failure to respect the member's rights.

1.16 Managed Care Organization (MCO): An entity that has or is seeking to qualify for a comprehensive risk contract and that is: (1) a Federally Qualified HMO that meets the advance directives requirements of 42 CFR 489.100-104; or (2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: a) makes the services that it provides to its Medicaid Enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid Recipients within the area served by the entity; and b) meets the solvency standards of 42 CFR 438.116.

1.17 Managing Employee: A general manager business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency as defined in 42 CFR §455.101.

1.18 Minnesota Health Care Programs (MHCP): Medical Assistance, General Assistance Medical Care, Prepaid Medical Assistance Program, and MinnesotaCare.

1.19 Minnesota Senior Care Plus (MSC+): The benefit set that includes all services under MSC plus the Elderly Waiver home and community-based services and one hundred and eighty days (180) of nursing facility care.

1.20 Minnesota Senior Health Options (MSHO): The prepaid managed care program for Medical Assistance-eligible seniors, age 65 and over, with or without Medicare. SCHA's MSHO product is called SeniorCare Complete.

1.21 MSHO Community Well Members: Members enrolled in SeniorCare Complete, SCHA's MSHO product and SCHA is receiving a Community Well rate cell payment.

1.22 National Committee for Quality Assurance (NCQA): A nonprofit organization that seeks to improve patient care and health plan performance in partnership with Managed Care Plans, purchasers, consumers and the public sector. NCQA evaluates health plans' internal quality processes through accreditation reviews and works to develop health plan performance measures.

1.23 Ownership Interest: The possession of equity in the capital, the stock, or the profits of the Disclosing Entity.

1.24 Person with an Ownership or Control Interest: Person or corporation that: A) has an ownership interest, directly or indirectly totaling five percent (5%) or more in the MCO or a Disclosing Entity; B) has a combination of direct and indirect Ownership Interests equal to five percent (5%) or more in the MCO or the Disclosing Entity; C) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the MCO or the Disclosing Entity; or D) is an officer or director of the MCO or the Disclosing Entity (if it is organized as a corporation) or E) is a partner in the MCO or the Disclosing Entity (if it is organized as a partnership).

1.24.1 Direct Ownership Interest is defined as the possession of stock, equity in capital or any interest in the profits of the Disclosing entity.

1.24.2 Indirect Ownership Interest is defined as ownership interest in an equity that has a direct or indirect ownership interest in the Disclosing Entity. The amount of indirect ownership interest in the Disclosing Entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5% or more in the Disclosing Entity. Example: If C owns 10% of the stock in a corporation that owns 80% of the stock of the Disclosing entity, C's interest equates to an 8% indirect ownership and must be disclosed.

1.24.3 Controlling Interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity, (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity or the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

1.25 Provider: An Individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services.

1.26 Significant Business Transaction: Any business transaction or series of related transactions that, during any one fiscal year, exceeds either $25,000 or 5 percent (%) of a provider's total operating expenses.

1.27 Special Needs BasicCare (SNBC) Plan: A service delivery system in which the State contracts with a Medicare Advantage Special Needs Plan to provide Medicaid services and/or integrated Medicare and Medicaid services to Medicaid eligible people with disabilities who are between the ages of 18 through 64 at the time of enrollment. SCHA's SNBC products are called AbilityCare, SingleCare and SharedCare.

1.28 State: The Minnesota Department of Human Services or its agents, and the Commissioner of Human Services.

1.29 State Contract: The contract between SCHA and the Minnesota Department of Human Services for the purpose of providing and paying for health care services and supplies to recipients enrolled in SCHA under Minnesota Health Care Programs, MSC+, MSHO, or the SNBC Plan.

1.30 TruCare: A secure web-based case management system that allows users to see a holistic picture of a member via case notes, referrals, assessments, care plans, authorizations and other clinical information which helps facilitate care coordination activities.

SECTION 2
SCHA RESPONSIBILITIES

2.1 Delegated Activities. SCHA shall delegate to Delegated Entity the provision of Care Coordination duties and other services as set forth in Exhibit A, which is attached hereto and incorporated herein, and in accordance with SCHA policies and procedures, applicable laws and regulations, and NCQA accreditation standards.

2.2 SCHA Policies and Procedures. Prior to execution of this Agreement, SCHA shall provide to Delegated Entity copies of SCHA policies and procedures applicable to this Agreement either through regular mail or electronically. SCHA may change its policies and procedures by providing thirty (30) days prior written notice to Delegated Entity of the changes and their effective dates. However, if required by state or federal law, regulation, or regulatory action, SCHA may change its policies and procedures by providing written notice to Delegated Entity of the changes and their effective dates. Any notice provided to Delegated Entity under this section may be in an electronic format.

2.3 Oversight, Monitoring and Audit. SCHA shall perform ongoing oversight and monitoring of Delegated Entity's performance under this Agreement, including but not limited to, review of any required reporting under this Agreement. At any time, but at least annually, SCHA will audit records and documents related to the activities performed under this Agreement. This process does include the annual care plan audits required through DHS MSHO/MSC+ and SNBC products. SCHA will perform the annual care plan audits as per DHS' protocol. SCHA, in its sole discretion, will conduct review of Delegated Entity's written policies and procedures and member files. SCHA will provide written notice of annual audits at least thirty (30) calendar days prior to the audit. SCHA shall provide a report of its audit findings to Delegated Entity within ninety (90) calendar days of the audit's conclusion. For all additional audits, SCHA shall provide at least fourteen (14) calendar days prior written notice, unless state or federal regulators or NCQA accreditation agencies require a shorter timeframe. The audit notes shall include a list of the records to be reviewed.

2.4 Revocation of Delegation. SCHA may revoke the delegation of some or all of the activities which Delegated Entity is obligated to perform under this Agreement in the event Delegated Entity fails to perform the delegated activities or correct non-compliant delegated activities as outlined in the Corrective Action Plan, as provided in Section 3.3 of this Agreement, in a timely manner and to the satisfaction of SCHA and in accordance with SCHA policies and procedures and applicable laws, regulations and NCQA accreditation standards. The delegate agrees to allow SCHA to perform additional audits as necessary to verify compliance of the Corrective Action Plan. In such event, SCHA may elect to terminate or modify this Agreement pursuant to Section 5.

2.5 SCHA Accountability. SCHA shall oversee and at all times remain accountable to CMS and the State for any functions or responsibilities of SCHA under its contracts with CMS and the State, including functions or responsibilities delegated to Delegated Entity under this Agreement.

2.6 Public Health Goal. SCHA agrees to meet with Delegated Entities to develop and discuss mutual objectives related to public health priorities.

2.7 Provision of Member Data. South Country agrees to provide the following information when requested: member experience data, if applicable and clinical performance data. This data requested may be, but not limited to, results of member experience surveys, relevant to delegate functions, relevant claims data or results of relevant clinical performance measures. The delegate must give written notice of the data request to South Country at least 30 days in advance, unless state or federal regulators require a shorter timeframe. The delegate agrees to work with South Country as needed regarding the obtaining of the data.

SECTION 3
DELEGATED ENTITY RESPONSIBILITIES

3.1 Delegated Activities. Delegated Entity shall provide the services set forth in Exhibit A and Exhibit B in accordance with SCHA policies and procedures and applicable law, regulations and NCQA accreditation standards.

3.2 Law, Regulations and Licenses. Delegated Entity shall maintain all federal, state and local licenses, certifications, accreditations and permits, without material restriction, that are required to provide the services under this Agreement. Delegated Entity shall notify SCHA in writing within ten (10) business days after it learns of any suspension, revocation, condition, limitation, qualification or other material restriction on Delegated Entity's licenses, certifications, accreditation or permits.

3.3 Corrective Action Plans. In the event that, during an audit or any other time during the term of this Agreement, SCHA discovers any deficiencies in Delegated Entity's performance of any services under this Agreement, Delegated Entity shall develop a Corrective Action Plan for the specific activity that SCHA determines to be deficient. The Corrective Action Plan shall include specifics of and timelines for correcting any deficiencies and shall be provided to SCHA within two (2) weeks after SCHA notifies Delegated Entity of the deficiency (ies) or issues its annual audit report to Delegated Entity. SCHA shall review and comment on the Corrective Action Plan within two (2) weeks after receiving it from Delegated Entity. Delegated Entity shall implement the Corrective Action Plan within the specified timeframes. In the event the Corrective Action Plan is not developed and/or implemented within such timeframes, SCHA may revoke all or certain delegated activities pursuant to Section 2.4 and/or terminate this Agreement pursuant to Section 5. If deficiencies are identified or repeated, SCHA retains the right to increase its monitoring, evaluations, and audits of Delegated Entity until the deficiencies are corrected.

3.4 **Reporting.** Delegated Entity shall provide SCHA with regular reports; at least semi-annually, regarding the provision of services under this Agreement. SCHA shall review any required reporting as part of its ongoing oversight and monitoring of compliance with this Agreement. SCHA shall promptly notify Delegated Entity of any concerns identified as a result of regular reporting or as a result of a failure to provide regular reports. Reports are identified on Exhibit C of this Agreement.

3.5 **Document Submission.** Delegated Entity shall provide to SCHA its Waiver Quality Assurance Plan Survey and Gaps Analysis in availability of EW services if requested by SCHA within 60 days of the request.

3.6 **Appeals and Grievance.**

a) Notify SCHA's Grievance & Appeals (G/A) department of any potential grievance and appeals requests (filed by or on behalf of the member) as follows (requests are to be submitted via email to Grievances-Appeals@mnscha.org or via FAX to SCHA's G/A department at (507) 444-7774): **No later than** one business day of receipt for all standard grievance and appeal requests.

b) **No later than** four (4) regular business hours of receipt ***AND*** no later than end of the same business day in which it is first received, for all expedited grievance and appeal requests.

   i. Place "EXPEDITED G/A REQUEST" in the Subject headline of the email.

3.7 **Utilization Management.** Delegated Entity agrees to forward all requests to SCHA Health Services for prior authorization or pre-certification regarding dental, medical or pharmacy within one business day of knowledge of request. If the service is expedited, the Delegated Entity will forward the request within three hours of receipt and will verbally notify SCHA.

3.8 **Long Term Care Screening Document Entry.** The Delegated Entity will be responsible to enter all Long Term Care (LTC) Screening Documents into MMIS for all Senior health risk assessments completed which include but not limited to LTCC, MNChoices, South Country Health Risk Assessment, member refusals, and unable to reach screenings performed, as applicable. South Country enters the SNBC members health risk assessments into MMIS after a task is created in TruCare and sent to South Country. Pre-Admission Screening (PAS) for skilled nursing facility placements are required to be entered into MMIS by the delegated entity.

3.8.1 Enter member Elderly Waiver –

LTC Screening Documents into MMIS prior to the first capitation cut-off date each month or alert SCHA Community Engagement team of the delay and rational for the delay.

3.8.2 Enter and exit LTCC Screening Document exiting a member from the Elderly Waiver when the member has been in a skilled nursing facility more than 30 days. The LTCC screening document must be entered within 60 days of the living arrangement change.

3.8.3 Complete a Level I PAS for all skilled nursing facility admissions and make these available to SCHA within one (1) week. Send the Level I PAS to the nursing home who is admitting the member. If the Level I PAS identifies that a Level II is needed refer to appropriate county.

3.8.4 The Delegated Entity will notify SCHA within one business day of a Member who previously was determined to meet Nursing Facility Level of Care but upon subsequent assessment is determined to not meet the Nursing Facility Level of Care criteria, to request a review of the assessment results.

3.9 Request for a Long Term Care Consultation (LTCC). The Delegated Entity must provide for a LTCC within 20 calendar days of request and make that assessment available to SCHA upon request. The Delegated Entity agrees to provide SCHA with a LTCC or MNChoices assessment performed for a member to determine the member's risk of nursing home placement or current need for nursing home care according to applicable MN statutes.

3.10 Care Coordinator Assignment: The Delegated Entity will assign a care coordinator to each newly enrolled member on SeniorCare Complete, MSC+, AbilityCare, and SingleCare for the required Care Coordination Activities. The Delegated Entity will ensure all members enrolled on SeniorCare Complete, MSC+, AbilityCare and SingleCare will have an assigned care coordinator at all times. Members must be reassigned to a new care coordinator if a care coordinator resigns from their position. If the care coordinator is out on leave and will be returning to their position, there is no need to reassign members to new care coordinators. Delegated Entity will need to follow all processes outlined in the Care Coordination Grids and to enter all required information into TruCare.

3.11 LTCC Expansion. The Delegated Entity will assist the member moving to a registered housing with services facility to obtain or recover a verification code from the Senior Linkage Line or found in MMIS.

3.12 Comply with Minnesota Statute 62Q75 Subd.3. Delegated Entity will comply with said statute that states that "healthcare providers and facilities must submit their charges to a health plan company or third-party administrator (TPA) within 6 months from the date of service or the date the healthcare provider knew or was informed of the correct name and address of the responsible health plan company or TPA, whichever is later."

3.13 Enrollee Satisfaction Survey. The Delegated Entity agrees to cooperate with SCHA to conduct a satisfaction survey of members.

3.14 Care Coordinator Performance: The Delegated Entity shall have a process to evaluate the performance of individual care coordinator in the provision of care coordination for SCHA Members and report to SCHA performance that is negatively affecting the care coordination of the SCHA Member.

Members may request and be offered a different care coordinator and the Delegated Entity will immediately notify SCHA of any such request. South Country can also

request the Delegated Entity to change the member to a new care coordinator if the member reaches out to South Country.

SCHA will share care coordinator performance information with the Delegated Entity as appropriate (i.e. feedback from the care coordinator survey, care plan audits, etc.)

3.15 **Personal Care Assessments (PCA):** The Delegated Entity agrees to complete PCA assessments within the DHS required timeframe after referral and annually their after once the request is received from the PCA Agency. The Delegated Entity will communicate the PCA assessments results to South Country.

SECTION 4
SUB-DELEGATION

Under certain circumstances, SCHA may allow Delegated Entity to sub-delegate all or part of the delegated Services under this Agreement to another entity. Prior to any such sub-delegation arrangement, Delegated Entity must receive written approval from SCHA and must:

(a) Provide SCHA with Delegate entity's pre-delegation assessment finding of the potential sub-delegate;
(b) Warrant the delegation agreement between Delegated Entity and sub-delegate meets (1) all applicable SCHA, (2) all applicable state and federal law requirements, and (3) all terms and conditions of this Agreement;
(c) Agree to oversee and perform audits of those activities it has delegated to another entity;
(d) Provide all reports to SCHA that are required under this Agreement; and
(e) Agree that Delegated Entity and the Sub-Delegate adhere to delegation requirements as per applicable State and Federal law and NCQA requirements, including the Medicare Advantage Special Needs Plan regulations.

SECTION 5
TERM, TERMINATION, MODIFICATION

5.1 Initial Term. This Agreement shall commence on January 1, 2020 and continue through December 31, 2020.

5.2 Contract Renewal. Unless otherwise terminated pursuant to Section 5.3, this Agreement will automatically renew on the termination date and on each one (1) year anniversary of such date for additional terms of one (1) year.

5.3 Termination. This entire Agreement, complete sections of this Agreement, or certain delegated services contained in this Agreement, may be terminated as follows:

(a) by either party, without cause upon one hundred twenty (120) days written notice to the other party;

(b) by either party, in the event of a material breach of this Agreement by the other party, upon thirty (30) days prior written notice to the other party;

(c) by SCHA immediately, due to failure of Delegated Entity to perform delegated activities under this Delegation Agreement that could endanger or harm SCHA health plan enrollees;

(d) by SCHA, upon thirty (30) days prior written notice to Delegated Entity, in the event Delegated Entity is out of compliance with this Agreement and refuses to enter into a Corrective Action Plan or agree to a modification of this Agreement;

(e) by SCHA, upon thirty (30) days prior written notice to Delegated Entity, in the event Delegated Entity does not comply with an established Corrective Action Plan;

(f) by SCHA immediately, if Delegated Entity seeks to sub-delegate the performance of delegated services under this Agreement without SCHA's written prior approval to sub-delegate; or

(g) by SCHA immediately, due to Delegated Entity's loss or suspension of any applicable licensure status or loss of liability insurance.

5.4 Counterparts; Electronic Signatures. This Agreement may be executed in one or more counterparts, each of which, taken together, shall constitute a single original. Electronic, scanned or facsimile signatures shall be deemed originals for the purpose of this Agreement.

SECTION 6
REGULATORY COMPLIANCE

6.1 SCHA, Delegated Entity and Delegated Entity's contractors and subcontractors, agree to comply with all applicable federal and state statutes and regulations, as well as local ordinances and rules now in effect and hereinafter adopted, including, but not limited to all applicable Medicaid and Medicare laws, regulations, and CMS instructions.

6.2 Disclosure of Ownership Information: All subcontracts must be in writing. Delegated Entity must update disclosure information as needed in accordance with 42_CFR455.104. The required information includes**:** (a) the name, address, date of birth, social security number (in case of an individual), and tax identification number (in the case of a corporation) of each Person with an Ownership or Control Interest in the Delegated Entity or in any subcontractor in which there is direct or indirect ownership of 5% or more. The address for corporate entities must include primary business address, every business location, and P.O. box address; (b) a statement as to whether any Person with an Ownership or Control Interest in the entity as identified in Paragraph (a) is related (if an individual) to any other Person with Ownership or Control Interest as a spouse, parent, child, or sibling; and (c) the name of any other Disclosing Entity in which a Person with Ownership or Control Interest in the Disclosing Entity also has an ownership or control interest; and (d) the name, address, date of birth and social security number of any Managing Employee of the Delegated Entity.

6.3 All tasks performed under the Agreement must be performed in accordance with SCHA's

Policy and Procedure regarding Care Coordination for MSC+ and SeniorCare Complete(MSHO) and AbilityCare, SingleCare, SharedCare (SNBC) programs, the provisions of which are incorporated into the Agreement by reference. Nothing in the Agreement relieves SCHA of its responsibility under such contracts with the State and CMS. If any provision of the Agreement is in conflict with provisions of such contracts, the terms of such contracts shall control.

6.4 Delegated Entity is obligated to comply with other laws, specifically Federal laws and regulations designed to prevent or detect fraud, waste, and abuse including, but not limited to: applicable provisions of Federal criminal law; the False Claims Act (31 U.S.C. 3729 et seq.); the Anti-kickback statute (Section 1128B (b) of the Act); HIPAA administrative simplification rules at 45 CFR Part 160, 162, and 164, and with Title XIII, Subtitle D of the American Recovery and Reinvestment Act of 2009, Pub Law 111-5 ("ARRA") and any implementing regulations that may be enacted.

6.5 Delegated Entity agrees that members are not discriminated against in the delivery of health care services consistent with benefits covered in their Certificate of Coverage based on medical coverage, health status, receipt of health care services, claims experience, medical history, genetic information, disability (including mental or physical impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, or public assistance status.

6.6 Delegated Entity assures that services are provided in a culturally competent manner.

6.7 Delegated Entity adheres to the prohibited use of Medicare excluded practitioners.

6.7.1 Delegated Entity will search the OIG List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List (EPLS) databases monthly, and require all subcontractors to search the LEIE monthly, for any Employees, Agents, Providers, or Persons with an Ownership or Control Interest to verify that these persons:

6.7.1.1 Are not excluded from participation in a federal health care program under Section 1128 or 1128A of the Social Security Act; and

6.7.1.2 Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX services program.

6.7.2 Delegated Entity will report to SCHA within five (5) days any information regarding individuals or entities specified in 6.7.1.1, who have be convicted of a criminal offense related to the involvement in any program established under Medicare, Medicaid, and title XX services program, or those have been excluded from participation in a federal health care program under Sections 1128 or 1128A of the Social Security Act.

6.7.3 Upon discovery of an ineligible individual or entity, Delegated Entity will immediately relieve the employee, agent, Provider or subcontractor from his or her responsibilities or the business relationship will immediately be discontinued.

6.7.4 Delegated Entity shall report within one business day to SCHA the Name, specialty, and address, and reason for nonrenewal or termination of each Contracted Healthcare Provider whose contracts have been terminated not renewed during the previous quarter.

6.8 Delegated Entity agrees to send to members only SCHA approved written materials, related to SCHA benefits. Mailed care coordination and benefit items must include the disclaimer: SCHA Important Plan Information.

6.9 Delegated Entity recognizes and agrees that it is obligated by law to meet the applicable provisions of the Health Insurance Portability and Accountability Act of 1996, Pub Law 104-191, and its implementing regulations, 45 C.F.R. Parts 160, 162 and 164 ("HIPAA"), including the safeguarding of individuals' Protected Health Information ("PHI"), and with Title XIII, Subtitle D of the American Recovery and Reinvestment Act of 2009, Pub Law 111-5 ("ARRA") and any implementing regulations that may be enacted, as detailed in the Business Associate Agreement (Exhibit D) attached to this Agreement.

6.10 Upon request, Delegated Entity must report to SCHA information related to business transactions in accordance with 42 CFR 455.105(b). Delegated Entity must be able to submit this information to SCHA within fifteen (15) days of the date of a written request from the State or CMS.

SECTION 7
BOOKS AND RECORDS

7.1 Confidential and Accurate Records. SCHA and Delegated Entity agree to maintain the confidentiality of protected health information regarding SCHA enrollees and to comply with all state and federal requirements for accuracy and confidentiality of enrollees' records, including the requirements established by SCHA and each applicable product.

7.2 Collection and Retention of Information. Delegated Entity shall maintain an accurate and timely record system through which all pertinent information relating to this Agreement is documented. Delegated Entity shall retain all information and records related to this Agreement for a period of ten (10) years following the termination of this Agreement or for such longer period as required by applicable state or federal law or regulation.

7.3 Right to Inspect; Release of Information to SCHA. Delegated Entity agrees to provide to SCHA during the term of this Agreement and for a period of ten (10) years following the provision of services access to all information and records, or copies of records, related to this Agreement. Delegated Entity shall promptly provide information to SCHA as requested for payment purposes, administration of benefits or any other obligation SCHA has to an enrollee under the law. SCHA shall develop and implement a process

for securing necessary consents from enrollees or their legal representatives in connection with the enrollment process to authorize the release of records provided under this Section. Delegated Entity has no obligation to release records to the extent such release is unlawful.

7.4 Right to Inspect; Release of Information to Federal and State Agencies. Delegated Entity shall provide the state and federal government and any of their authorized representatives, including but not limited to CMS, the Comptroller General and the State with the right, in accordance with state and federal laws and regulations, to inspect, evaluate, and audit any pertinent books, documents, financial records, papers, and records pertaining to any aspect of services performed, reconciliation of benefit liabilities, determination of amounts payable or financial transactions related to this Agreement. The right to inspect, evaluate and audit under this Section shall extend through ten (10) years from the termination date of the Agreement or such longer period as permitted or required by applicable state or Federal law or regulation.

Delegated Entity shall make all such records available to authorized representatives of the state and federal government during normal business hours and at such times, places, and in such manner as authorized representatives may reasonably request for the purposes of audit, inspection, examination, and for research as specifically authorized by the state in fulfillment of state of federal requirements.

Delegated Entity specifically acknowledges and agrees that the U.S. Department of Health and Human Services and the Comptroller General, or their designees, shall have the right to audit, evaluate, and inspect pertinent books, contracts, documents, papers, and records involving transactions related to the CMS Contract. This right shall extend for ten (10) years following the termination of this Agreement or from the date of completion of any audit, whichever is longer. SCHA shall develop and implement a process to authorize the release of records provided under this section. Delegated Entity has no obligation to release records to the extent such release is unlawful.

SECTION 8
RESPONSIBILITY FOR DAMAGES

Each party shall be responsible for all damages, claims, liabilities, or judgments that may arise as a result of its own negligence or intentional wrongdoing. Any costs for damages, claims, liabilities, or judgments incurred as a result of the other party's negligence or intentional wrongdoing shall be the responsibility of the negligent party.

SECTION 9
DISPUTE RESOLUTION

SCHA and Delegated Entity agree to work together in good faith to resolve any and all disputes related to this Agreement. In the event SCHA and Delegated Entity are unable to resolve disputes arising as a result of this Agreement, this Agreement shall be modified or terminated pursuant to Section 5.

SECTION 10
FEES AND REIMBURSEMENT

The parties agree that SCHA will pay Delegated Entity those rates specified in Exhibit D and Exhibit E for the services rendered by Delegated Entity pursuant to this agreement.

SECTION 11
MISCELLANEOUS

11.1 Incorporation of Relevant Statutes and Regulations. The parties agree that the services to be provided under this agreement, the contractual arrangements between the parties, and the respective responsibilities and obligations of the parties, shall be further specified in relevant state and federal regulations and contracts, and that those regulations and contracts shall be incorporated into the subsequent contract between the parties.

11.2 Binding Effect of Agreement; Subsequent Contract. The parties agree to be bound by the terms of this Agreement for the services to be provided under this agreement until the parties enter a subsequent agreement or the Agreement is terminated by either party.

11.3 Notices. All notices, payments, requests or demands or other communications required or permitted under this Agreement shall be in writing and shall be deemed to have been given (i) two (2) days after when mailed by registered or certified U.S. mail, postage prepaid, and addressed to the recipient at the address shown in the signature block to this Agreement; or (ii) upon receipt when delivered in person, by courier or by delivery service, return receipt requested, to the address of the parties set forth herein. A party may change the address to which notices may be sent by giving written notice of such change of address to the other party.

11.4 Assignment. Neither party may assign, delegate or transfer this Agreement or the rights granted herein without consent of the other party, with the exception of the Sub-Delegation arrangements outlined in Section 4, and which consent shall not be unreasonably withheld.

11.5 Amendment. This Agreement may only be modified through a written amendment signed by both parties. Notwithstanding the foregoing, SCHA may unilaterally amend this Agreement to comply with applicable state or federal law or regulation or NCQA accreditation standards. Such amendment will be effective on the date the applicable statue, regulation or NCQA accreditation standard becomes effective. The amendment will not require agreement by Delegated Entity.

11.6 Waiver. The waiver of any provision (including the waiver of breach of any such provision) of this Agreement shall not be effective unless made in writing by the party granting the waiver. Any waiver by a Party of any provision or the waiver of breach of any provision of this Agreement shall not operate as, or be construed to be, a continuing waiver of the provision or a continuing waiver of the breach of the provision.

11.7 Governing Law. This Agreement shall be governed by and construed under the laws of the State of Minnesota.

11.8 Entire Agreement. This Agreement, which incorporates all exhibits, attachments, addenda, and appendices to it, constitutes the entire understanding between the parties in regard to its subject matter and supersedes all other previous oral or written agreements concerning all or any part of the subject matter of this Agreement.

11.9 Severability. If any part of this Agreement should be determined to be invalid, unenforceable, or contrary to law, that part shall be deleted and the other parts of this Agreement shall remain fully effective.

11.10 Survival. Any section of this Agreement that by its terms contemplates or requires continuing effect following termination of this Agreement shall survive such termination.

11.11 Approvals of this Agreement. The effectiveness of this Agreement is subject to the approval of this Agreement by the Minnesota Department of Human Services.

IN WITNESS WHEREOF, the parties have executed this Delegation Agreement to be effective as of the Effective Date.

DELEGATED ENTITY:	**SOUTH COUNTRY HEALTH ALLIANCE**
Goodhue County	2300 Park Drive Owatonna, Minnesota 55060
By: _____	By: _____
Print Name: _____	Print Name: Leota B. Lind_____
Title: _____	Title: CEO, South Country Health Alliance
Date: _____	Date: _____
By:_____	
Print Name:_____	
Title:_____	
Date: _____	
By: _____	
Print Name: _____	

Title: _____ Date: _____	

EXHIBIT A

SERVICES TO BE PROVIDED BY DELEGATED ENTITY

Delegated Entity agrees to perform the following services and/or meet the following State mandated requirements on behalf of South Country:

1. Hire staff qualified to perform the duties outlined in the Community Care Connector Position Description. Duties are outline in Exhibit B.

2. Ensure all duties outlined in the Exhibit B are completed within required timelines.

3. Hire staff to perform Care Coordination duties consistent with MCO/DHS contracts which read that for MSHO/MSC+ the Certified Assessor must also serve as the on-going care coordinator/case manager of the Enrollees assessed. For SNBC, the case manager/care manager must be a social worker, licensed social worker, registered nurse, physician assistant, nurse practitioner, public health nurse, or a physician with experience working with individuals with disabilities, primary care, nursing, behavioral health, or social services and/or community-based services. All care coordinators must not be in a position to directly influence an Enrollee's housing or employment to help avoid possible conflicts of interest.

4. Perform the Care Coordination duties outlined in the South Country Policy and Procedures and Care Coordination Grids including, but not limited to, Care Coordination for members on MSC+ and SeniorCare Complete and AbilityCare, SingleCare, SharedCare and other members as requested by South Country.

5. Delegated Entity shall provide South Country with written reports or supply the information specified therein as identified by South Country. South Country agrees to provide reasonable advance notice when requesting information from the Delegated Entity. The Delegated Entity shall submit written reports or supply the information to South Country as Reports are identified on Exhibit C.

6. Delegated Entity agrees to appoint representatives to participate in South Country work groups and scheduled meetings with South Country for the regular sharing and exchange of information. It is the responsibility of the Delegated Entity's participant to transfer information to the appropriate others.

7. The Delegated Entity will fully cooperate with the annual Care Plan Audit and Care System Review and any other audits requested and/or completed by South Country personnel. The County will provide all necessary documentation as requested by South Country and have available supporting evidence of required elements within the designated time lines as requested by South Country.

8. The Delegated Entity will act as a pass-through entity for Elderly Waiver Direct-Delivery Services (tier 2) or Purchased-Item Services (tier 3). Providers of tier 2 and tier 3 services must meet State service standards, but may deliver goods as enrolled or non-enrolled

providers. For non-enrolled providers, the delegated entity on behalf of South Country must assure that the provider is qualified according to State standards, execute a purchase agreement utilizing MN DHS eDoc 7004c, follow record retention guidelines, and maintain a written record of approved tier 2 and 3 providers. Delegated Entities will submit copies of the provider approval log at least one (1) time per year and/or as requested by South Country.

9. Delegated Entity shall individually develop a written plan which works for their specific system regarding the establishing of caseload ratios. South Country expects delegates to consider the following when weighting cases and developing caseload ratios: members on the caseload with low English proficiency or need for translation; case mix; rate cell designation; member need for high intensity acute Care Coordination; mental health status; travel time to/from member's home; or lack of family or informal supports. South Country generally recommends that non-Elderly Waiver caseloads be no more than 1:100 and Elderly Waiver caseloads be no more than 1:50. Delegated Entities must submit their plan to South Country upon request.

SOUTH COUNTRY HEALTH ALLIANCE
Bringing Wellness Home

EXHIBIT B

Position: Community Care Connector
Reports to: County Supervisor and Director of Community Engagement
Effective Date: **October 2019**

PRIMARY FUNCTION:

Assure that members receive the services necessary to meet their needs and experience smooth transitions between care settings. Connectors also assure that communication between care settings and communication between South Country, County and community partners and resources occur in order to support member's needs. Desired outcomes are attained through collaborative problem-solving approaches.

The Connector works to assure a collaborative approach between the South Country and County team members. The position will develop positive relationships with and between SCHA, County, local health care providers, nursing facilities and members. They will help to ensure timely and accurate communication between team members. The Connector serves as the South Country liaison within the community/county, working towards positive outcomes for the member and South Country. The position promotes preventive services, early intervention to members and utilizes referral services available throughout the county.

Connectors can chose to delegate specific tasks to a case aide as outlined in the Connector and Case Aide Task List and as agreed upon between South Country and the County.

Reporting: Under the general direction of the South Country Director of Community Engagement, and the County Supervisor.

MINIMUM QUALIFICATIONS OF EDUCATION & EXPERIENCE

Registered Nurse, licensed in Minnesota; or Social Worker; or Bachelor Degree in a related field

ESSENTIAL DUTIES AND RESPONSIBILITIES:

- Collaborate
    1. Assist in identifying moderate to complex members by informing South Country of members health issues;

2. Assist in creating and maintaining reports and follow-up as requested by South Country.
3. Promote early intervention and preventative services to members and importance of establishing care with a primary care provider.
4. Work with South Country to ensure members appropriate use of the Emergency Department, hospitalization, and re-admissions to hospital through telephonic, written or face-to-face follow-up with members after discharge to promote provider follow-up.
5. Collaborate with South Country to schedule and assist with the facilitation of the South Country meetings.
6. Assist with transitions of care through working with discharge planners, providers, members and/or authorized representatives.

- Communicate
    1. Reach out and follow up with members and connect members to resources.
    2. Document in TruCare members responses to outreach as directed by South Country
    3. Develop relationships with key community partners and resources Develop and maintain strong communication and relations with South Country and county entities.

- Coordinate
    1. Organize and attend monthly interdisciplinary care team meetings.
    2. Refer members and/or families, county, providers, community resources to Member Services or other appropriate SCHA staff for benefit and issue resolution.
    3. Refer member issues to county staff and/or other agencies as needed to assure member's access to community services and resources;
    4. Coordinate activities and information with the County Supervisor.

- Other duties as assigned.

PROFILE REQUIREMENTS:

- Works as a team with South Country and County staff
- Promotes SCHA policies and mission in performing all duties and responsibilities
- Incorporates best practice into all process initiatives
- Valid driver's license
- Excellent communication skills

- Working knowledge of community services and resources
- Working knowledge of SCHA products and operations including the website.

SOUTH COUNTRY HEALTH ALLIANCE
Bringing Wellness Home

Community Care Connector or Case Aide	Community Care Connector
• Organize and attend Interdisciplinary Care Team meetings monthly • Be available for South Country Staff • Be knowledgeable about all South Country products and programs • Field non-South Country member calls about South Country products for potential enrollment • Send new membership information to appropriate county staff within same day of receipt from South Country. • Follow up with Care Coordinators to ensure Care Coordinator has been assigned to all new members • Notify Care Coordinators of Hospitalizations or Medication Reconciliation follow up within same day of receipt from South Country. • Retro Enrollment notification • County financial worker information such as the member's assigned CC, member updated phone or member updated address within 10 days of receipt • PMAP MNCare Survey outreach calls • Report any outdated materials • Send Dental tools send to CC	• Actively connect with other County departments • Be the liaison between South Country and the County • Attend and provide case consultation at Interdisciplinary Care Team meetings • Document in all member contact within TruCare unless otherwise instructed by South Country. • Be a local resource for PCP, Specialist, and dental for any South Country questions and help promote South Country's mission • Communicate South Country updates to Care Coordinators • Have a backup Connector for when absent and notify South Country • Look into and assist in billing issues from providers and members • Emergency Department follow up • Durable Medical Equipment Follow Up • PMAP/ MNCare Hospital Follow Up • Turning 65/ Gaining Medicare Report

EXHIBIT C

2020 Delegated Entity Reporting Responsibility

1. **Recommendation for Action Denial, Termination or Reduction of Waivered Services**
   Complete the Recommendation for Action DTR Note in TruCare within one (1) business day of the recommended action.

2. **Recommendation for Request of Services**
   DSD Waiver Case Managers are to complete and send to South Country the Recommendation for State Plan Home Care services DHS eDoc 5841.
   Fax to: 1.888.633.4052 or send securely to CountyInfo@mnscha.org
   Attention: Utilization Management Department

3. **Member Care Coordination Activity Report**
   The delegated entity will complete Care Coordination tasks within TruCare or Care Plan Application to allow South Country to pull reports.
   a. Complete the Health Risk Assessment (HRA) in TruCare or upload a hard copy health risk assessment and enter the data from the HRA into the HRA Data Collection Tool within 30 days of the completed HRA.
   b. Complete a care plan in the South Country Care Plan Application/URL within 30 days form the HRA.

4. **Transitions of Care Follow-Up Contacts and designated ER Visits**
   a. The delegated entity will document in TruCare all hospital follow-up and designated ER visit contacts according to South Country requirements.
   b. The delegated entity will notify a member's Care Coordinator of a hospital admission, the same day of the notification being sent from South Country.
   c. The delegated entity Care Coordinator will provide and document care transitions for EW and Community Well members on SCC, MSC+, AbilityCare, and SingleCare using a Transition of Care Log in TruCare, case notes, and offering a Medication Reconciliation service as appropriate and submit to South Country upon request.

5. **Report of Special Health Care Needs**
   South Country will inform the Connector of a member with Special Health Care Needs. The Connector will follow up with the member and document in TruCare. The Connector will notify the member's Care Coordinator if one is assigned.

6. **Elderly Waiver Provider Network Analysis**
   Delegated Entity will inform South Country of any observed EW provider gaps within their county and work with South Country staff as appropriate to resolve any member unmet needs and ensure provider access for all members on the Elderly Waiver program.

7. **Community Care Connector Activity Report**
   a. The delegated entity will document Community Care Connector tasks in TruCare, unless otherwise directed by South Country, to allow South Country to pull reports.
   b. The delegated entity will document referrals made on members behalf within TruCare.

c. The delegated entity will return the PMAP/ MNCare Survey outreach calls to South Country by the deadline identified. If unable to meet the deadline the delegated entity will notify South Country, no later then three (3) business days prior to the deadline.
d. The delegated entity will return the No PCP Visit outreach calls to South Country by the deadline identified. If unable to meet the deadline the delegated entity will notify South Country no later than three (3) business days prior to the deadline.

EXHIBIT D

2020 Rates

1. **Non-Elderly Waiver (EW) Community Well and Skilled Nursing Facility Members**
   Procedure Code: G9005
   - Care Coordination Activity for:
     - SeniorCare Complete (SCC) and MSC+ $24.01/15 Minute Unit
       Non-EW Community Well and Skilled Nursing Facility
       SNBC (AbilityCare, SingleCare, SharedCare)

2. **Relocation Service Coordination for all MSC+ and SCC** $15.53/15 Minute Unit
   Procedure Code: T1017

3. **Elderly Waiver SCC and MSC+ Members**
   - Care Coordination Activity $25.46/15 Minute Unit
     Procedure Code: T1016 UC

   - Case Management Aide Activity $9.39/15 Minute Unit
     Procedure Code: T1016 TF UC

   - CDCS Mandatory Case Management $25.46/ 15 Minute Unit
     Procedure Code: T2041
     Maximum $2,444 per service agreement date span

4. **Community Care Connector and Community Care Connector Case Aide Position**
   - 25 average Connector weekly hours dedicated to South Country Connector duties
   - 15 average Connector Case Aide weekly hours dedicated to South Country Connector Case Aide duties

Connector	$62,346.50 Annually
Connector Case Aide	$30,964.80 Annually

   Payment will be made bi-annually on or about mid-June and mid-December 2020.

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (GCHHS)

REQUEST FOR BOARD ACTION

Requested Board Date:	February 18, 2020	**Staff Lead:**	Mike Zorn
Consent Agenda:	☐ Yes ☒ No	**Attachments:**	☐ Yes ☒ No
Action Requested:	Approve January 2020 HHS Warrant Registers		

BACKGROUND:
This is a summary of Goodhue County Health and Human Services Warrant Registers for: January 2020

	Date of Warrant		Check No. Series		Total Batch
IFS	January 3, 2020	ACH	29835	29842	$4,003.46
IFS	January 3, 2020		448714	448748	$26,729.07
IFS	January 10, 2020	ACH	29870	29883	$15,041.21
IFS	January 10, 2020		448841	448896	$79,859.45
IFS	January 17, 2020	ACH	29896	29906	$7,328.18
IFS	January 17, 2020		448963	449003	$16,254.13
IFS	January 24, 2020	ACH	29959	29964	$2,001.25
IFS	January 24, 2020		449053	449083	$23,165.80
IFS	January 31, 2020	ACH	30043	30061	$5,692.73
IFS	January 31, 2020	ACH	449155	449215	$56,673.45
SSIS	January 31, 2020	ACH	29966	29983	$40,755.72
SSIS	January 31, 2020		449084	449144	$297,759.62
IFS	January 31, 2020	ACH	29984	30042	$7,496.59
IFS	January 31, 2020		449145	449154	$60,112.33
				Total	$642,872.99

RECOMMENDATION: Goodhue County HHS Recommends Approval as Presented.

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (GCHHS)

REQUEST FOR BOARD ACTION

Requested Board Date:	February 18, 2020	**Staff Lead:**	Nina Arneson
Consent Agenda:	☐ Yes ☒ No	**Attachments:**	☒ Yes ☐ No
Action Requested:	Approve the following two requests – Public Health Nurse (PHN) and Live Well Goodhue County Intern		

BACKGROUND:

The following two requests will be brought forward for the Goodhue County Personnel Committee's review on February 18, 2020 at 9:00 am.

- **Public Health Nurse (PHN) – FTE Change**
- **Live Well Goodhue County Intern – Temporary, SHIP Grant Funded Position**

Please see attached two memos. The HHS Department staff will inform the HHS Board of the Personnel Committee's actions at our February 18, 2020 Health and Human Services Board meeting.

RECOMMENDATION: GCHHS Department recommends approval as requested.

Goodhue County
Health and Human Services

DATE: February 3, 2020

TO: Goodhue County Personnel Committee

FROM: Nina Arneson, Goodhue County Health and Human Services Director

RE: Replace Public Health Nurse - Family Health Division

BACKGROUND:

Goodhue County Health and Human Services is requesting to fill a Public Health Nurse (PHN) position within our Family Health Division. On April 30, 2020 our Women, Infants, and Children (WIC) Coordinator is retiring after 36 years of excellent public service to Goodhue County residents. We have internally posted and filled this anticipated WIC Coordinator vacancy with an internal PHN.

We are requesting to backfill the open PHN position. We request that this position be filled as a full-time position, the current position is .8 FTE. Our plan is to increase this position to full time to assist with Disease Prevention & Control (DP&C) duties. Our current DP&C Coordinator will be retiring in the next 5 years and we intend to have this position serve as the succession plan; becoming the new DP&C Coordinator when our current coordinator retires. DP&C is a very specialized program area and we would like to have time to train sufficiently in this area. This replacement position would serve as DP&C back up in the interim in addition to other Family Health duties. Family Health duties would include primary WIC back up, daycare consultation, lead case management, family home visiting, and car seat distribution.

The current rate of pay for the PHN being replaced is $45.57 per hour. The starting pay (step 1) for a PHN position is $ 26.83 per hour.

	Single Health	Family Health
Public Health Nurse	step 1	step 1
Rate	$26.83	$26.83
Gross	$55,807.00	$55,807.00
PERA/FICA/Medicare/Life	$8,518.00	$8,518.00
Health Coverage/H.S.A.	$11,054.00	$24,169.00
	$75,379.00	$88,494.00
Total Benefits	$19,572.00	$32,687.00
Wages + Benefits less Health	$64,325.00	$64,325.00
Health Insurance	$11,054.00	$24,169.00
Total	$75,379.00	$88,494.00
	Plan 1	Plan 2

RECOMMENDATION:

The HHS Department recommends approving the following:

1. Moving forward immediately to post for 1 Public Health Nurse (1.0 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 after GCHHS Board's review and approval.

Goodhue County
Health and Human Services

DATE: February 12, 2020

TO: Goodhue County Personnel Committee

FROM: Nina Arneson, HHS Director

**RE: Live Well Goodhue County Intern -
SHIP Grant Funded**

BACKGROUND:

The GCHHS Public Health Division, Healthy Communities Unit operates the Minnesota Department of Health (MDH) Statewide Health Improvement Partnership (SHIP) 100% 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.

GCHHS has received these SHIP grant funds from the MDH since the legislature created SHIP in 2009, with a two-year break in funding 2011-2013. In 2014, we officially rebranded as "Live Well Goodhue County."

We are nearing the end of our current 5-year grant project agreement (November 1, 2015 through October 31, 2020). Each year we submit a budget to MDH and often we are able to carry unspent funds forward. We are anticipating $39,151 in unspent grant funds, however, this year the MDH is not allowing any carryovers past October 31, 2020.

Based on Live Well Goodhue County, agency and customers' needs, and after receiving approval from MDH, we request to hire a Live Well Goodhue County intern for summer 2020. This will be a temporary position, 100% covered by the SHIP grant.

The Live Well Goodhue County intern will be paid with SHIP grant funds (no county levy) and as funds are available at $13.50 per hour for up to 400 hours, equal to 10 weeks at 40 hours per week.

The total pay will be 400 hours x $13.50 = $5400. FICA for this position will be $334.80 and Medicare for this position will be $78.30. The total cost of the Live Well Goodhue County intern will be $5,813.10. This will be 100% covered by our 2019-2020 SHIP grant budget as amended to include the carryover.

RECOMMENDATION:

The HHS Department recommends approving the following:

1. Moving forward immediately to post for one Live Well Goodhue County intern (400 hours).
2. Hire Live Well Goodhue County intern for up 400 hours as SHIP Grant funds are available after GCHHS Board's review and approval.

Goodhue County
Health and Human Services

Goodhue County Health & Human Services Board's Proclamation

Goodhue County Health & Human Services Employee Appreciation Day

March 11, 2020

WHEREAS, Health & Human Services are core functions of county government in Goodhue County and in Minnesota; and

WHEREAS, Goodhue County Health and Human Services is committed to promote, strengthen, and protect the health of individuals, families and communities; and

WHEREAS, Goodhue County recognizes this important work rest on the dedication, skills and professionalism of Goodhue County Health and Human Services Employees; and

WHEREAS, Goodhue County Health & Human Services Employees work with numerous legislative, program, customer, community and service demands and because of their commitment to the citizens of Goodhue County and healthier future; and

NOW, THEREFORE, We, the Goodhue County Health and Human Services Board hereby proclaim our gratitude and recognition of Goodhue County Health & Human Services Employees for their dedication, skills, professionalism and outstanding work, and declare March 11, 2020 as the Goodhue County Health and Human Services Day in Goodhue County.

_____ _____

Goodhue County Health and Human Services Board Chair Date

CREST REGIONAL AMHI

CRISIS CENTER TALKING POINTS

CRISIS CENTER OVERVIEW

- History
- Timeline
- Core Services
- Building Updates

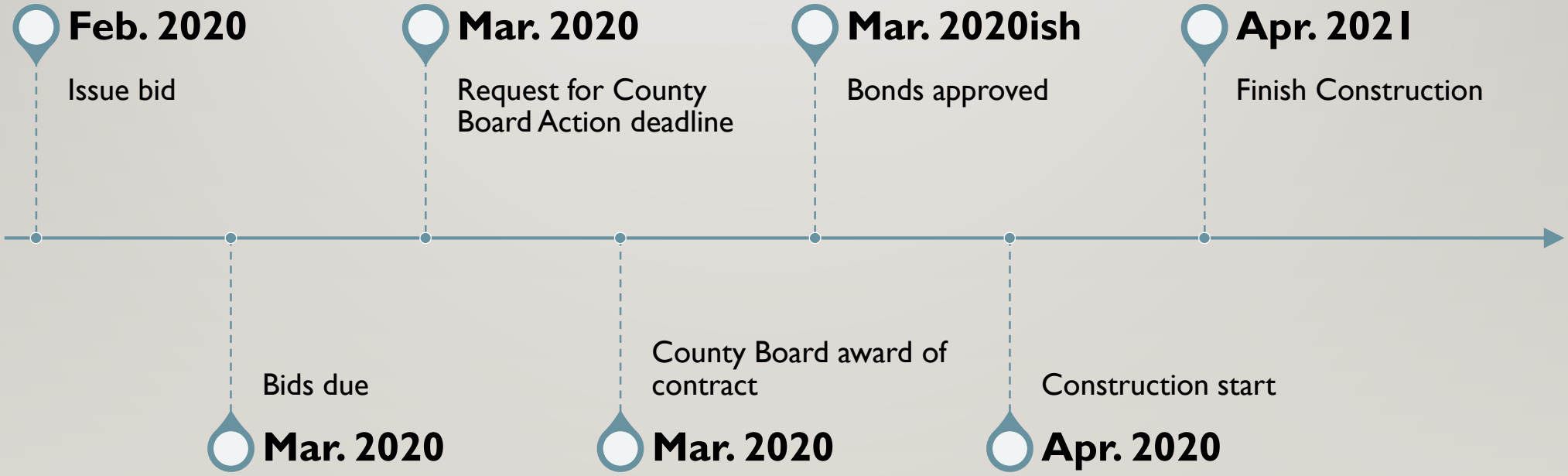
HISTORY

- Regional community partners came together to discuss needs in our mental health delivery system
  - Identified access and housing as two priorities
- Sub-groups and leadership groups were developed to collaborate and illustrate the need and service delivery methods
- Applied for bonding dollars December of 18
- Selected as a tier 1 applicant for full funding spring of 19
- Executed grant agreement September of 19

WHERE ARE WE TODAY?

- Continue an unprecedented partnerships between our medical partners, county partners, health plans and other stakeholders
- Finalizing a governance structure for the first three years of operation
- On-going design work on the facility and parcel on the Olmsted County Campus
- RFP committee has finalized the RFP to be disseminated for an operational partner

TIMELINE TO START CONSTRUCTION



SERVICE TIMELINE

- ❑ Finalize Governance January 20
- ❑ Issue RFP February 20
- ❑ Select service provider March/April of 20
- ❑ Begin committee work March/April of 20
- ❑ Onboard staff Winter/Spring of 20-21
- ❑ Launch Services April of 21

CORE SERVICES

- West area of the facility:
  - Immediate real-time access to assessment, intervention, and crisis planning for individuals and families experiencing a mental health crisis
  - Rapid Access
    - Psychotherapy
    - Diagnostic Assessments
    - Psychiatry
    - Peer-Support
    - Groups
  - Care-Coordination for individuals not needing residential level of care
    - Referral for crisis stabilization in their community

CORE SERVICES

- East area of the facility
  - Residential dwelling spaces
    - Pod-style arrangement
    - Magnetic locking doors to separate adult and youth spaces
  - Group space
  - Healing/spiritual space
  - Catering kitchen
  - Nursing/medication area

DESIGN CONSIDERATIONS

Safety features in both rooms and special design

- De-escalation space
- Anti-ligature considerations
- Cameras to ensure line of sight

Non-clinical feel

- Wood trim
- Warm and inviting color schemes

Recovery space

- Specific room for spiritual requests
- Flexibility for practitioners/professionals to operate programs
- Larger therapy space to accommodate family/siblings

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (HHS)

Monthly Report

CD Placements

CONSOLIDATED FUNDING LIST FOR JANUARY 2020

In-Patient Approval:

#00717963R – 56 year old male – one previous treatment – Oakridge, Rochester
#00354425R – 37 year old male – numerous previous treatments – Oakridge, Rochester
#01765090R – 26 year old male – numerous previous treatments – Fergus Falls CARE, Fergus Falls
#02188133R – 40 year old female – numerous previous treatments – Burkwood, Hudson WI
#01444294R – 43 year old male – numerous previous treatments – Burkwood, Hudson WI
#00230360R – 47 year old male – numerous previous treatments – NorthStar Regional, Shakopee
#00988367R – 50 year old male – three previous treatments – CARE WILLMAR, Willmar

Outpatient Approvals:

#05219828R – 37 year old female – two previous treatments, HVMHC, Caledonia
#02719251 – 17 year old male – no previous treatment – Anthony Lewis Center, Burnsville
#03635025R – 25 year old female – two previous treatments – Valhalla, Woodbury
#01217724R – 54 year old female – one previous treatment – Valhalla, Woodbury
#02727070R – 30 year old male – three previous treatments – Valhalla, Woodbury
#00610476R – 30 year old male – one previous treatment – Valhalla, Woodbury
#04445110R – 24 year old female – four previous treatments – Progress Valley, Bloomington
#02640398R – 21 year old female – one previous treatment – Common Ground, Red Wing

Halfway House Approval: None

GOODHUE COUNTY
HEALTH & HUMAN SERVICES (GCHHS)

Monthly Update
Child Protection Assessments/Investigations

	2016	2017	2018	2019	2020
January	18	21	25	21	16
February	26	22	21	20	
March	16	17	27	34	
April	32	17	22	20	
May	21	31	19	23	
June	17	28	23	16	
July	18	21	22	16	
August	19	33	11	19	
September	25	20	17	25	
October	18	28	28	29	
November	22	19	22	24	
December	15	16	19	21	
Total	**247**	**273**	**256**	**268**	

Quarterly Trend Report

Quarter 4 (October-December) 2019

Goodhue County Health and Human Services

February 18, 2020

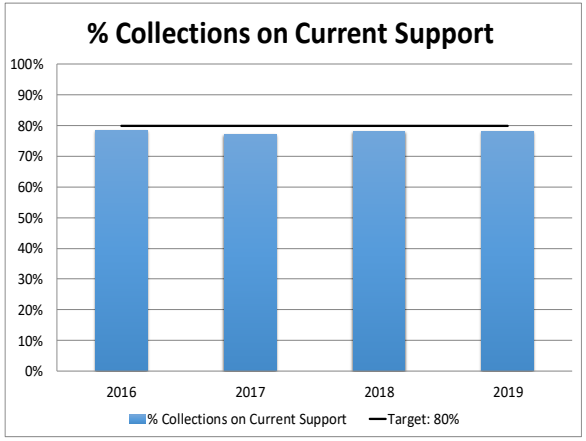
Table of Contents

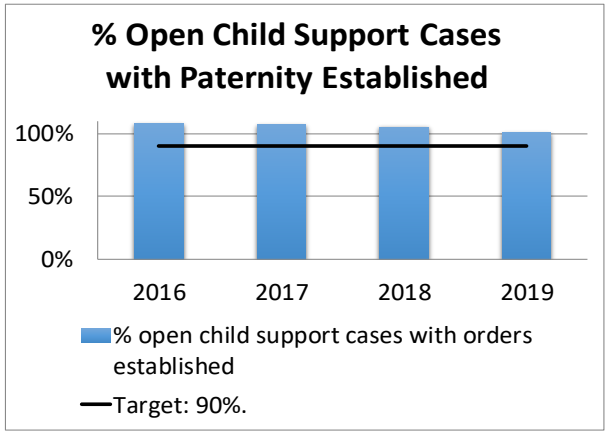
Goodhue County
Health & Human Services

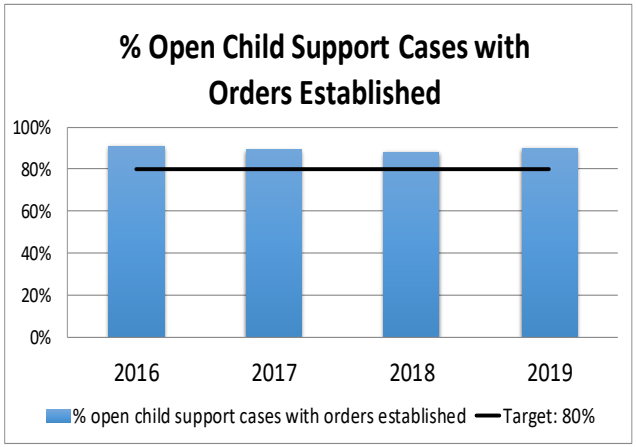
Economic Assistance
Child Support

Purpose/Role of Program

Minnesota's Child Support Program benefits children by enforcing parental responsibility for their support. The Minnesota Department of Human Services' Child Support Division supervises the Child Support Program. County child support offices administer it by working with parents to establish and enforce support orders. The child support staff also works with employers and other payors, financial institutions, other states and many more to implement federal and state laws for the program. The program costs for the Child Support Program are financed by a combination of federal and state money. The measures included below are measures the federal office uses to evaluate states for competitive incentive funds.







Story Behind the Baseline

- **LEFT:** Children need both parents contributing to their financial security and child support is one means of accomplishing that.
- **CENTER:** Establishing parentage gives a child born outside of marriage a legal father and the same legal rights as a child born to married parents. The paternities established during the federal fiscal year may not necessarily be for the same children born of non-marital births in the previous year. This is why percentages often exceed 100.
- **RIGHT:** This is a measure of counties' work toward ensuring children receive financial support from both parents. Through our role in the Child Support program, we help ensure that parents contribute to their children's economic support through securing enforceable orders, monitoring payments, providing enforcement activities, and modifying orders when necessary.

Child Support data is available at the end of the year.

Where Do We Go From Here?

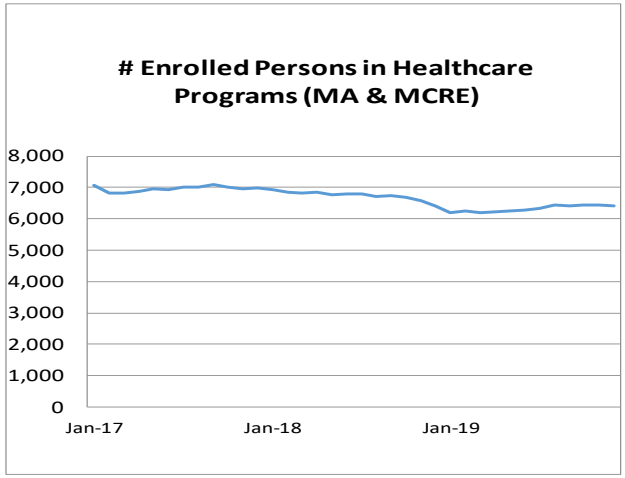
- **LEFT:** Continue to focus on reaching out to the non-custodial parents. Phone calls, building rapport and working together for reasonable payments helps to increase the % of collections on current support.
- **CENTER:** Staff factors influence all the measures. Continue to support our dedicated workers and utilize experienced, skilled staff in training new staff as staff retire.
- **RIGHT:** Continue to work closely with Goodhue County Attorney's Office and share information between courts, tribal nations, and other states that impact the ability to collect support across state boundaries.

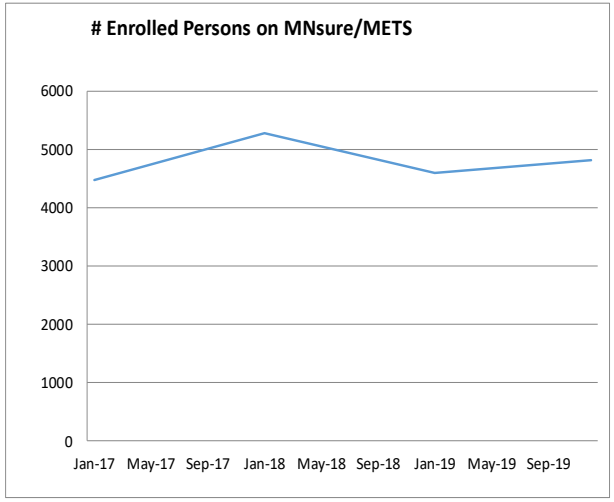
Goodhue County
Health & Human Services

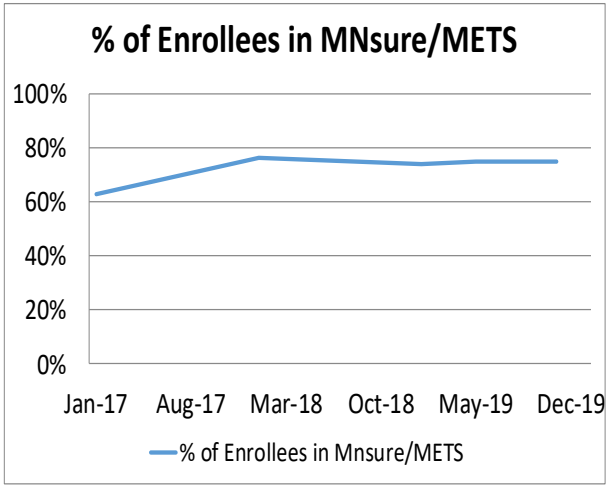
Economic Assistance
Healthcare

Purpose/Role of Program

Minnesota has several health care programs that provide free or low-cost health care coverage. These programs may pay for all or part of the recipient's medical bills. The healthcare programs administered by the county agencies are done so under the supervision of the state Department of Human Services. Eligibility for the healthcare programs is determined via a combination of system determination (MNsure/METS/MAXIS) and Eligibility Workers. Eligibility is based on varying factors including income and assets. Funding for the healthcare programs is a combination of federal and state money.







Story Behind the Baseline

- **LEFT:** The number of enrollees on healthcare for Medical Assistance (MA) and MinnesotaCare (MCRE) has remained stable over the past year since the significant increases of Affordable Care Act (ACA) implementation.
- **CENTER & RIGHT:** The number of healthcare recipients enrolled through the MNsure/METS system has increased over the years as more people enroll and those on the legacy system (MAXIS) transfer to MNsure/METS. With transfer complete, we are no longer seeing increases.

Where Do We Go From Here?

LEFT: Continue to make accessing services easy for all county residents needing assistance with healthcare.

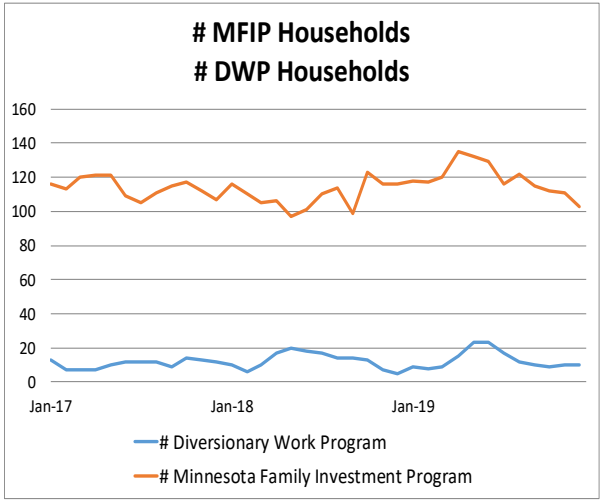
CENTER & RIGHT: We continue to work closely with MNsure and DHS in order to improve the applicant and worker experience with the MNsure system. This continues to be very challenging due to METS' technical and system issues, program complexities, changing policies, and inadequate supports from the state.

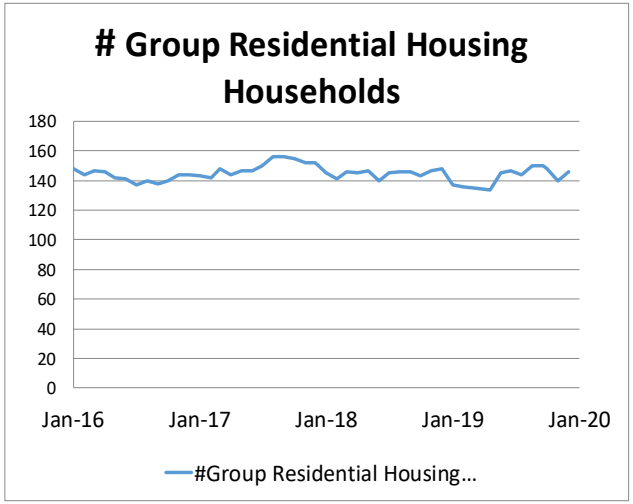
Goodhue County
Health & Human Services

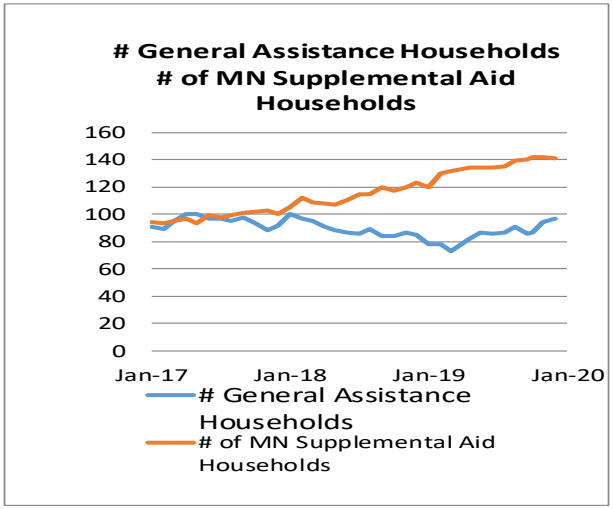
Economic Assistance
Cash Assistance

Purpose/Role of Program

The cash assistance programs administered at the county are entitlement programs that help eligible individuals and families meet their basic needs until they can support themselves. Eligibility for these programs is determined by Eligibility Workers and is based on an applicant's financial need. The programs are administered by county agencies under the supervision of the state Department of Human Services. The program costs for the cash programs are financed by federal and/or state money (depending on the specific program). The MFIP and DWP program are time-limited and include work requirements and access to employment services. Income Maintenance staff work closely with local job counselors.







Story Behind the Baseline

LEFT, CENTER & RIGHT: These figures demonstrate steady volumes of services for the MFIP, DWP, GRH, General Assistance and MN Supplemental Aid Households.

Where Do We Go From Here?

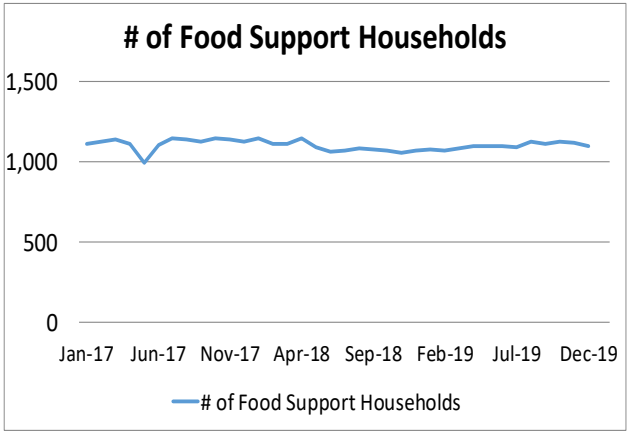
LEFT, CENTER & RIGHT: Many factors influence the need for these safety net programs including economy and availability of community resources such as food shelves, and natural disasters that result in increased applications.

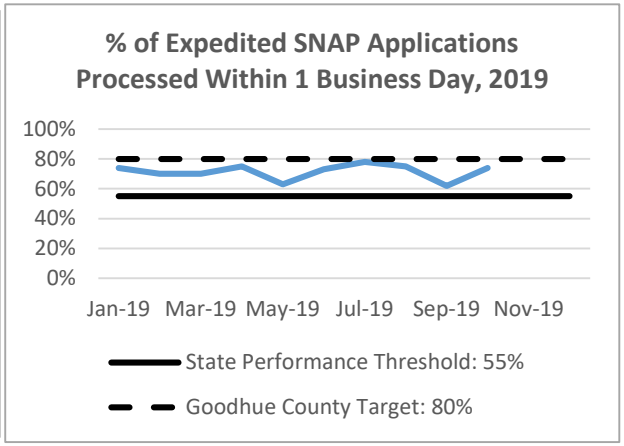
Goodhue County
Health & Human Services

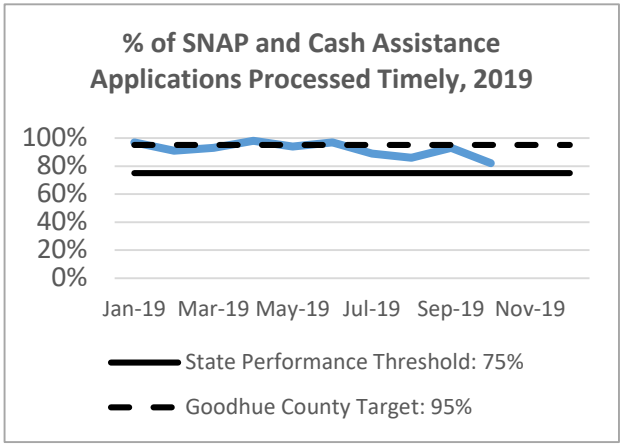
Economic Assistance
SNAP

Purpose/Role of Program

SNAP is a federal entitlement program that increases the food purchasing power of low-income households. Eligibility for this program is determined by Eligibility Workers and is based on an applicant's financial need. The benefit level is determined by household income, household size, housing costs and more. SNAP applicants are given expedited service when they have little to no other resources available to pay for food and, therefore, need basic safety net programs to meet a crisis. This program is administered by county agencies under the supervision of the state Department of Human Services. The program costs for the SNAP program are financed by a combination of federal and state money. The program includes work requirements for some recipients.







Story Behind the Baseline

- **LEFT:** The number of households receiving food benefits in Goodhue County has been stable around 1100 since 2017. This follows the state trend. There are a number of factors contributing to this including changes in program rules, stronger economy and increased fraud prevention efforts.
- **CENTER:** GCHHS has been above the 55% state performance threshold since this measure was created in 2014 and has some of the most timely processing in the region. It is hard to process all expedited applications within a day because we may not correctly identify which applications to expedite, and we may not be able to reach applicants by phone the same day their application is received.
- **RIGHT**: Goodhue County well exceeds the 75% state performance threshold for processing SNAP and Cash applications, and has since this measure was created in 2014. GCHHS met our internal goal of 95% in 2015 and 2018. Applications interviews held late in the processing period result in an extension of the processing timeline. This extension can exceed past state criteria for timeliness.

Where Do We Go From Here?

- **LEFT:** Continue to make accessing services easy for all county residents who need help with food support.
- **CENTER:** Continue to identify expedited applications, offer same-day interviews and process applications timely.
- **RIGHT:** Continue to support our dedicated workers and utilize experienced, skilled staff in training new staff as staff retire.

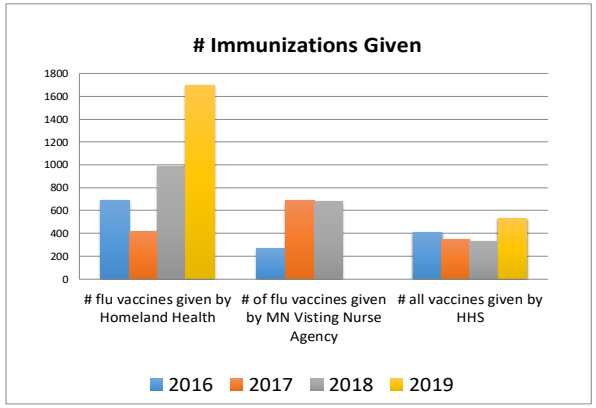
Goodhue County
Health & Human Services

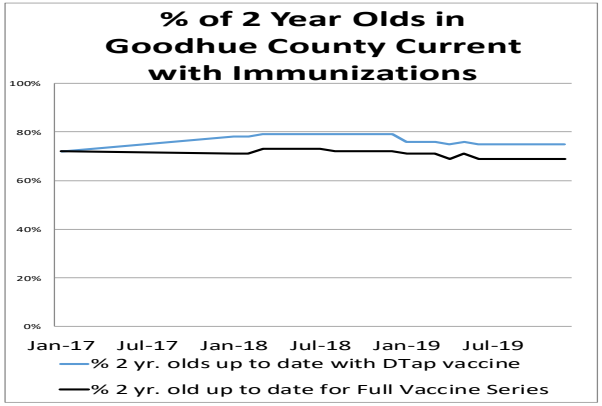
Public Health

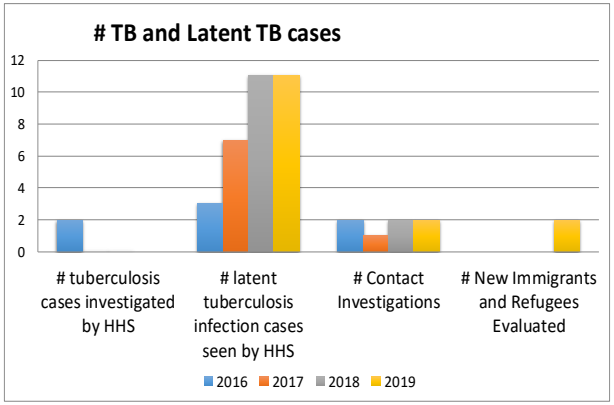
Disease Prevention and Control (DP&C)

Purpose/Role of Program

Disease Prevention and Control activities include evaluating, promoting, and providing immunizations. HHS investigates and monitors treatment of active and latent tuberculosis cases. Minnesota Department of Health monitors and investigates all other reportable infectious diseases and disease outbreaks. DP&C notifies medical providers and the public when outbreaks occur and provides education about preventing communicable diseases.







Story Behind the Baseline

- **LEFT:** HHS gave 531 immunizations to uninsured adults and children through the MN Vaccines For Children and Un/Underinsured Adult vaccine programs in 2019. Homeland Health Services gave over 1,700 flu shots at 14 schools for students and staff during school and for the community at 10 schools, in addition to 132 county employees. Some school districts had 20-30% of their students vaccinated while at school. HHS also provided 40 Hepatitis A shots for inmates at Goodhue County Jail and at a homeless event in response to Hepatitis A outbreaks in MN and nationally. (GCHHS did not partner with MN Visiting Nurse Agency in 2019.)

- **CENTER:** The % of 2 year olds up to date in Goodhue Co. is 69%. DTap is at 75% which continues to improve, however the % of children who get their immunizations on time is below the 90% Healthy People 2020 goal.

- **RIGHT:** 11 people were provided free medication and monitoring of Latent TB Infection, including 2 who were evaluated to rule out active TB at the free TB clinic in Olmsted County.

Where Do We Go From Here?

LEFT: Hepatitis A vaccinations will continue to be given at the county jail. HHS is working with the jail health service to encourage them to obtain and provide hepatitis shots to detainees through the State adult vaccine program. Information regarding Hep. A and vaccination will continue to be shared with agencies who work with people at high risk: homeless, drug users, incarcerated.

CENTER:MDH sent letters to all 16 years olds not up to date on the meningitis series which will be required for high school students in Fall 2020. HHS continues to send birthday postcard immunization reminders to all one year olds. More effort is being made to schedule the next immunization appointment and give reminder cards when next shots are due. DP&C nurses have provided immunizations to 10 students at 2 schools to students whose families are unable to get to clinics. Many counties assist schools in the Fall to provide back to school immunization clinics at schools for those students. This is something HHS may consider doing.

RIGHT: HHS met with our medical director at Mayo Clinic and revised the protocol for TB referrals for medication and monitoring of latent TB cases. DP&C will continue to obtain medications from MDH for anyone with latent TB who is at high risk of progression to active tuberculosis and will monitor active TB cases. Mayo clinic will monitor their patients who have insurance to cover the drugs unless they are likely to be non-compliant in which case they'll be referred them to HHS.

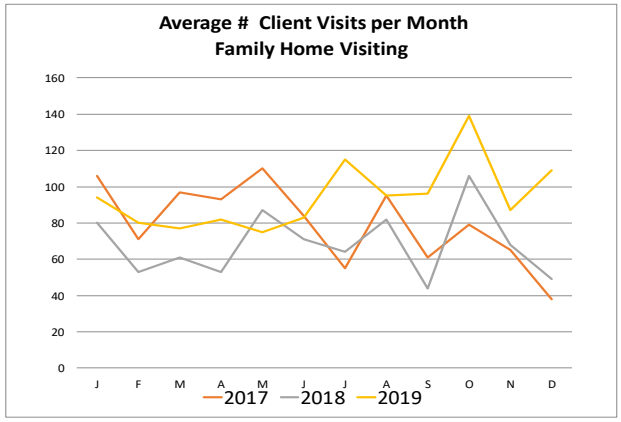
Goodhue County
Health & Human Services

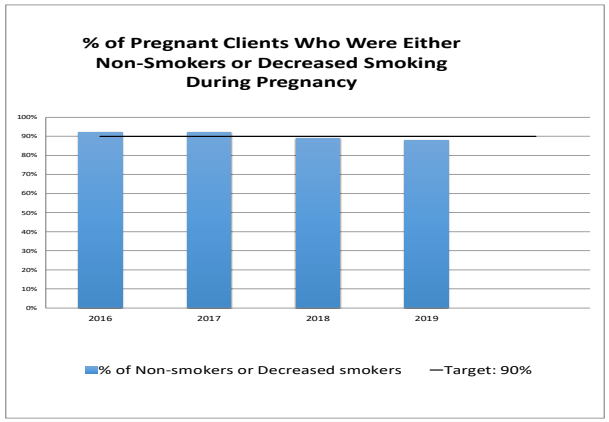
Public Health

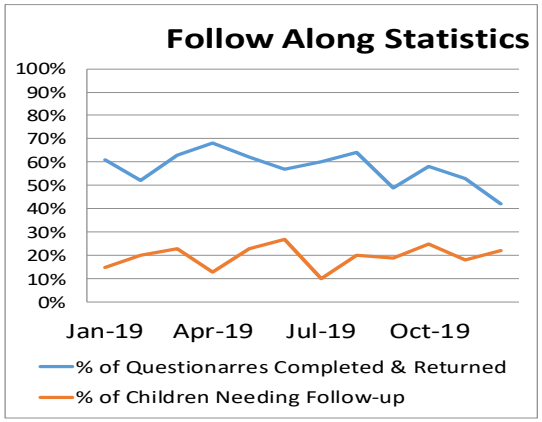
Family Home Visiting and Follow Along

Purpose/Role of Program

Family home visiting is a health promotion program that provides comprehensive and coordinated nursing services that improve pregnancy outcomes, teach child growth and development, and offer family planning information, as well as information to promote a decrease in child abuse and domestic violence. Prenatal, postpartum, and child health visits provide support and parenting information to families.







Story Behind the Baseline

- **LEFT:** Our quarterly average is approximately 115 visits per month. We are starting to see an increase in our monthly visits. This could be because our Evidence Based Family Home Visiting Program requires weekly visits thus increasing our monthly average. However, how many families we see and subsequently how many visits we make depends on the birth rate. If the birth rate is down, we do not receive as many referrals thus a decrease in how many visits we can make. Our monthly visit rate also depends on how many visits a family wishes to receive. Some families may want weekly visits, others may only want to be seen once per month. How many visits we make per month is very fluid and depends on many contributing factors.
- **CENTER:** The percent of pregnant clients who were either non-smokers or decreased smoking during pregnancy is an annual number that we track. Thus far in 2019 we have exceeded our target rate of 90%. We know that smoking during pregnancy can cause baby to be born early or to have low birth weight-making it more likely the baby will be sick and have to stay in the hospital longer. We also know that smoking during and after pregnancy is a risk factor of sudden infant death syndrome (SIDS). Since 2015 we have met our target of 90% this is likely due to the education we can provide about the dangers of smoking, we can also provide families with educational materials, and resources to help them quit.
- **RIGHT:** Follow Along Program monitors the development of children enrolled in the program by sending the parents validated screening questionnaires. These questionnaires indicate how many children are not meeting developmental milestones, therefore requiring follow up by a public health nurse and also a possible referral to Early Childhood Special Education for an assessment. Our current goal is to increase questionnaires that are completed and returned to us, which enables us to reach more children. This has been made possible by our current collaboration with Every Hand Joined. As we can see our return rate averages around 60%. In 2017 or return rate was 37%. This increase is due to additional staff time dedicated to the program as well as new means of communicating with families. This past year we were able to introduce text message reminders to return the questionnaires, which has increased the number returned. We can also see that the number of children needing follow up has increased. This is likely due to the fact that we are simply identifying more children that need follow up. We have increased the number of screeners that are returned thus increasing the number of children that have been identified needing follow up.

Where Do We Go From Here?

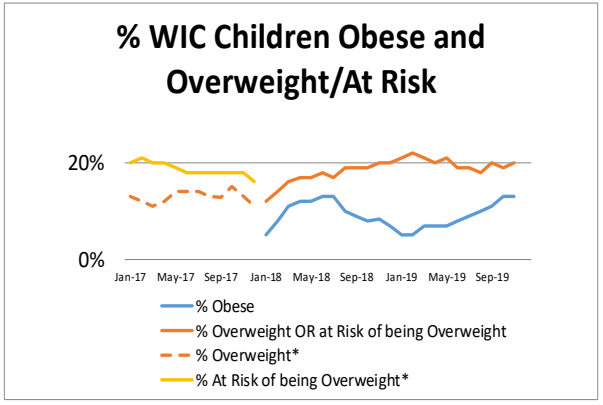
- **LEFT:** We will continue to offer home visits to clients to improve education and support, increase bonding and attachment, and in turn, reduce the risk of child abuse and neglect.
- **CENTER:** We will continue to educate on the importance of not smoking during pregnancy and continue to offer resources to assist with smoking cessation.
- **RIGHT:** We will continue to monitor the development of children and refer as appropriate. This will assist children with staying on task for meeting developmental milestones and getting early intervention services as soon as possible to make sure they are school ready.

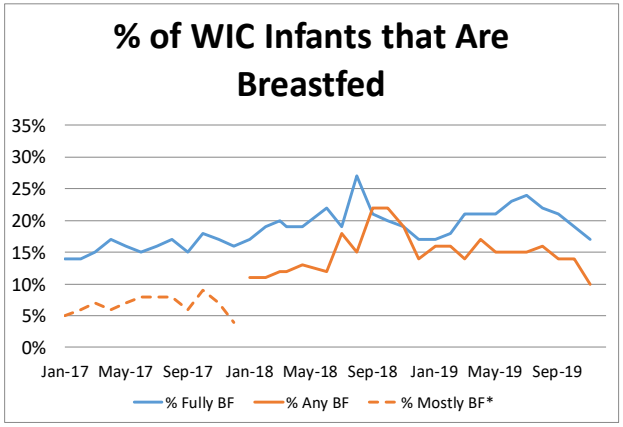
Goodhue County
Health & Human Services

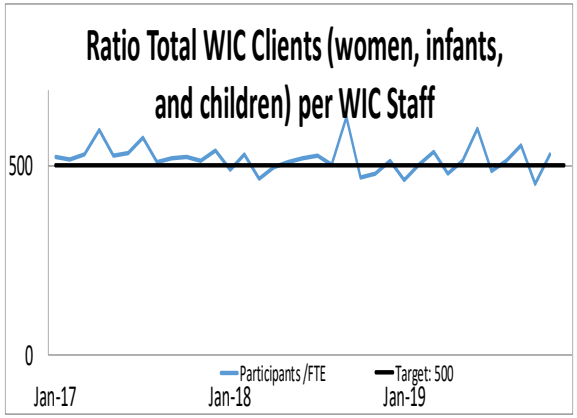
Public Health
WIC

Purpose/Role of Program

WIC is a nutrition education and food supplement program for pregnant and postpartum women, infants and children up to age 5. Eligibility is based on family size and income. WIC participants are seen regularly by a Public Health Nurse who does a nutrition and health assessment, provides nutrition education and refers to appropriate resources. WIC is federally funded.







Story Behind the Baseline

- **LEFT:** WIC promotes a healthy weight. The rates of obesity and overweight or at risk among Goodhue County WIC children 2 up to 5 years of age are stable and similar to the state average. *In 2018, WIC added a measure for obesity and combined the measures for overweight and at risk into one. *(Data will be skewed until old data is phased out.)*
- **CENTER:** The statewide WIC goal is to increase breastfeeding of infants 0-12 months. Breastfeeding initiation has increased; however, duration of breastfeeding continues to be an issue. *Starting in 2018, WIC is measuring babies who are totally breastfed and babies who are receiving breastmilk and formula. Exclusively breastfed babies tend to breastfeed longer. Babies receiving **any** breastmilk are still getting the benefits of breastfeeding.
- **RIGHT:** Looks at staffing ratio to determine adequate staffing.

Where Do We Go From Here?

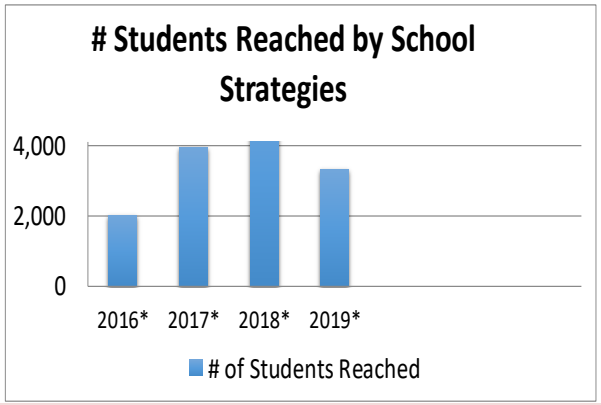
- **LEFT:** Offering nutrition education regarding healthy eating habits and the importance of physical activity. Education is done with a 'participant centered' approach so that they have more ownership in making changes.
- **CENTER:** We are participating in a statewide continuous quality improvement collaborative to improve breastfeeding rates in 2019.
- **RIGHT:** Outreach Activities include building rapport with clients to foster person-to-person referrals (the majority of our referrals), communication with health care providers, newspaper articles, participation in health/resource fairs. Although caseloads have decreased families that we are serving seem to have more issues/needs than we have seen in the past.

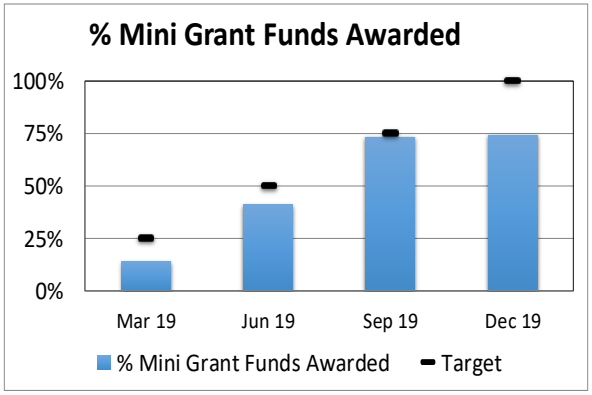
Goodhue County
Health & Human Services

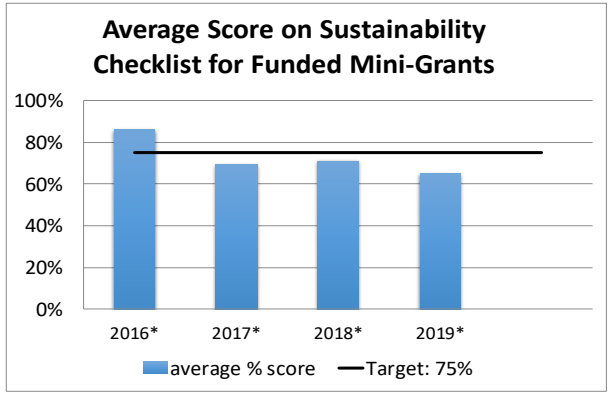
Public Health
Live Well Goodhue County

Purpose/Role of Program

Live Well Goodhue County's mission is to improve the health of our residents by making it easier to be active, eat nutritious foods & live tobacco-free. We partner with child care providers, schools, worksites, cities, non-profits and other organizations. We provide mini-grants for sustainable projects that fit within our mission. We are supported by the Minnesota Statewide Health Improvement Partnership of the Minnesota Department of Health.







Story Behind the Baseline

- **LEFT**: The new year started in November, so this number of students reached includes current partners that we continue to collaborate with (Cannon Falls School District) and new partners (Pine Island School District, St. John's Lutheran School, Twin Bluff Middle School and Sunnyside School).
  CENTER: Mini-grants are available to community organizations, child care providers, schools, worksites, non-profits and other organizations that are interested in partnering with us to improve the health of our residents. This number reflects our end of the year total for 2018-19.
  RIGHT: A sustainability survey was sent out to 2018/19 partners in November. 10 of 14 partners completed the survey and their sustainability score came to an average of 65%.

***2015 grant year=11/1/14-10/31/15. *2016 grant year= 11/1/15-10/31/16. *2017 grant year=11/1/16-10/31/17 *2018 grant year =11/1/17-10/31/18 *2019 grant year=11/1/18 – 10/31/19**

Where Do We Go From Here?

- **LEFT**: Live Well Goodhue County staff will be working on Safe Routes to School initiatives with Pine Island School District and with the staff at Twin Bluff Middle School and Sunnyside in Red Wing. We will continue to offer technical assistance and mini-grant funding to all of our schools.
  CENTER: A new year for SHIP began November 1, 2020. Staff members will actively work with current partners and new partners to implement initiatives that will help us accomplish our mission.
- **RIGHT:** Our goal is for 100% of our partners who receive mini-grant funding develop, implement and fund a sustainability plan so their initiative continues to improve the health of their residents, students, employees, etc.

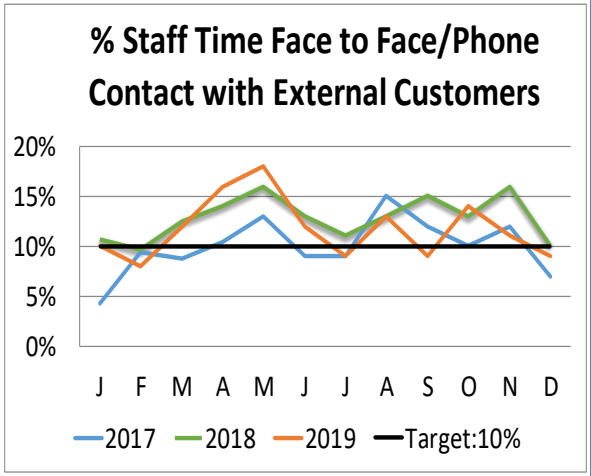
Goodhue County
Health & Human Services

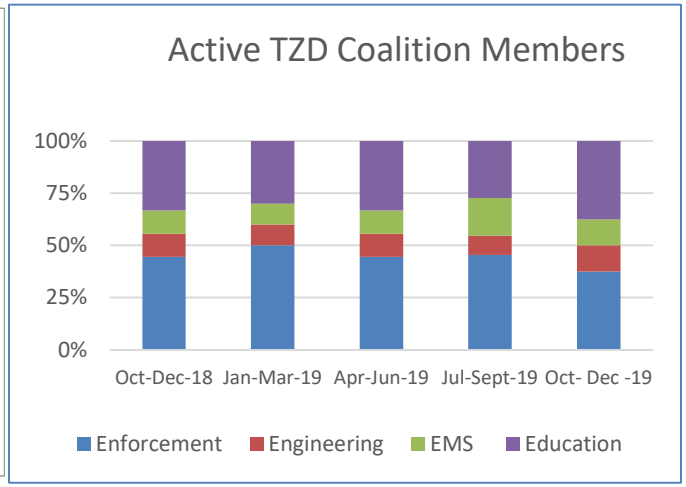
Public Health
Healthy Communities
Toward Zero Deaths

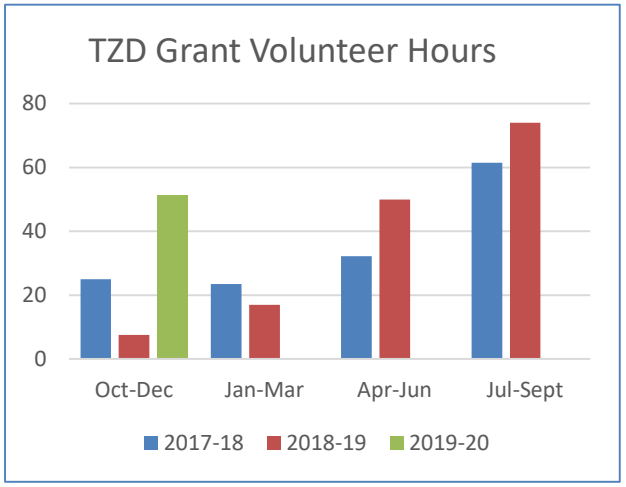
Purpose/Role of Program

Healthy Communities Unit promotes healthy behaviors and health equity with programs such as Live Well Goodhue County, Emergency Preparedness, Towards Zero Deaths (TZD), and Make it OK. Staff engage the community in developing and implementing strategies.

Towards Zero Deaths is based on the belief that even one traffic-related death on our roads is unacceptable. TZD uses an interdisciplinary, data-driven approach to reduce traffic fatalities and is funded by a grant from the Minnesota Department of Public Safety. Our goal is to maintain a balance of active representation from each "E."







Story Behind the Baseline

- **LEFT:** Staff time spent face to face with the community has been steady around 10% or 4 hrs. per full-time staff per week since 2017. We raised our target from 7% to 10% for 2019. May is a peak with a Mental Health month event.
- **CENTER:** Our goal is to maintain a balance of representation from each "E" because a combination of strategies and approaches are often most effective.
- **RIGHT**: Much of the TZD safe roads grant activity revolves around the "enforcement wave" calendar, busiest from April to September. Activity was up for October-December 2019, because the TZD Coordinator planned additional meetings and act ivies with the coalition.

Where Do We Go From Here?

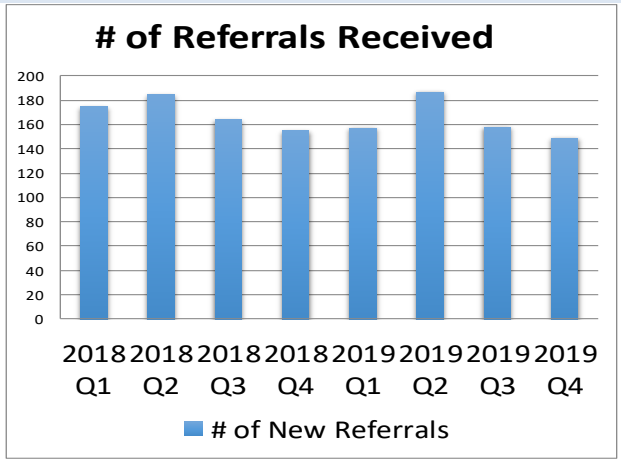
- **LEFT:** To maintain 10%, we share upcoming meetings and events at monthly staff meetings, and discuss this measure one-to-one on a quarterly basis.
- **CENTER:** Engage existing members and recruit new members in the 4 sectors of education, enforcement, engineering, and emergency medical services (EMS).
- **RIGHT**: The TZD Coordinator is aiming to balance TZD efforts across all 4 quarters this grant year by doing more planning when there's no wave.

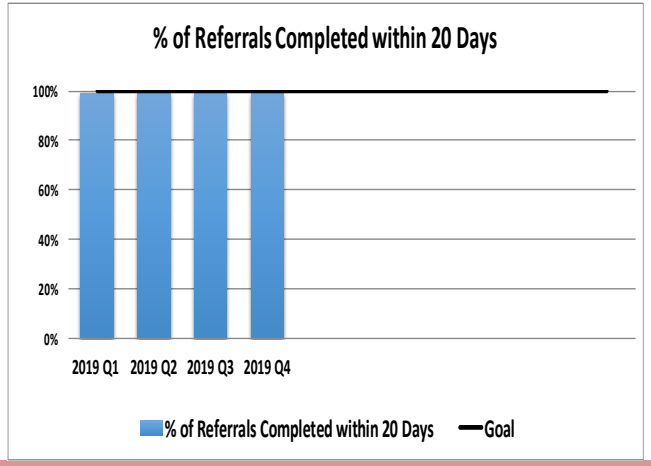
Goodhue County
Health & Human Services

Public Health
Waiver Management Team

Purpose/Role of Program

Home and Community Based Services are provided to residents of counties in Minnesota to help keep them in their homes or the least restrictive environment safely.





Story Behind the Baseline

- **LEFT:** This quarter there were 149 referrals. The break down of these referrals are as follows: County of Residence, 8; Alternative Car/Elderly Waiver, 37; Community Access for Disability Inclusion Waiver/Brain Injury Waiver/Community Alternative Care Waiver, 39; Consumer Support Grant/Family Support Grant, 3; Developmental Disability Waiver, 10; Under 65 Year Old Nursing Home Screens, 37; Personal Care Assistance, 15. The majority of referrals were in the under 65 year old programs again this quarter. The number of referrals stayed steady from last quarter.
- **CENTER:** Staff (15) completed a total of 967 visits this quarter. This is down from last quarter which is to be expected with holidays. Visits included in this total are for new referrals, yearly reassessments and routine check-in visits. During visits, staff get to know the people, work on meeting their needs to prevent crisis and build rapport. Staff follow person centered planning practices and strive to have people in the least restrictive environment that meets their individual health and safety needs. Staff work in close collaboration with other departments and agencies to meet these needs.
- **RIGHT:** Department of Human Services requires that all referrals are completed in 20 days from the date of intake. We completed all our referrals within that timeline, except for one.

Where Do We Go From Here?

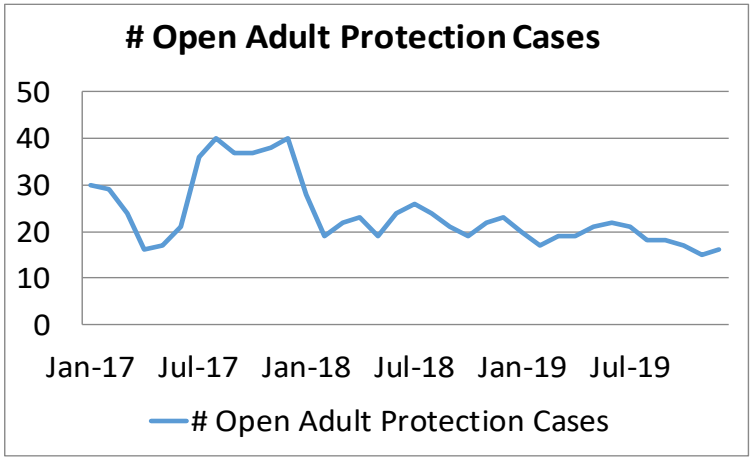
- **Left:** We want to continue to make sure we are receiving referrals and citizens are aware of Home and Community Based Services available.
- **Center:** Visits equal revenue, so we want to maintain visit counts. Our case managers build rapport with clients and increased visits maintains this working relationship to ensure health and safety needs are met in the least restrictive environment.
- **Right:** We need to strive to be 100% compliant with completing screens in 20 days. Timely screens means timely services to the citizens of Goodhue County.

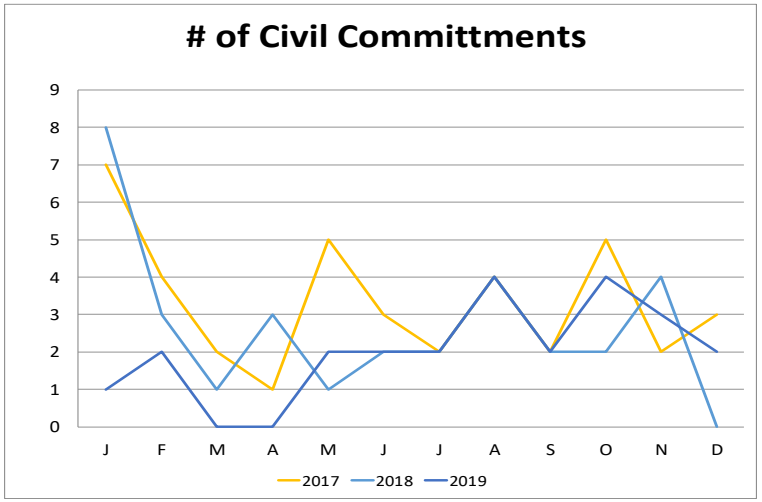
Goodhue County
Health & Human Services

Social Services
Adult Protection

Purpose/Role of Program

Counties are required by law to investigate reports of maltreatment to vulnerable adults who reside in the community, while the state investigates reports of vulnerable adults who reside in facilities. Adult Protection is funded by county, state, and federal dollars.





Story Behind the Baseline

- **RIGHT:** There were fewer Civil Commitments in early 2019; however it is unknown why this is and whether this trend will continue. Resources for clients who need inpatient treatment are becoming more scarce. Some clients have experienced very long waits for an inpatient mental health bed.

Where Do We Go From Here?

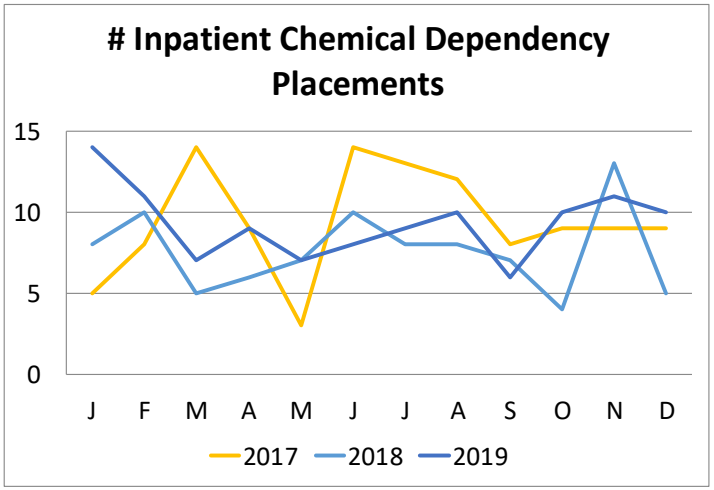
- **LEFT:** In adult protection, DHS has offered more guidance and training, so we are working on standardizing our approach to adult protection assessments.
- **CENTER:** We are utilizing more community based programs, such as the South Country Health Alliance (SCHA) Healthy Pathways program, with the hope of decreasing the need for inpatient hospitalization and residential treatment.

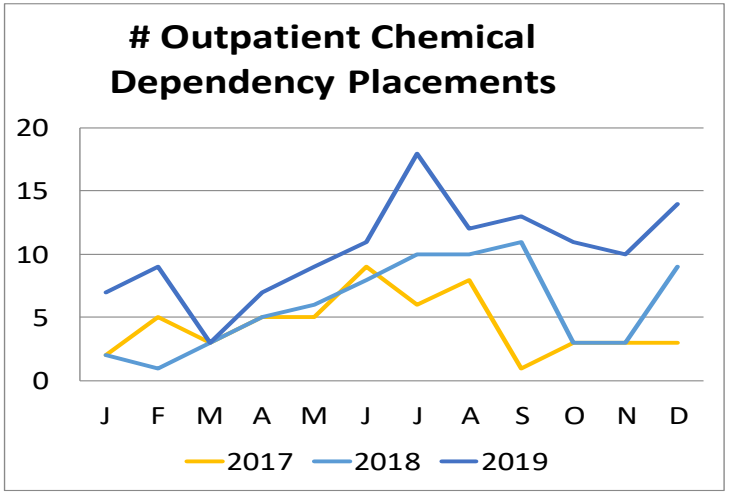
Goodhue County
Health & Human Services

Social Services
Rule 25

Purpose/Role of Program

Counties are required to administer the consolidated fund, which is a combined funding source for chemical dependency assessments and treatment that includes local, state and federal dollars. We conduct Rule 25 assessments to determine the client's level of treatment that is needed. The Rule 25 assessor also provides case management for a large caseload of clients who are in treatment.





Story Behind the Baseline

- **LEFT & RIGHT:** We are seeing a large increase in methamphetamine abuse, as well as an increase in clients seeking treatment for heroin addiction. These clients tend to require longer stays in treatment and aftercare.
- Many clients seeking treatment are dual diagnosed with mental health issues. These clients often need specialized dual diagnosis treatment programs and more intensive aftercare.
- We are completing more assessments on child protection clients with highly complex issues, creating increased need for programs that are family friendly to facilitate visits, or programs where children can reside with parents.

Where Do We Go From Here?

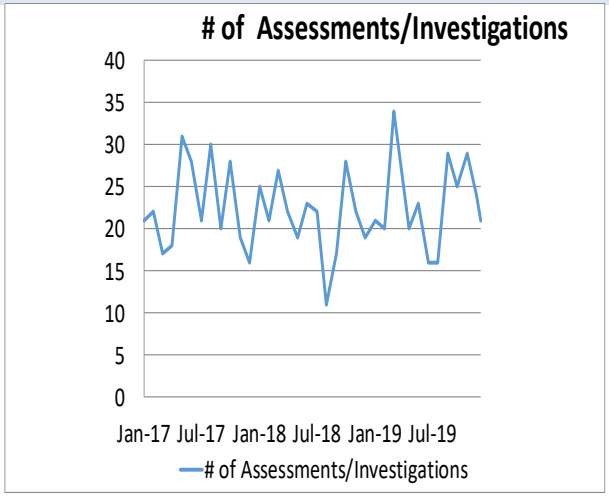
- **LEFT & RIGHT:** Our Rule 25 assessors are well trained in the assessment process and do a great job collaborating with county staff, probation, treatment programs, etc.

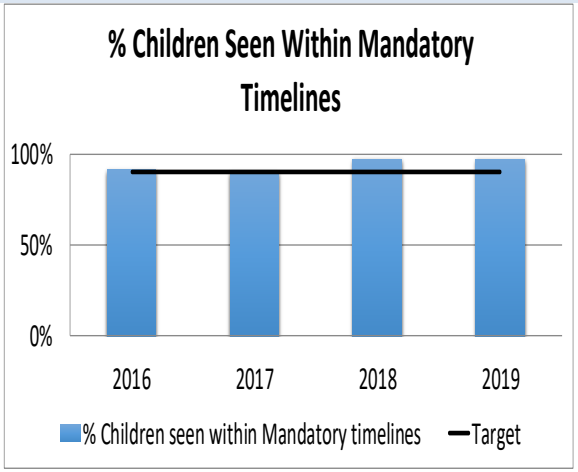
Goodhue County
Health & Human Services

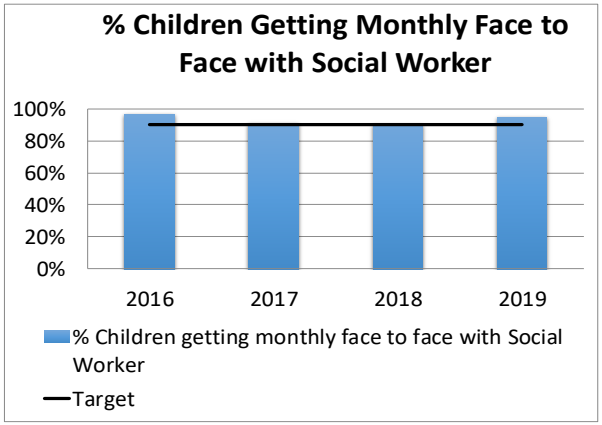
Social Services
Child Protection

Purpose/Role of Program

Counties are required by state law to respond to reports of child maltreatment, conduct assessments/investigations, and provide ongoing services and support to prevent future maltreatment. Child protection is funded by county, state and federal dollars.







Story Behind the Baseline

LEFT: The number of total assessments in 2019 increased slightly from 2018, which is consistent with regional and state trends.

CENTER: In 2019 Goodhue County saw 96.9% of children within mandatory timelines, which requires a great deal of teamwork and flexibility from staff.

RIGHT: In 2019 Goodhue County saw 95% of children in foster care within timeframes. Because children are placed all over the state in foster care and/or with relatives, seeing every child in placement involves extensive planning and coordination.

Where Do We Go From Here?

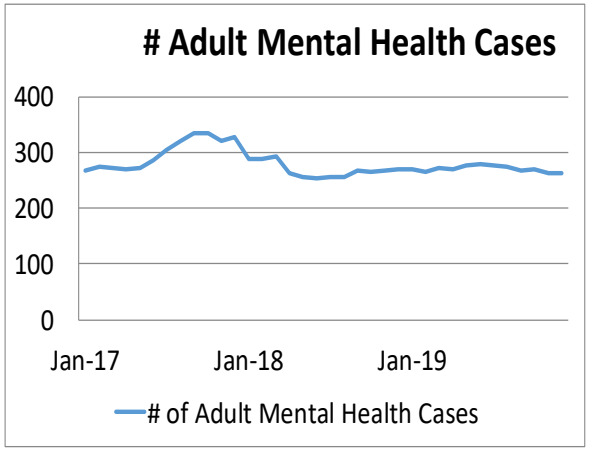
- **LEFT :** We will continue to monitor trends throughout the region and state to ensure we are able to thoroughly complete these assessments on a timely basis.
- **CENTER:** Goodhue County is successfully meeting the timeliness guidelines.
- **RIGHT:** Goodhue County continues to meet this standard, as the number of children in foster care has remained relatively steady.

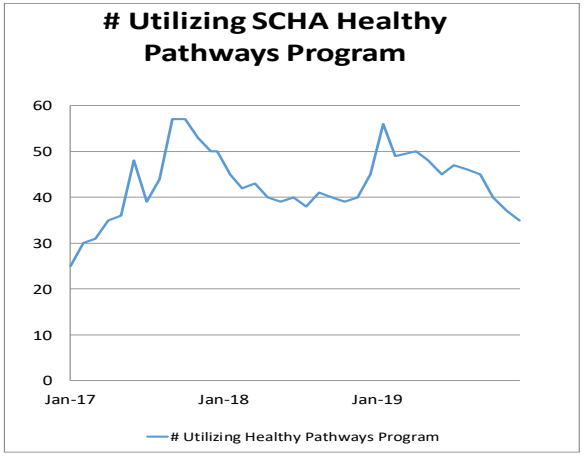
Goodhue County
Health & Human Services

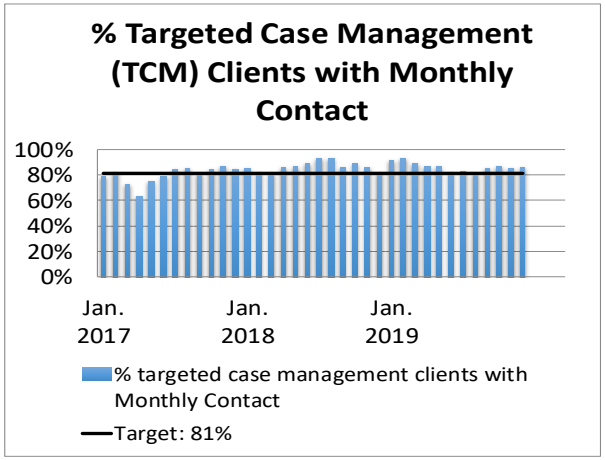
Social Services
Mental Health

Purpose/Role of Program

Counties are required to provide Adult Mental Health (AMH) case management to clients who meet the eligibility criteria. AMH case management is funded by a combination of county, state and federal funds, including Medical Assistance funding.







Story Behind the Baseline

- **LEFT:** The AMH caseload has become more manageable since the addition of 2 case managers in 2014, but caseloads are still above the state recommended guideline of 30/worker. We are seeing an increase in referrals again.
- **CENTER:** Healthy Pathways is a newer South Country Health Alliance (SCHA) program focusing on providing early intervention to persons exhibiting mental illness to avoid crisis (such as incarceration or civil commitment).
- **RIGHT:** Staff are making strong efforts to meet with clients on a monthly basis, and currently approximately 80% of mental health clients have monthly contact. There were several holidays and vacations in November/December which contributed to lower % of contacts.

Where Do We Go From Here?

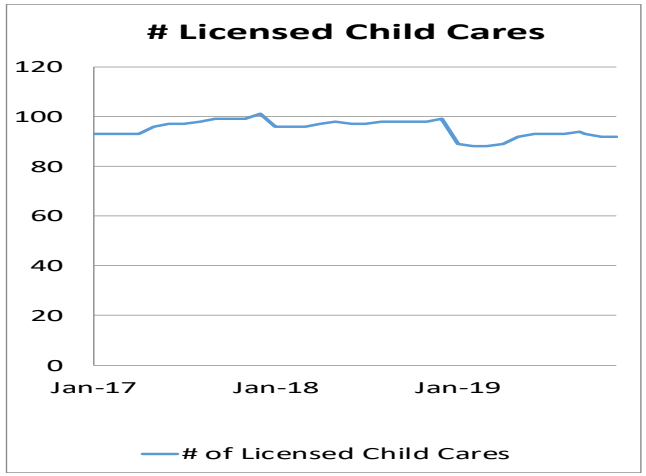
- **LEFT, CENTER & RIGHT:** Staff ensure clients receive monthly contact which ensures quality services with prevention focus along with maximizing revenue for continued services.

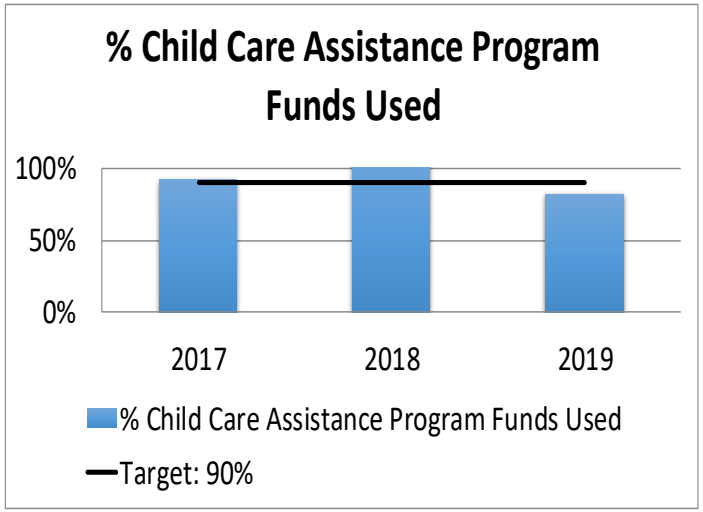
Goodhue County
Health & Human Services

Social Services
Child Care Licensing and Funding

Purpose/Role of Program

Counties are required to license private daycare homes. Counties also administer the Child Care Assistance Program (CCAP) which is a funding source for child care for low income families. Counties receive a yearly CCAP grant that is calculated based on a number of factors including population, number of families receiving public assistance, etc. The goal is for counties to spend 90-100% of their CCAP grant.





Story Behind the Baseline

- **LEFT :** The number of licensed child care homes has remained relatively steady in 2019.
- **RIGHT:** Our utilization is currently above our allotment. The goal is to remain between 90-100% of our allotment, but few counties are able to hit this target due to many factors that are out of the county's control.

Where Do We Go From Here?

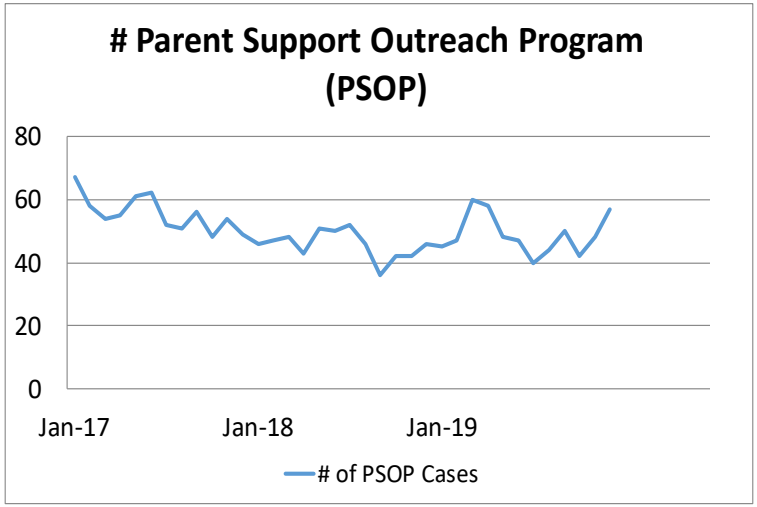
- **LEFT & RIGHT:** The shortage of flexible child care is a major issue in most communities and is often a barrier for parents to be able to work. We will continue to discuss this concern with community partners and encourage more individuals and agencies to consider providing child care. This is a vital service to increase self sufficiency and reduce dependency on public assistance.

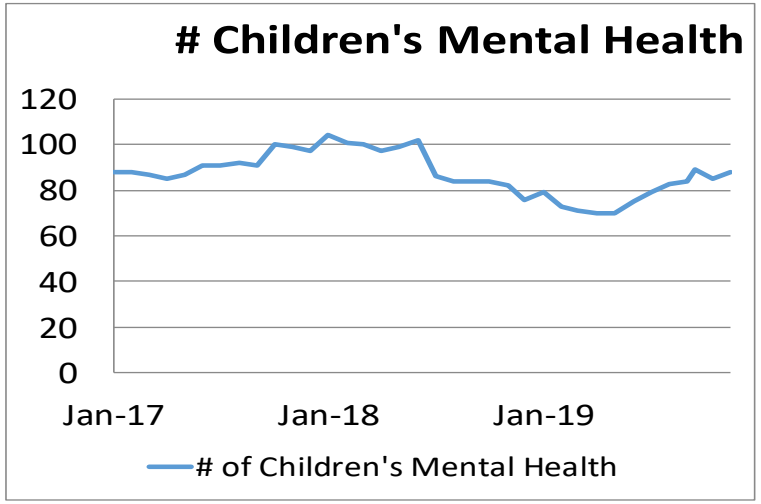
Goodhue County
Health & Human Services

Social Services
Children's Programs

Purpose/Role of Program

The Parent Support Outreach Program (PSOP) started in Goodhue County in July, 2013, and expanded under a Community Investment Grant from South Country Health Alliance. It is currently funded by a small DHS grant. Children's Mental Health case management is mandated to be provided by counties. Goodhue County contracts with Fernbrook Family Center to provide CMH services.





Story Behind the Baseline

- **LEFT:** The Parent Support Outreach Program (PSOP) continues to be well utilized, and we have expanded our efforts to include Early Childhood Family Education classes and a Teen Parent's support group.
- **RIGHT:** Fernbrook continues to provide Children's Mental Health case management.

Where Do We Go From Here?

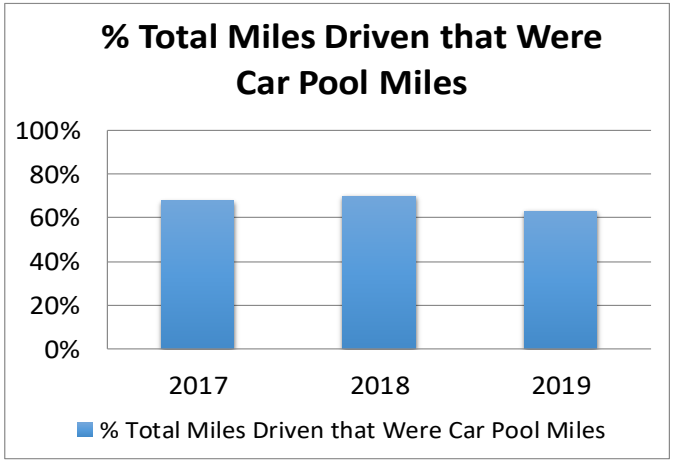
- **LEFT:** PSOP has become a vital part of our service array for families with young children. Evidence demonstrates that when counties heavily utilize PSOP, child protection reports decrease. Goodhue County's strong utilization of PSOP could explain, in part, the decrease in child protection assessments/investigations.
- **RIGHT:** We continued to work closely with Fernbrook to ensure that program is widely utilized and effective.

Goodhue County
Health & Human Services

Health & Human Services
County Cars

Purpose/Role of Program

All mileage is turned in whenever Goodhue County Health and Human Services staff drive for work. The cost to the county for driving a county car is lower than the rate employees are reimbursed for driving their own car. The majority, more than half, of miles driven by our HHS department are car pool miles.



Story Behind the Baseline

CENTER: The HHS Department continues to use county pool cars for about 60-70% of miles travelled on county HHS business. In 2019, county car usage was slightly down, which may be because the first few months of 2019 were very snowy. Accounting staff calculate this percentage based on personal miles turned in, so the slight decrease could be explained by staff turning in personal mileage more often (not necessarily using personal cars more). Many factors determine whether someone uses a county car, including preference, demand for county cars (all checked out), what cars are available (4 wheel drive), weather, destination, needing to transport bulky items, and employee's residence (whether it is faster to drive to a meeting than first go to Red Wing to get a car).

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Where Do We Go From Here?

- **CENTER:** We will continue to encourage staff to utilize county pool cars for county business. This is the preferred, and cost effective method for HHS county business travel.

DHS-5408K-ENG 12-19

DEPARTMENT OF HUMAN SERVICES

Minnesota's Child Maltreatment Report, 2018

Children and Family Services

December 2019

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

Child Maltreatment Report summary, 2018

Purpose

The purpose of this annual report is to provide information on children involved in maltreatment reports, and the work that happens across Minnesota 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 2018, Minnesota child protection agencies received **86,060** reports of child maltreatment, a **2.3**% increase from 2017[1]

The screening process

- Of the **86,060** child maltreatment reports, local agencies screened in **37,467**, **43.5**% 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 (**69,275** of **86,060** reports, **80.5**%).

Completed assessments and investigations

- There were **38,872** alleged victims involved in **30,655** completed assessments or investigations following screened in child maltreatment reports.
- The number of completed assessments/investigations of alleged victims with at least one screened in and completed report has remained stable since 2016.
- 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 two or more races and African American children were both approximately **three** times more likely to be involved.
- Children ages 8 and younger represented the majority involved in completed maltreatment assessments/investigations (**58.7**%).
- Alleged victims with allegations of neglect constituted the largest group of children by far, with approximately **60.8**% of all children in 2018.

[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 total number of reports in 2017 and 2018 with numbers from previous publications.

Child protection response path assignment

- The number and proportion of reports being assigned to Family Assessment (Minnesota's alternative response path) remained consistent for a third year, at **60%** of the total **30,655** cases. This comes after a noticeable decrease in use of Family Assessment Response from 2015 to 2016. 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 **88.4**% of victims seen within the time frames established in statute. This is almost a **5%** increase from 2017, when **just under 84%** of victims were seen within time frames.
- Family Investigations completed in 2018 were more likely to be indicated as high risk for future maltreatment (**31.9**%) compared to Family Assessments (**14.3%**). Generally, 2018 had fewer high risk cases than 2017 (**6,225** vs. **8,603**, respectively).
- There were **17,256** children in completed maltreatment assessments/investigations who experienced a Family Investigation, with **44.4%** having a determination of maltreatment; there were **1,569** children in completed assessments/investigations who received a Facility Investigation, with **19.7%** having a maltreatment determination.
- There were **26** child deaths and **31** life-threatening injuries determined to be a result of maltreatment in 2018.

Outcomes after child maltreatment assessments/investigations conclude

- Minnesota met the federal maltreatment recurrence standard in 2018, with **9%** 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 2018 by agency, including the number of:

- And percent of child maltreatment reports by screening status and agency
- Completed child maltreatment assessments/investigations by response path and agency
- Alleged victims in completed assessments/investigations by maltreatment type and rate per 1,000 children by agency
- Alleged victims by age group and agency
- Alleged victims by race and ethnicity and agency
- Alleged and determined victims in completed assessments/investigations and rate per 1,000 children by agency
- Social service agency referrals to early intervention for infants and toddlers involved in substantiated cases of maltreatment
- Assessments/investigations by Structured Decision Making (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 from 2015 to 2016, the following years showed a leveling-off. In 2018, patterns have remained largely unchanged.

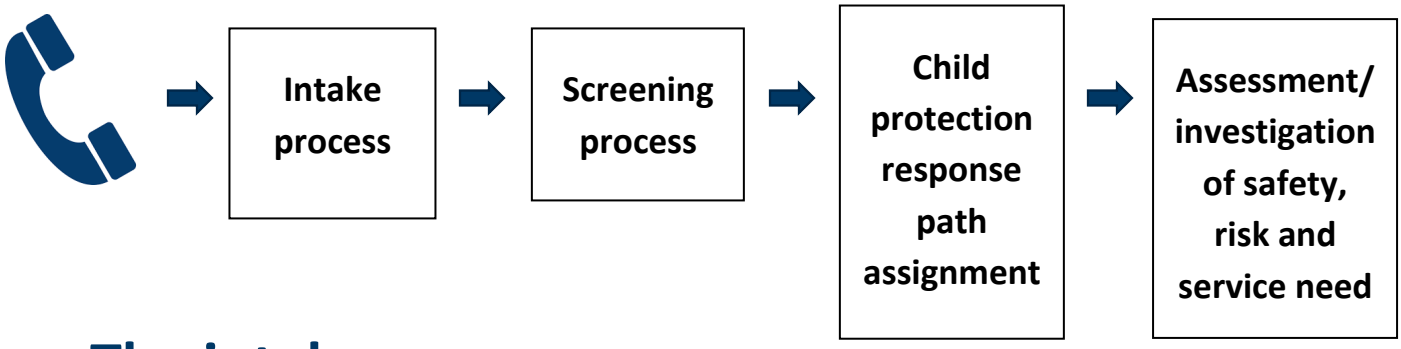
What is child maltreatment?

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 Minnesota 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

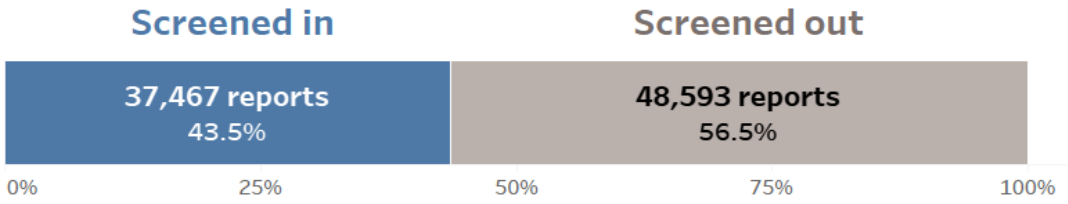
- When a community member has a concern that a child is being maltreated, they can (or must if they are a mandated reporter – see Minn. Stat. 626.556, subd. 3, for information about who is a mandated reporter) call their local child protection agency to report this concern. Local agencies document reports 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 2018 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 included in the report will be based on assessments/investigations completed during the calendar year because it includes information not known until an assessment/investigation closes**. Although these two groups of reports are related, they are not identical populations of reports or corresponding children. For example, some reports made to child protection in 2018 (i.e., reports at the intake phase) will not have an assessment or investigation of allegations completed until 2019, and included in that year's annual report (e.g., reports received in December 2018). Likewise, some assessments/investigations completed in 2018 were based on maltreatment reports received later in 2017.
- Minnesota child protection agencies received **86,060** reports of maltreatment in 2018, a **2.3**% increase from 2017.

The screening process

Once a report of maltreatment has been received, local agency staff reviews the information and determines if allegation(s) meet the statutory threshold for child maltreatment. If it does, and the allegations have not been previously assessed/investigated, staff screen in the 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 (**48,593, 56.5**%), and screened in for assessment or investigation (**37,467**, **43.5**%).

Figure 1. Screening decisions of child maltreatment reports received in 2018

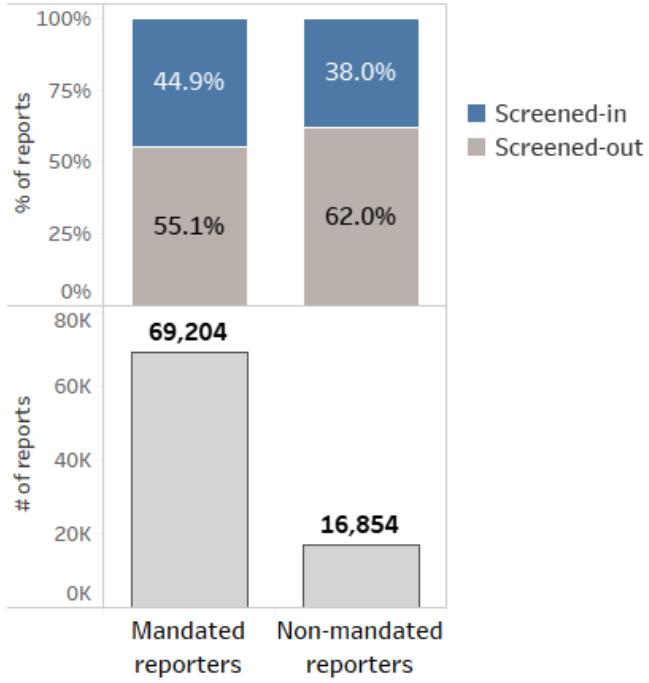


Screened out maltreatment reports

- In 2018**, 44,174** of the **48,593** screened out reports (**95.2%**) were screened out because allegations did not meet the statutory threshold for maltreatment. The remaining reports (**4,419, 4.8**%) were screened out for various reasons, including the following:
  - Report did not include enough identifying information (**2.1%**)
  - Allegations referred to an unborn child (**4.5%**)
  - The alleged victims were not in a family unit or covered entity (**3%**) and referred to the appropriate investigative agency.
- Information regarding the identity of alleged victims was provided and entered for **44,874** of the **48,593** screened out reports (**92.3%**).
- 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% of screened out reports each month. Each review is completed by a team and is appraised both for screening decisions and the quality of information in reports. The review team requested further consultation with local agencies regarding their screening decisions in **123** of **2,933** reports reviewed (**4.2%**) in 2018. Of the **123**, consultations resulted in agencies screening in reports **52** times, and upholding screening decisions **67** times. The few remaining cases required further discussions with county attorneys and agency management.

Referral source of child maltreatment reports

Figure 2. Reports screened in and out by source of reporter in 2018

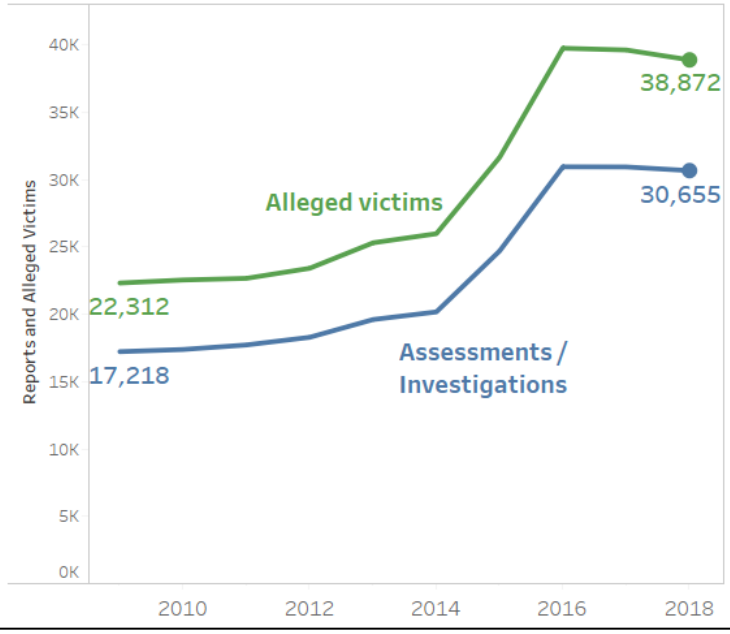


- Mandated reporters made the vast majority of reports of maltreatment to local agencies, with nearly four of five reports (**69,204** of **86,058** reports, **80.3**%). Two reports had an unidentified reporter.
- Mandated reporters include those in health care, law enforcement, mental health, social 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 (**44.9%** versus **38.0%**). 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 **30,655** assessments/investigations completed in 2018 after screened in reports of maltreatment; these reports involved **38,872** 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 2018. 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 2018. Therefore, the number of screened in reports shown in Figure 1 (**37,467** reports) is different from the number of completed assessments/investigations (also referred to as cases throughout the rest of this report) in Figure 3 (**30,655** reports). All reports received in 2018, but not yet closed will be closed in the subsequent year, with outcomes reported in the 2019 annual Maltreatment Report.
- 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 2009, there was a **78.0**% and **74.2**% increase in assessments/investigations and alleged victims, respectively. The last three years have been very stable in terms the number of child protection investigations and assessments completed.

Figure 3. Trends of completed assessments/ investigations and alleged victims, 2009 – 2018



- Some alleged victims had more than one completed assessment/investigation within the year. Table 1 shows how many victims had completed assessments/investigations in 2018.
- There were **33,971** (**87.4**%) alleged victims who had a single completed assessment or investigation in 2018. Just over **12**% had multiple assessments or investigations.

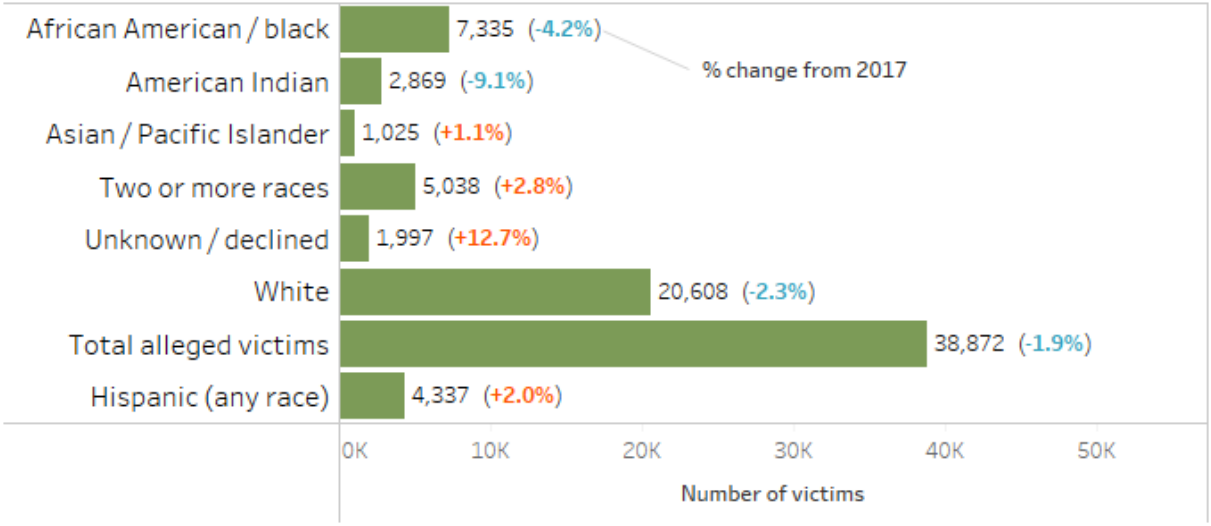
Table 1. Number of victims with one or more completed assessment/investigation in 2018

	Number	Percent
1 assmnt/inv	33,971	87.4%
2 assmnt/inv	4,037	10.4%
3 assmnt/inv	678	1.7%
4 or more assmnt/inv	186	0.5%
Total	38,872	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 4 and 6 show the number of alleged victims and rates per 1,000 by race.

Figure 4. Number of alleged victims with at least one completed assessment/investigation by race/ethnicity in 2018

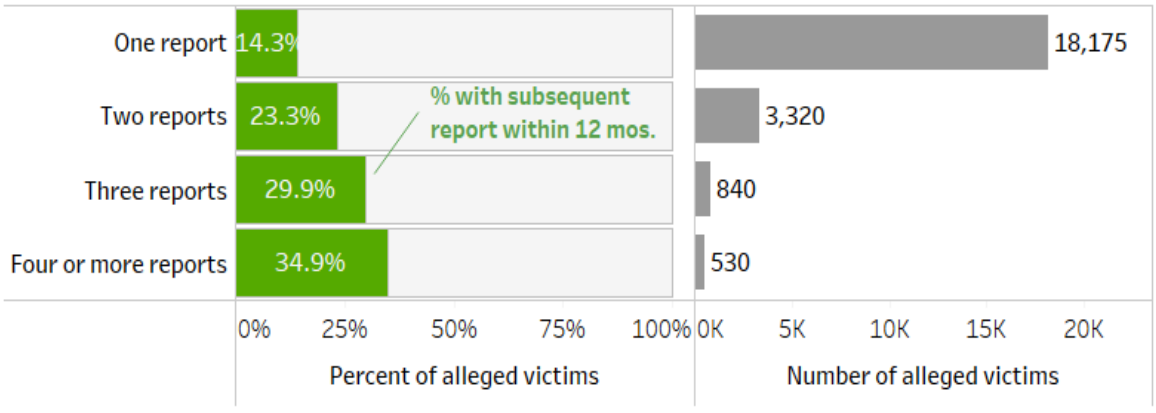


Were children who had a screened out maltreatment report in 2017 involved in a screened in (and subsequent completed assessment/investigation) maltreatment report within 12 months?

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 2017 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 **22,865** children who had at least one screened out report in 2017 and no prior history in the previous four years. Of these children, **18,175** had one screened out report, **3,320** had two, **840** had three, and **530** had four or more screened out reports in 2017.
- Overall, **16.6%** (N = **3,801**) 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 5, children in multiple screened out reports were more likely to have a screened in maltreatment report within 12 months of their first screened out report.

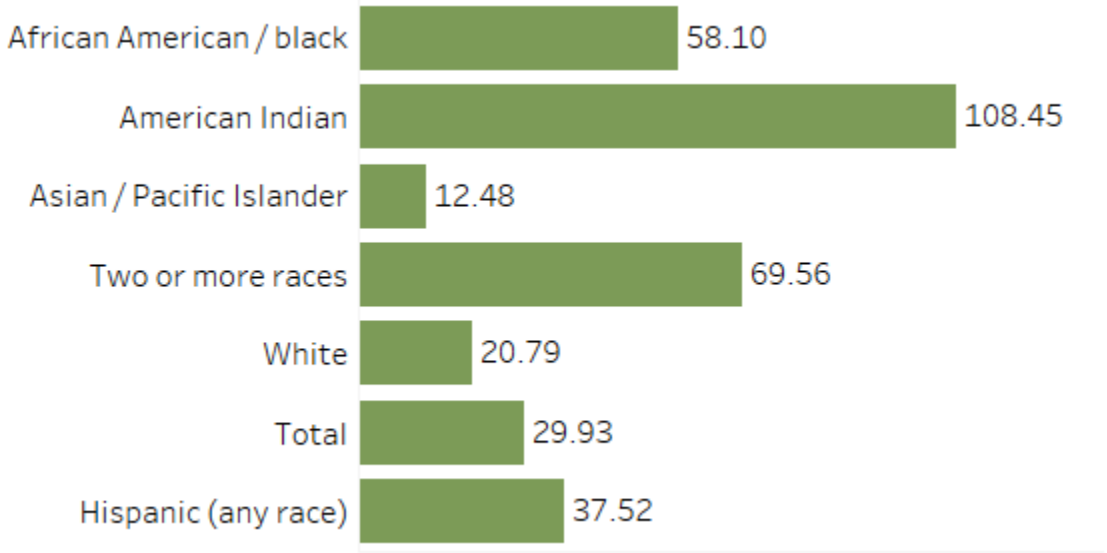
Figure 5: Percent and number of alleged victims with a screened in report by number of prior screened out reports



- 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 4).
- 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 **5.2 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 2017 and 2018, most groups saw minimal increases or decreases in the number of alleged victims. In contrast, American Indian children saw a decline of **9.5%** from 2017.
- Minnesota child welfare agencies struggle 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 2017 and 2018, the number of children identified as American Indian and alleged victims in maltreatment assessments/investigations decreased by about 9.5%.

Figure 6. The per 1000 rate of alleged victims in screened in reports by race/ethnicity in 2018



A closer look at the two or more race category

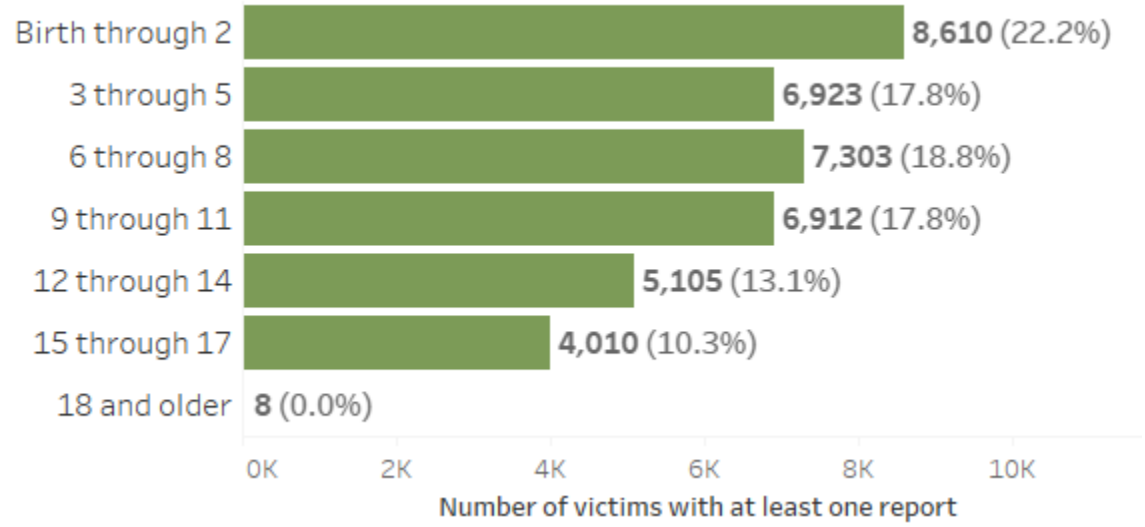
Minnesota is becoming more diverse with many children and families identifying with more than one race or ethnicity. In child welfare, the number of families self-reporting as two or more races has more than doubled since 2012. Of children who identify with more than one race:

- **87.7%** identified at least one race as white
- **62.4%** identified at least one race as African American/black
- **48.9%** identified at least one race as American Indian
- **8.2%** identified at least one race as Asian
- **1.4%** identified at least one race as Pacific Islander.

- Children ages 8 and younger represented the majority of children involved in maltreatment assessments and investigations (**58.8%**) in 2018. There were likely multiple reasons why this age group constituted the largest 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.

- 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.

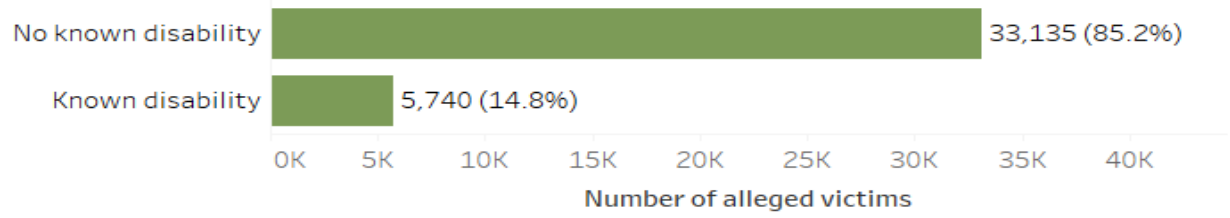
Figure 7. Number and percent of alleged victims with at least one completed assessment/investigation by age group in 2018



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.

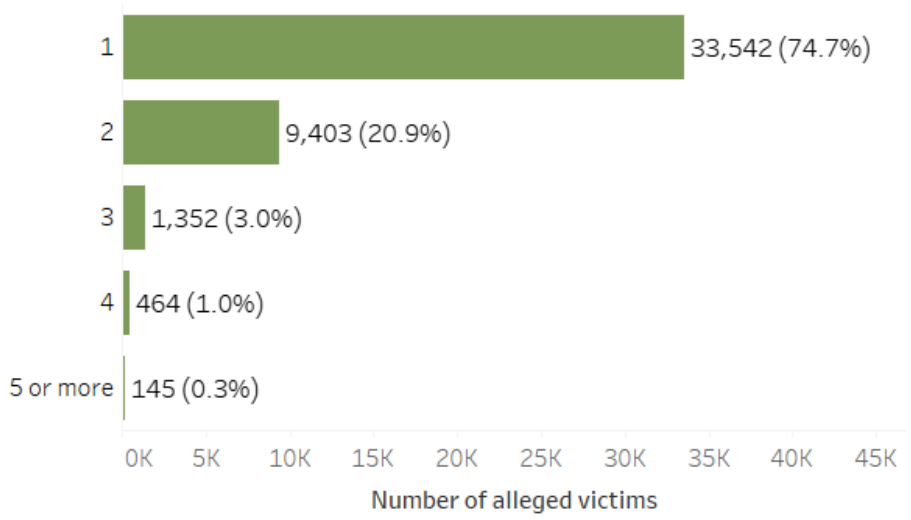
- Just under **15%** of children who had screened in maltreatment reports in 2018 had a known disability (some disabilities may be undiagnosed). This rate of disability is **five times** more frequent than in the general population of children. [Sedlak et al., 2010]

Figure 8. Number and percent of alleged victims by disability status in 2018



- 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** (not providing medical care for a child deemed necessary by a medical professional); **mental injury** (behavior of a caregiver that causes emotional or mental injury to a child); **neglect** (not adequately providing for the physical, mental or behavioral needs of a child); **physical abuse** (behavior that is intended to and/or results in physical harm to a child); **sexual abuse** (any behavior towards or exploitation of children by a caregiver that is sexual in manner); and **threatened injury** (attempting or threatening harm to a child or placing a child in a situation that puts them at risk for serious harm). Refer to 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 2018. The vast majority of children (**74.7%**) had a single allegation of maltreatment in each completed assessment/investigation.

Figure 9. Number and percent of alleged victims by number of allegations per assessment/investigation in 2018



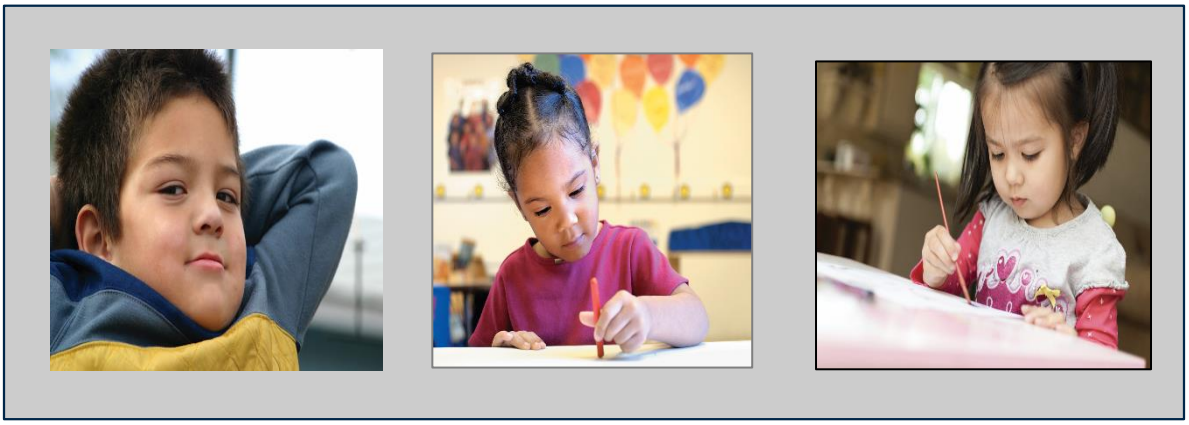
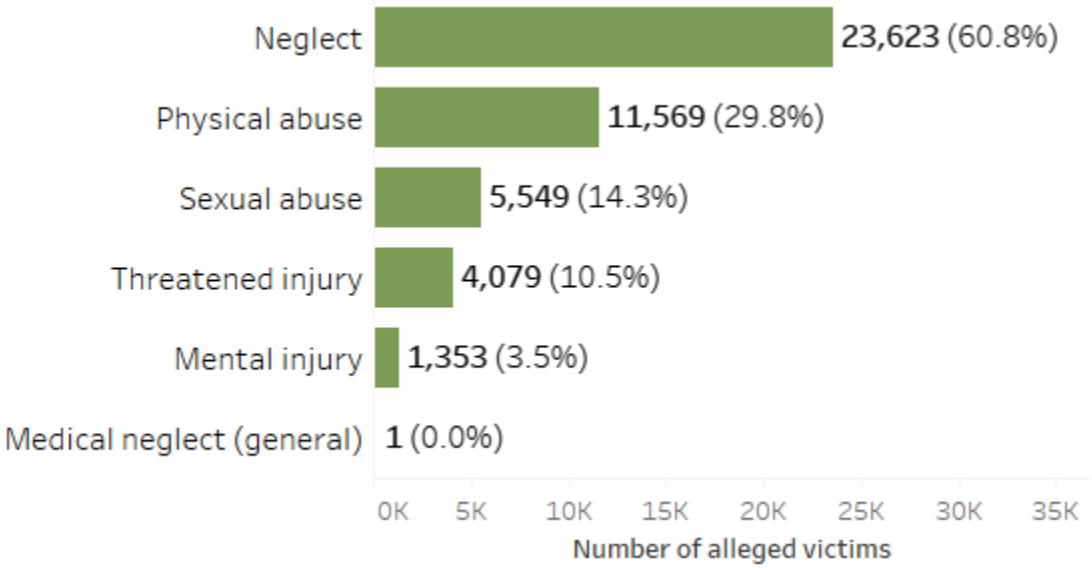


Figure 10. Number and percent of alleged victims by maltreatment type, 2018



- Alleged victims with allegations of neglect was the largest group, about **60.8%** of all children who experienced maltreatment in 2018 (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 **10.5%** of all victims of maltreatment in 2018.

Threatened injury, a new category for maltreatment type introduced in 2016, was identified for 10.5% of all alleged victims of maltreatment in 2018.

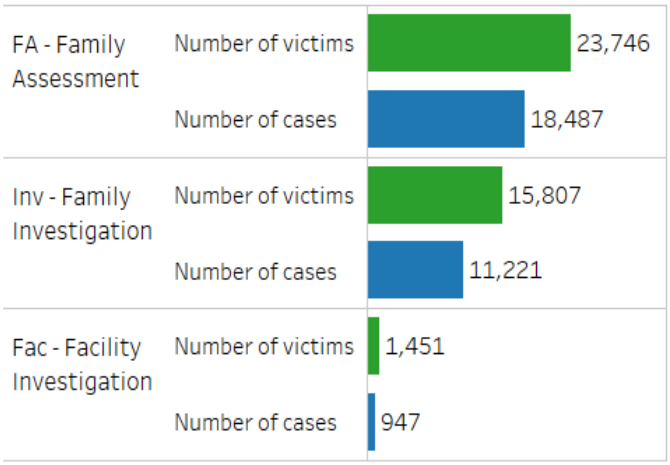
Child protection response path assignment

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' means an investigation or assessment has been completed.)

Assignment of child maltreatment cases to child protection response paths

- Figures 11 and 12 show just over **60%** of child maltreatment reports were assigned to the Family Assessment path, while the rest received either a Family or Facility Investigation.

Figure 11. Number of cases and victims by path assignment in 2018



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

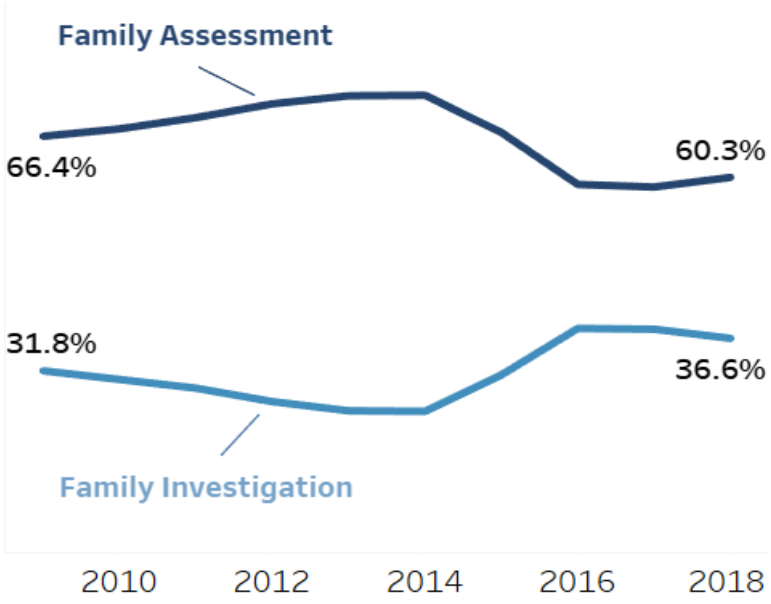
Assigning reports

- 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 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 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.

- Identify and resolve immediate safety needs of children
- Conduct fact-finding regarding circumstances described in a maltreatment report
- Identify risk of ongoing maltreatment
- Identify needs and circumstances of children (and families)
- 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: Use the evidence gathered through fact-finding to determine if allegations of maltreatment occurred. If a determination is made, information is maintained for a minimum of 10 years.

Figure 12. Trend of percent of cases assigned to FA and FI paths, 2010 – 2018



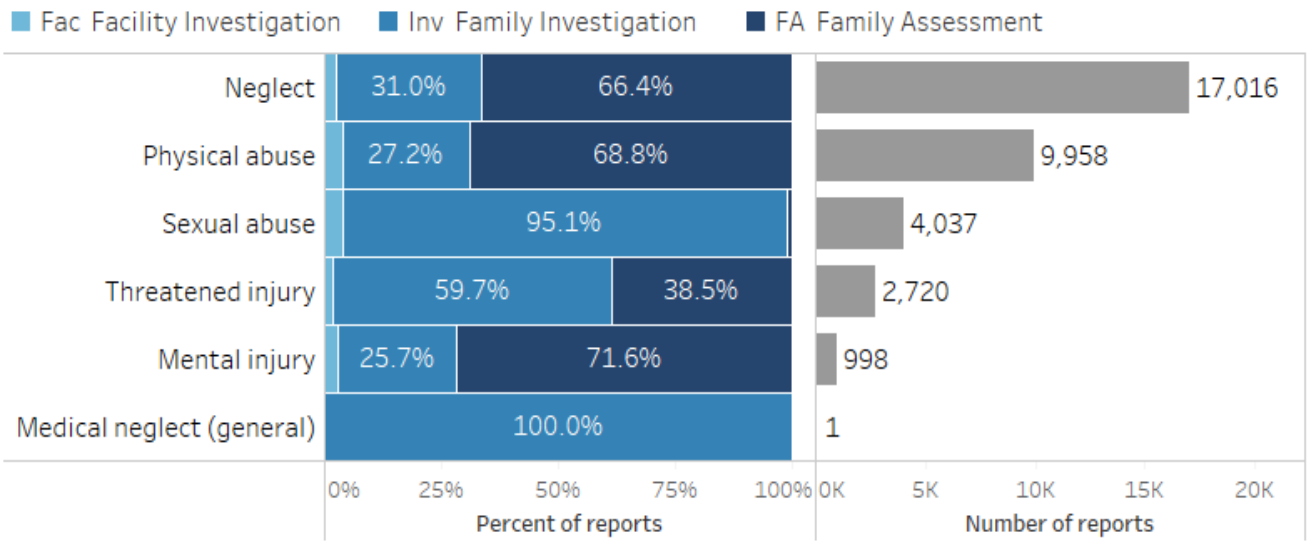
- After a long steady decline, there was a large increase in the percentage of reports being assigned to Family Investigation in 2015 and 2016. This has been followed by slight declines in 2017 and 2018.

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 13).
- Despite a statute indicating that all sexual abuse allegations should receive a Family Investigation response**, 1.1%** of screened in maltreatment reports (N = **44** reports) having allegations of sexual abuse were closed as having received a Family Assessment response. However, **43** of those reports were at some point **prior to case closure** assigned to a Family or Facility Investigation, but were switched back to a Family Assessment once it was indicated a Family/Facility Investigation was not needed, permissible under Minnesota Statutes. That leaves **one** report, or about **2.3%** of all reports including sexual abuse allegations, that were closed as Family Assessment and never had an Investigation.

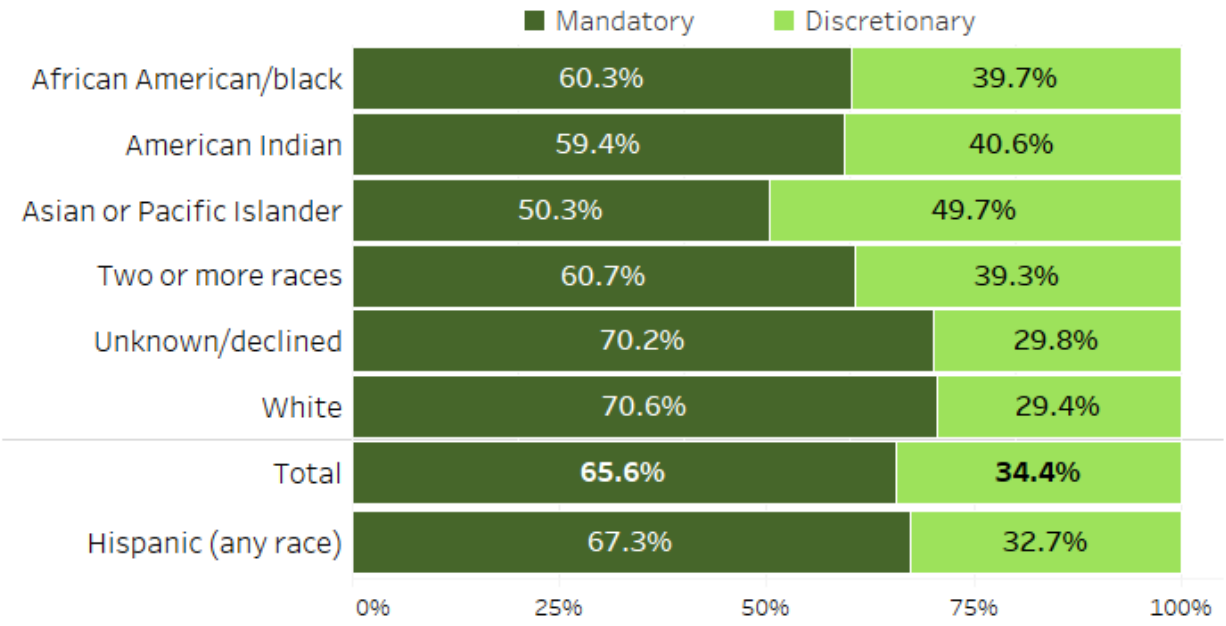
- Beginning in 2015, Child Safety and Permanency Division staff began reviewing every report that was assigned to Family Assessment and had a sexual abuse allegation, contacting agencies to review these decisions. Beginning in September 2017, new cases that include an allegation of sexual abuse are forced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

Figure 13. The percent and number of cases by child protection response path and maltreatment type in 2018



- As mentioned previously, there are both mandatory and discretionary reasons that local child protection agency staff will assign a case to the Family Investigation response path.
- Figure 14 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. There are a variety of reasons for discretionary investigation; the most common reason associated with discretionary assignment to a Family Investigation was frequency, similarity, or recentness of past reports (**39.5%**).

Figure 14. The percent of alleged victims by race/ethnicity assigned to Family Investigation by discretionary versus mandatory reasons in 2018



Assessment or investigation of safety, risk and service need

After a maltreatment report is screened in and a case is assigned to the appropriate child protection response path, caseworkers 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 paths, 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, caseworkers, along with other partners, will determine whether a safety plan can keep a child/ren safe, or if further intervention is warranted, such as placement 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 feel a child/ren is/are 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/ren is/are safe or in need of protection. Occasionally, at the time a report is received, a child/ren may already be placed on a 72-hour hold by local law enforcement. Caseworkers must see all alleged victims in a report.
- Two response time frames align with assignment of 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 (**75.6%**), 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 Family Assessment response and Family Investigation, at the discretion of agency staff (rather than for mandatory reasons because of severity of current allegation/s).

- In 2018, **88.4%** of victims were seen within the time frames established in statute for face-to-face contact with alleged victims (see Figure 15). This is an increase of almost 5% since 2017. Continued efforts in this area are underway.

Figure 15. Timeliness of face-to-face contact with alleged victims, 2018

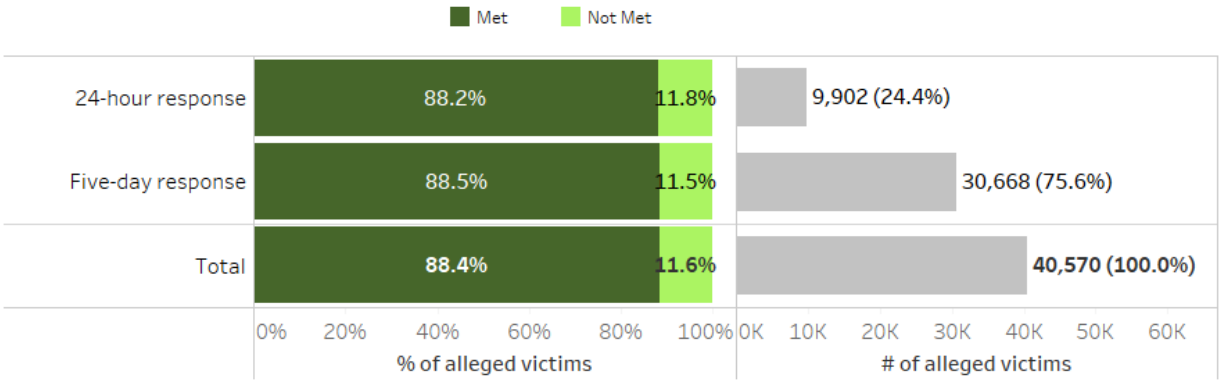
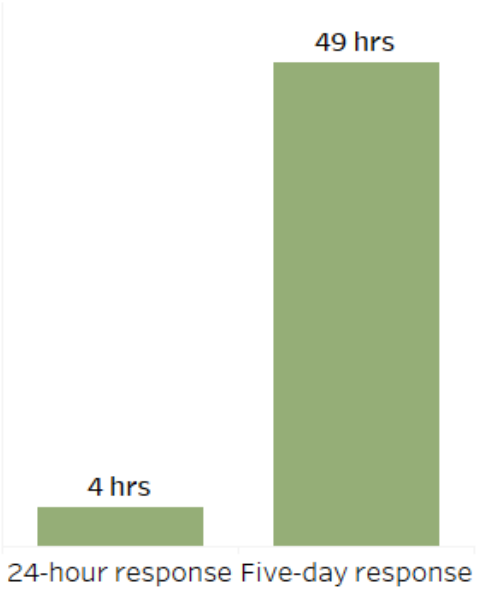


Figure 16. Median time of face-to-face contact by response type



- Despite not meeting the performance standard, the median time to face-to-face contact between child protection workers and alleged victims with allegations indicating substantial child endangerment was just under **four** hours. The median time of contact for all other victims was **49** hours (see Figure 16).
- Both department staff and local child protection agency staff 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.

Assessment of safety and risk

- After making initial contact with alleged victims and the family, child protection caseworkers conduct a formal assessment tool regarding safety.
- A higher percentage of maltreatment cases assigned to Family Investigation compared to Family Assessment are rated as unsafe (**17.5%** vs **3%**; see Figure 17).
- 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 17. Number and percent of cases by safety levels and child protection response path

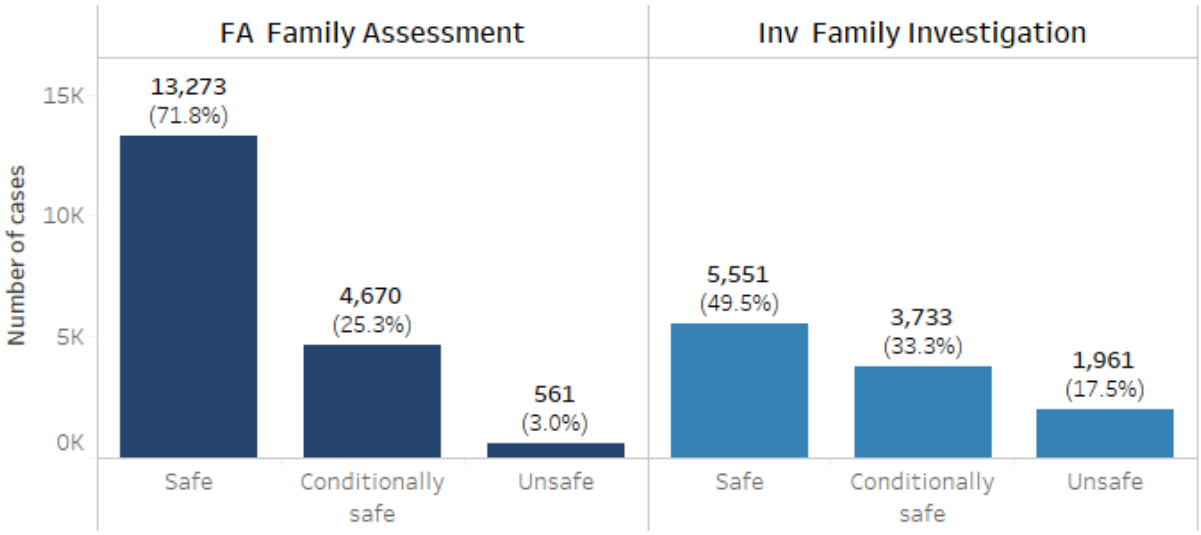
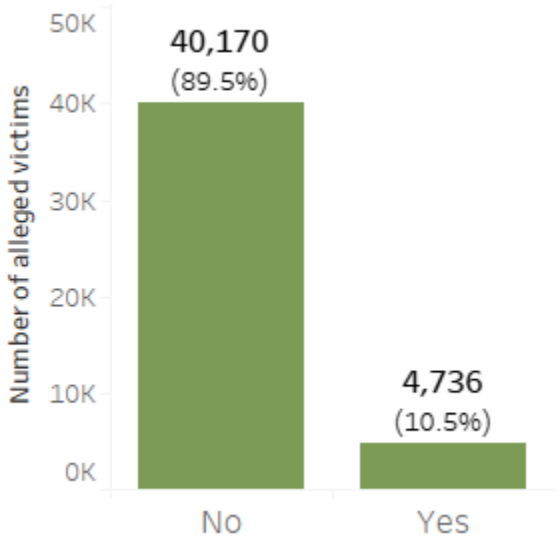


Figure 18. The number and percent of alleged victims who have an out-of-home placement during the assessment or investigation phase



- 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 18 shows a small proportion of all children who were involved in screened in child maltreatment reports in 2018 were placed in out-of-home care during an assessment or investigation (**10.5%**). 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 2018 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 19 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 (**31.9%**) than reports that were Family Assessments (**14.3%**).

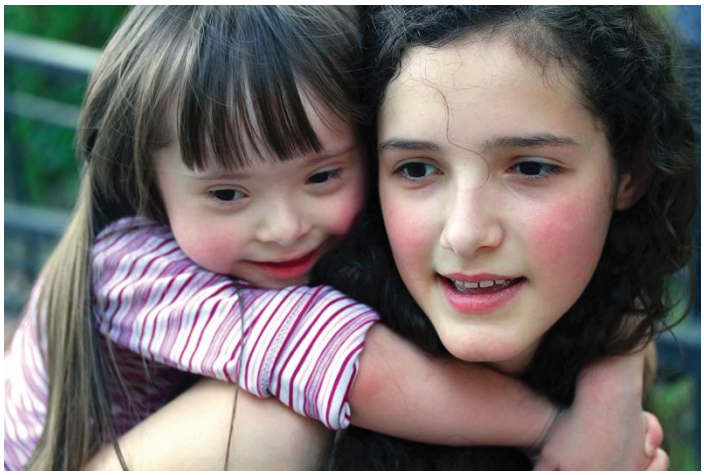
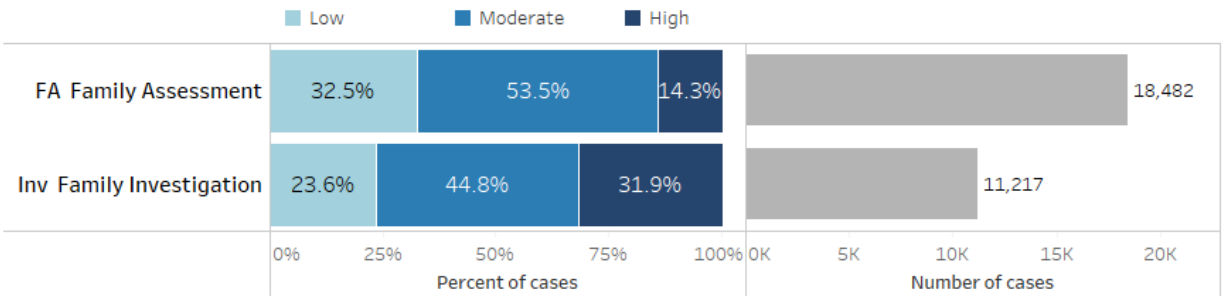


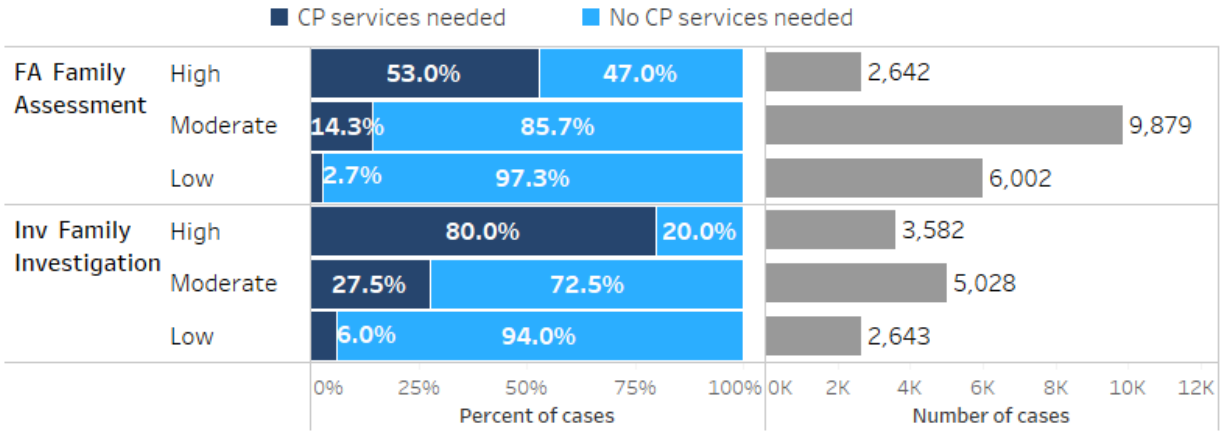
Figure 19. The number and percent of cases by risk assessment level and child protection response path



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 20 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.

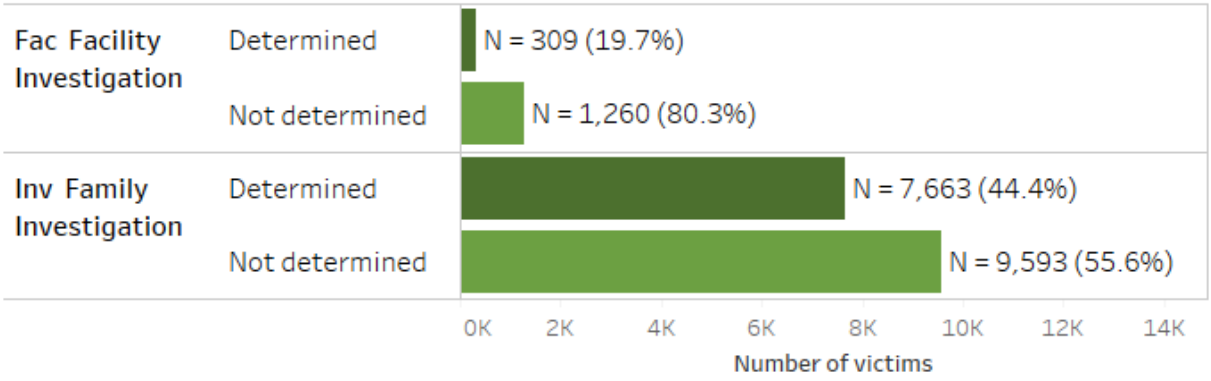
Figure 20. The percent and number of cases where child protective services were indicated by response category and risk level



Determining maltreatment

- For both Family and Facility Investigations, there is a final step at the conclusion of a child maltreatment case not made in a Family Assessment. The final step is to make a determination of whether maltreatment occurred based on information gathered during an investigation.
- Figure 21 provides information about the number of determined reports and victims by Family or Facility Investigation. There were **7,663** children in Family Investigations and **309** in Facility Investigations who had a maltreatment determination in 2018.
- For less than half of all victims in reports that were in either type of investigation, there was a determination that maltreatment occurred (**42.3%**). However, the pattern is different for Facility and Family Investigations, with a maltreatment determination being made for about **44.4%** of victims in Family Investigations, and **19.7%** of victims in Facility Investigations.

Figure 21. 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.
- Other professionals had the lowest determination rate, at **15.4%**.
- There were **25** 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 is explained by data entry errors in documentation of relationships, rather than inappropriate assignment of these cases to a Family Assessment response. There were fewer errors in 2018 than in previous years. The department reviews these cases on a monthly basis, and consults with local agencies when there are concerns about data entry.

Table 2. Number of alleged offenders by relationship to alleged victims, and percent child protection response and determination status in 2018

Offender relationship	Family Assessment	Investigations	Investigations determined	Percent determined
Non-caregiver sex trafficker	2	12	9	75.0%
Biological parent	16,850	9,394	4,646	49.5%
Unmarried partner of parent	1,181	1,101	544	49.4%
Step-parent	777	540	244	45.2%
Unknown or missing	31	59	26	44.1%
Other relative (non-foster parent)	440	726	318	43.8%
Friends or neighbors	32	92	39	42.4%
Other	140	471	199	42.3%
Adoptive parent	215	213	82	38.5%
Legal guardian	301	184	70	38.0%
Child daycare provider	9	156	59	37.8%
Sibling	132	684	237	34.6%
Group home or residential facility staff	0	44	14	31.8%
Relative foster parent	10	267	49	18.4%
Non-relative foster parent	6	232	37	15.9%
Other professionals	0	13	2	15.4%

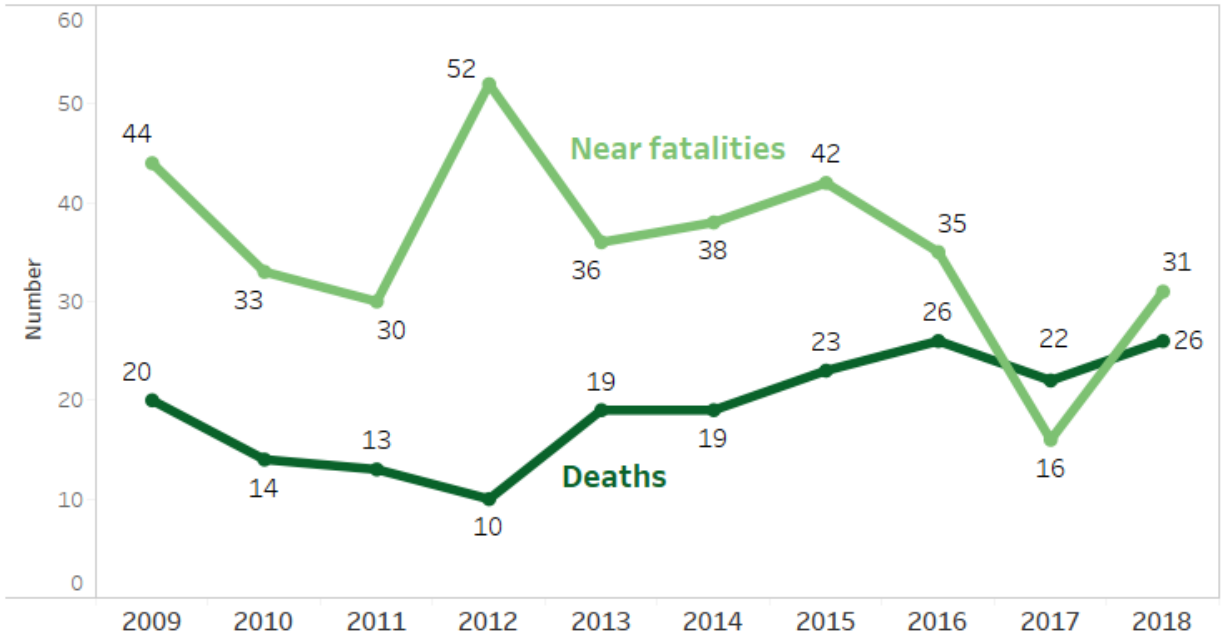
Child fatalities and near fatalities due to maltreatment

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 1,600 individuals statewide since 2017 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 22 provides trend information regarding both near fatalities and deaths that were determined to be a result of maltreatment from 2009 to 2018.
- There were **26** deaths and **31** near fatalities determined to be a result of maltreatment in 2018.

Figure 22. Victims who died or had a near fatality as a result of maltreatment, 2009 – 2018



- Tables 3 and 4 provide detailed information about victims who died as a result of maltreatment in 2018. 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.
- Of the **26** children whose deaths were determined to be a result of maltreatment in 2018, **nine children** had been involved in prior screened in child protection reports, and **17** had not.
- 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 2018, which is why it is included in the 2018 report.
- Other information included in the table provides age at time of death, gender, and the type of maltreatment that resulted in death.

Table 3. Details regarding deaths determined to be a result of maltreatment in 2018, with a prior child protection history

Year of death	Age and gender	Type of maltreatment
2017	3 years old, female	Neglect, physical abuse
2017	1 year old, female	Neglect
2018	8 years old, male	Neglect, physical abuse
2018	7 years old, male	Neglect
2018	Less than 1 year old, male	Physical abuse
2018	Less than 1 year old, female	Neglect
2018	6 years old, male	Physical abuse
2018	Less than 1 year old, female	Neglect
2018	Less than 1 year old, female	Physical abuse

Table 4. Details regarding deaths determined to be a result of maltreatment in 2018, with no prior child protection history

Year of death	Age and gender	Type of maltreatment
2017	3 years old, female	Physical abuse
2017	3 years old, male	Physical abuse
2017	1 year old, male	Neglect
2017	1 year old, male	Neglect
2017	13 years old, female	Neglect
2017	Less than 1 year old, female	Neglect
2017	Less than 1 year old, male	Neglect
2017	Less than 1 year old, female	Neglect
2017	Less than 1 year old, female	Neglect, physical abuse
2018	3 years old, male	Physical abuse
2018	3 years old, male	Neglect
2018	Less than 1 year old, male	Physical abuse
2018	Less than 1 year old, female	Neglect
2018	Less than 1 year old, male	Neglect
2018	Less than 1 year old, female	Neglect
2018	Less than 1 year old, female	Neglect
2018	Less than 1 year old, male	Physical abuse

Outcomes after child maltreatment assessments/investigations 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 2018 had another screened in maltreatment report within 12 months of the first report by child protection response path.

Table 5. Number and percent of alleged victims with a re-report of maltreatment within 12 months by child protection response path in 2018

Response path	Total number of victims	Victims who had a re-report	Percent of victims with a re-report
Family Assessment	23,332	4,701	20.1%
Family Investigation	15,307	3,198	20.9%
Facility Investigation	1,301	190	14.6%
Total across response paths	**39,940**	**8,089**	**20.3%**

Recurrence of maltreatment determinations

- Table 6 provides information on how many children, by race, who were determined victims of maltreatment in 2017 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. The federal performance standard for recurrence requires that less than **9.1%** of children have a maltreatment determination recurrence within 12 months.
- Minnesota met the maltreatment recurrence standard in 2018, with **9.0%** of all children having a maltreatment determination.
- The recurrence rate for African American/black, American Indian, Asian/Pacific Islander, children of two or more races, and children of any race who identify as Hispanic is noticeably higher than recurrence for white children.

Table 6. Number and percent of victims with a maltreatment determination recurrence within 12 months by race in 2018

Race/ethnicity	Determined victims	Determined victims with maltreatment recurrence within 12 months	Percent with maltreatment recurrence
African American/black	1,861	198	10.6%
American Indian	878	85	9.7%
Asian/Pacific Islander	263	25	9.5%
Unknown/declined	255	7	2.7%
Two or more races	1,381	163	11.8%
White	3,790	281	7.4%
Total	**8,428**	**759**	**9.0%**
Hispanic (any race)	990	112	11.3%

Child maltreatment appendix

Table 7. Number and percent of child maltreatment reports by screening status and agency, 2018

Agency	Total child maltreatment reports received in 2018	Number of screened in reports	Number of screened out reports	Percent of reports screened in	Percent of reports screened out
Aitkin	305	98	207	32.1	67.9
Anoka	3,533	1,286	2,247	36.4	63.6
Becker	741	284	457	38.3	61.7
Beltrami	1,019	466	553	45.7	54.3
Benton	763	193	570	25.3	74.7
Big Stone	76	27	49	35.5	64.5
Blue Earth	1,173	360	813	30.7	69.3
Brown	598	230	368	38.5	61.5
Carlton	825	385	440	46.7	53.3
Carver	926	431	495	46.5	53.5
Cass	478	253	225	52.9	47.1
Chippewa	126	87	39	69	31
Chisago	924	316	608	34.2	65.8
Clay	1,781	430	1,351	24.1	75.9
Clearwater	253	114	139	45.1	54.9
Cook	111	42	69	37.8	62.2
Crow Wing	1,374	322	1,052	23.4	76.6
Dakota	4,882	2,019	2,863	41.4	58.6
Douglas	808	340	468	42.1	57.9
Fillmore	278	100	178	36	64
Freeborn	673	257	416	38.2	61.8
Goodhue	725	264	461	36.4	63.6

Agency	Total child maltreatment reports received in 2018	Number of screened in reports	Number of screened out reports	Percent of reports screened in	Percent of reports screened out
Grant	237	116	121	48.9	51.1
Hennepin	16,164	8,872	7,292	54.9	45.1
Houston	296	118	178	39.9	60.1
Hubbard	595	389	206	65.4	34.6
Isanti	869	209	660	24.1	75.9
Itasca	974	562	412	57.7	42.3
Kanabec	369	127	242	34.4	65.6
Kandiyohi	886	288	598	32.5	67.5
Kittson	40	12	28	30	70
Koochiching	278	76	202	27.3	72.7
Lac qui Parle	96	37	59	38.5	61.5
Lake	109	62	47	56.9	43.1
Lake of the Woods	33	13	20	39.4	60.6
Le Sueur	688	202	486	29.4	70.6
McLeod	640	225	415	35.2	64.8
Mahnomen	93	33	60	35.5	64.5
Marshall	119	36	83	30.3	69.7
Meeker	476	153	323	32.1	67.9
Mille Lacs	1,279	291	988	22.8	77.2
Morrison	629	122	507	19.4	80.6
Mower	964	426	538	44.2	55.8
Nicollet	451	160	291	35.5	64.5
Nobles	378	147	231	38.9	61.1
Norman	150	61	89	40.7	59.3
Olmsted	1,636	709	927	43.3	56.7

Agency	Total child maltreatment reports received in 2018	Number of screened in reports	Number of screened out reports	Percent of reports screened in	Percent of reports screened out
Otter Tail	998	539	459	54	46
Pennington	164	79	85	48.2	51.8
Pine	1,149	284	865	24.7	75.3
Polk	759	231	528	30.4	69.6
Pope	231	117	114	50.6	49.4
Ramsey	6,394	3,182	3,212	49.8	50.2
Red Lake	32	15	17	46.9	53.1
Renville	366	181	185	49.5	50.5
Rice	1,107	397	710	35.9	64.1
Roseau	128	62	66	48.4	51.6
St. Louis	4,354	2,846	1,508	65.4	34.6
Scott	1,853	821	1,032	44.3	55.7
Sherburne	1,626	492	1,134	30.3	69.7
Sibley	282	182	100	64.5	35.5
Stearns	2,170	969	1,201	44.7	55.3
Stevens	167	92	75	55.1	44.9
Swift	305	92	213	30.2	69.8
Todd	510	147	363	28.8	71.2
Traverse	135	65	70	48.1	51.9
Wabasha	342	111	231	32.5	67.5
Wadena	636	281	355	44.2	55.8
Washington	1,998	827	1,171	41.4	58.6
Watonwan	235	114	121	48.5	51.5
Wilkin	190	80	110	42.1	57.9
Winona	1054	395	659	37.5	62.5

Agency	Total child maltreatment reports received in 2018	Number of screened in reports	Number of screened out reports	Percent of reports screened in	Percent of reports screened out
Wright	2,440	801	1,639	32.8	67.2
Yellow Medicine	177	84	93	47.5	52.5
Southwest HHS	1,888	683	1,205	36.2	63.8
Des Moines Valley HHS	500	166	334	33.2	66.8
Faribault-Martin	586	305	281	52	48
Leech Lake Band of Ojibwe	581	192	389	33	67
White Earth Nation	464	314	150	67.7	32.3
MN Prairie	1,502	567	935	37.7	62.3
Minnesota	**86,144**	**37,463**	**48,681**	**43.5**	**56.5**

Table 8. Number of completed maltreatment assessments/investigations by response path and agency, 2018

Agency	Family Assessment	Family Investigation	Facility Investigation	Total reports
Aitkin	69	23	1	93
Anoka	646	481	28	1,155
Becker	107	112	5	224
Beltrami	154	210	15	379
Benton	114	66	1	181
Big Stone	18	6	1	25
Blue Earth	254	75	1	330
Brown	160	30	6	196
Carlton	139	106	16	261
Carver	302	65	5	372
Cass	120	78	9	207
Chippewa	48	34	4	86
Chisago	166	87	5	258
Clay	189	70	9	268
Clearwater	66	37	3	106
Cook	22	18	0	40
Crow Wing	161	77	9	247
Dakota	1,067	738	39	1,844
Douglas	148	124	6	278
Fillmore	79	9	0	88
Freeborn	151	55	1	207
Goodhue	131	33	4	168
Grant	42	49	4	95

Agency	Family Assessment	Family Investigation	Facility Investigation	Total reports
Hennepin	3,609	2,720	216	6,545
Houston	71	11	2	84
Hubbard	257	95	15	367
Isanti	109	57	4	170
Itasca	161	124	30	315
Kanabec	65	53	2	120
Kandiyohi	94	98	3	195
Kittson	12	2	0	14
Koochiching	61	21	0	82
Lac qui Parle	25	7	0	32
Lake	39	9	1	49
Lake of the Woods	12	1	0	13
Le Sueur	76	25	4	105
McLeod	76	117	4	197
Mahnomen	21	7	2	30
Marshall	18	14	1	33
Meeker	92	20	1	113
Mille Lacs	145	123	13	281
Morrison	81	36	0	117
Mower	293	62	0	355
Nicollet	122	24	3	149
Nobles	85	31	1	117
Norman	30	18	1	49
Olmsted	531	126	5	662
Otter Tail	178	252	6	436

Agency	Family Assessment	Family Investigation	Facility Investigation	Total reports
Pennington	32	37	4	73
Pine	147	84	9	240
Polk	136	51	9	196
Pope	51	43	7	101
Ramsey	1,451	1,323	72	2,846
Red Lake	15	2	0	17
Renville	86	59	1	146
Rice	218	104	2	324
Roseau	47	16	0	63
St. Louis	1,257	945	116	2,318
Scott	523	153	29	705
Sherburne	287	128	20	435
Sibley	68	70	1	139
Stearns	505	231	23	759
Stevens	61	18	3	82
Swift	42	37	2	81
Todd	87	27	6	120
Traverse	28	25	0	53
Wabasha	92	18	1	111
Wadena	161	68	7	236
Washington	415	265	34	714
Watonwan	75	24	0	99
Wilkin	49	13	2	64
Winona	197	78	12	287
Wright	367	267	17	651

Agency	Family Assessment	Family Investigation	Facility Investigation	Total reports
Yellow Medicine	50	27	2	79
Southwest HHS	334	198	16	548
Des Moines Valley HHS	108	40	4	152
Faribault-Martin	189	97	7	293
Leech Lake Band of Ojibwe	169	10	14	193
White Earth Nation	225	28	25	278
MN Prairie	399	99	16	514
Minnesota	**18,487**	**11,221**	**947**	**30,655**

Table 9. Number of alleged victims in completed assessments/investigations by maltreatment type and rate per 1,000 children by agency, 2018

Agency	Medical neglect	Threatened injury	Neglect	Sexual abuse	Mental injury	Physical abuse	Total alleged victims*	Child pop. est. (2016)	Rate per 1,000
Aitkin	0	19	91	17	0	22	128	2,654	48.2
Anoka	0	46	894	212	15	466	1,492	84,276	17.7
Becker	0	24	196	54	12	86	291	8,350	34.9
Beltrami	0	28	449	54	25	99	589	11,777	50
Benton	0	19	132	24	7	61	214	10,159	21.1
Big Stone	0	6	24	5	0	11	40	1,056	37.9
Blue Earth	0	17	299	44	0	83	422	13,265	31.8
Brown	0	22	166	20	31	63	245	5,567	44
Carlton	0	21	235	57	35	106	350	8,017	43.7
Carver	0	59	263	54	40	121	468	27,643	16.9
Cass	0	58	181	25	30	69	288	6,297	45.7
Chippewa	0	27	70	16	1	22	115	2,832	40.6
Chisago	0	24	204	31	9	87	323	12,745	25.3
Clay	0	41	267	67	4	72	402	15,517	25.9
Clearwater	0	12	95	17	18	29	134	2,200	60.9
Cook	0	4	35	4	1	5	43	858	50.1
Crow Wing	0	30	183	70	20	118	357	14,059	25.4
Dakota	0	63	1,476	254	6	590	2,205	103,532	21.3
Douglas	0	33	223	47	54	119	361	8,045	44.9
Fillmore	0	7	60	6	2	57	121	5,127	23.6
Freeborn	0	8	194	21	10	117	300	6,701	44.8
Goodhue	0	18	128	19	2	69	208	10,379	20

Agency	Medical neglect	Threatened injury	Neglect	Sexual abuse	Mental injury	Physical abuse	Total alleged victims*	Child pop. est. (2016)	Rate per 1,000
Grant	0	21	80	4	16	30	107	1,351	79.2
Hennepin	0	1,292	4,381	1,464	203	3,050	8,294	275,532	30.1
Houston	0	5	64	11	7	28	96	4,052	23.7
Hubbard	0	80	337	65	76	142	502	4,415	113.7
Isanti	0	16	132	30	5	66	208	9,428	22.1
Itasca	0	76	330	80	11	102	481	9,446	50.9
Kanabec	0	23	77	16	7	43	143	3,424	41.8
Kandiyohi	0	28	200	45	3	79	298	10,417	28.6
Kittson	0	1	10	2	0	3	14	887	15.8
Koochiching	0	1	53	10	2	18	75	2,313	32.4
Lac qui Parle	0	2	27	5	3	6	39	1,337	29.2
Lake	0	6	39	7	0	23	64	1,931	33.1
Lake of the Woods	0	0	4	1	1	8	14	691	20.3
Le Sueur	0	16	88	21	4	50	157	6,737	23.3
McLeod	0	18	215	47	10	64	306	8,355	36.6
Mahnomen	0	1	18	5	3	19	38	1,771	21.5
Marshall	0	5	21	17	1	10	50	2,137	23.4
Meeker	0	16	90	12	1	33	138	5,655	24.4
Mille Lacs	0	9	249	97	13	123	396	6,276	63.1
Morrison	0	8	94	29	3	26	157	7,790	20.2
Mower	0	5	244	58	5	139	399	9,848	40.5
Nicollet	0	17	118	16	21	52	194	7,487	25.9
Nobles	0	16	61	34	4	56	150	5,850	25.6
Norman	0	2	36	14	4	15	62	1,565	39.6
Olmsted	0	16	552	94	14	220	817	37,946	21.5

Agency	Medical neglect	Threatened injury	Neglect	Sexual abuse	Mental injury	Physical abuse	Total alleged victims*	Child pop. est. (2016)	Rate per 1,000
Otter Tail	0	10	369	45	44	156	523	12,741	41
Pennington	1	7	72	9	2	17	94	3,264	28.8
Pine	0	12	187	40	2	111	305	5,815	52.5
Polk	0	17	180	27	15	63	269	7,653	35.1
Pope	0	12	86	12	10	33	121	2,306	52.5
Ramsey	0	666	2,083	501	115	917	3,746	127,779	29.3
Red Lake	0	0	12	4	1	4	21	991	21.2
Renville	0	7	140	18	21	49	196	3,377	58
Rice	0	21	215	73	15	170	447	14,414	31
Roseau	0	4	67	9	0	11	88	3,728	23.6
St. Louis	0	381	1,674	363	79	821	2,578	38,171	67.5
Scott	0	136	420	111	7	284	820	40,626	20.2
Sherburne	0	16	300	88	30	168	530	25,132	21.1
Sibley	0	8	95	11	4	61	159	3,566	44.6
Stearns	0	106	564	122	11	278	922	36,346	25.4
Stevens	0	9	64	15	11	22	92	1,985	46.3
Swift	0	3	83	5	6	24	104	2,137	48.7
Todd	0	3	97	22	0	28	145	5,836	24.8
Traverse	0	10	43	5	5	20	58	682	85
Wabasha	0	7	78	13	8	48	141	4,724	29.8
Wadena	0	39	185	43	33	61	273	3,451	79.1
Washington	0	20	474	179	11	358	896	63,271	14.2
Watonwan	0	7	66	15	0	23	99	2,633	37.6
Wilkin	0	1	57	5	2	14	70	1,436	48.7
Winona	0	38	235	34	60	83	350	9,231	37.9

Agency	Medical neglect	Threatened injury	Neglect	Sexual abuse	Mental injury	Physical abuse	Total alleged victims*	Child pop. est. (2016)	Rate per 1,000
Wright	0	123	492	125	44	245	849	37,776	22.5
Yellow Medicine	0	10	71	21	3	23	100	2,322	43.1
Southwest HHS	0	76	468	122	34	174	715	18,148	39.4
Des Moines Valley HHS	0	15	112	43	2	61	199	4,899	40.6
Faribault-Martin	0	16	276	54	1	99	383	7,344	52.2
Leech Lake Band of Ojibwe†	0	2	199	4	0	37	236	1,975	119.5
White Earth Nation†	0	2	309	8	13	57	357	1,981	180.2
MN Prairie	0	29	465	101	25	172	691	19,176	36
Minnesota	**1**	**4,079**	**23,623**	**5,549**	**1,353**	**11,569**	**38,872**	**1,298,657**	**30**

† 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, 2018

Agency	Birth – 2	3 – 5	6 – 8	9 – 11	12 – 14	15 – 17	18 and older
Aitkin	27	19	20	32	22	9	0
Anoka	351	254	303	256	189	153	0
Becker	78	60	42	50	41	23	0
Beltrami	154	126	102	98	72	42	0
Benton	44	41	45	39	23	25	0
Big Stone	11	9	9	4	3	4	0
Blue Earth	119	81	77	82	49	19	0
Brown	58	52	53	41	30	17	0
Carlton	64	62	75	63	42	47	0
Carver	79	95	79	95	56	68	0
Cass	52	49	40	47	56	46	0
Chippewa	19	19	28	23	13	14	0
Chisago	59	59	62	62	49	36	0
Clay	93	87	85	62	50	28	0
Clearwater	22	21	31	24	24	17	0
Cook	12	11	6	4	7	4	0
Crow Wing	98	65	55	63	50	26	0
Dakota	418	376	429	454	285	269	0
Douglas	66	75	58	57	65	44	0
Fillmore	33	28	17	18	13	12	0
Freeborn	72	43	62	50	41	34	0
Goodhue	54	39	41	33	24	18	0
Grant	16	22	24	25	10	12	0
Hennepin	1,869	1,418	1,564	1,516	1,095	933	4

Agency	Birth – 2	3 – 5	6 – 8	9 – 11	12 – 14	15 – 17	18 and older
Houston	24	15	22	14	10	11	0
Hubbard	97	93	92	93	95	57	0
Isanti	47	38	39	26	31	31	0
Itasca	128	88	80	91	58	45	0
Kanabec	33	23	24	25	30	9	0
Kandiyohi	79	69	57	38	35	22	0
Kittson	3	0	5	2	2	2	0
Koochiching	8	21	19	15	10	2	0
Lac qui Parle	4	9	8	12	5	2	0
Lake	11	14	9	18	10	2	0
Lake of the Woods	0	3	2	3	3	3	0
Le Sueur	37	22	29	21	24	24	0
McLeod	54	60	64	62	44	23	0
Mahnomen	6	10	8	7	3	4	0
Marshall	16	6	6	11	8	4	0
Meeker	34	28	26	25	19	7	0
Mille Lacs	103	71	66	69	60	31	0
Morrison	46	35	28	21	19	9	0
Mower	89	75	59	94	56	32	0
Nicollet	33	29	44	38	28	22	0
Nobles	23	27	33	28	33	9	1
Norman	11	6	14	9	14	8	0
Olmsted	208	144	158	135	114	74	0
Otter Tail	113	94	108	89	79	55	0
Pennington	24	18	16	18	9	9	0
Pine	71	53	52	42	48	40	0

Agency	Birth – 2	3 – 5	6 – 8	9 – 11	12 – 14	15 – 17	18 and older
Polk	67	44	56	50	30	26	0
Pope	29	25	19	21	17	14	0
Ramsey	931	618	704	682	440	406	0
Red Lake	9	6	4	0	1	1	0
Renville	40	39	35	37	32	14	0
Rice	93	77	73	93	68	48	0
Roseau	20	20	23	13	5	7	0
St. Louis	570	519	516	467	339	245	3
Scott	155	137	155	144	117	119	0
Sherburne	101	71	118	104	74	64	0
Sibley	21	36	36	27	31	10	0
Stearns	198	168	184	170	107	108	0
Stevens	20	14	15	22	17	10	0
Swift	30	24	18	19	10	6	0
Todd	29	30	22	25	25	15	0
Traverse	16	10	17	4	6	6	0
Wabasha	37	24	24	30	20	10	0
Wadena	57	44	46	49	52	32	0
Washington	188	170	175	149	133	88	0
Watonwan	24	26	16	14	10	9	0
Wilkin	19	19	12	10	2	8	0
Winona	81	67	80	62	36	32	0
Wright	153	147	179	151	116	109	0
Yellow Medicine	18	20	19	22	16	5	0
Southwest HHS	151	159	146	120	91	58	0
Des Moines Valley HHS	42	46	34	33	27	21	0

Agency	Birth – 2	3 – 5	6 – 8	9 – 11	12 – 14	15 – 17	18 and older
Faribault-Martin	67	71	74	63	57	58	0
Leech Lake Band of Ojibwe	64	37	59	58	16	7	0
White Earth Nation	93	58	69	51	51	42	0
MN Prairie	121	130	136	156	97	65	0
Minnesota	**8,614**	**7,018**	**7,439**	**7,050**	**5,199**	**4,080**	**8**

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, 2018

Agency	African American/ black	American Indian	Asian/ Pacific Islander	Two or more races	Unknown/ declined	White	Total alleged victims	Hispanic (any race)
Aitkin	*	17	*	13	*	93	128	*
Anoka	297	37	16	201	74	867	1,492	108
Becker	*	47	*	54	9	175	291	12
Beltrami	12	360	*	61	*	143	589	20
Benton	40	*	*	45	*	124	214	15
Big Stone	*	*	*	*	*	30	40	*
Blue Earth	66	12	*	44	*	277	422	41
Brown	*	*	*	10	11	216	245	41
Carlton	*	110	*	63	*	174	350	9
Carver	52	8	12	64	36	296	468	57
Cass	*	29	*	19	11	228	288	*
Chippewa	8	*	*	12	9	80	115	16
Chisago	*	*	7	21	19	264	323	19
Clay	41	36	*	76	*	248	402	77
Clearwater	*	29	*	14	*	80	134	*
Cook	*	12	*	*	*	24	43	*
Crow Wing	*	18	*	30	*	303	357	*
Dakota	396	43	45	356	385	980	2,205	355
Douglas	12	*	*	45	14	286	361	22
Fillmore	*	*	*	8	7	102	121	7
Freeborn	16	*	17	30	*	217	300	63
Goodhue	23	10	*	20	*	144	208	16
Grant	*	*	*	*	7	96	107	*

Agency	African American/ black	American Indian	Asian/ Pacific Islander	Two or more races	Unknown/ declined	White	Total alleged victims	Hispanic (any race)
Hennepin	3,553	471	251	1,566	221	2,232	8,294	1,191
Houston	*	*	*	*	12	79	96	*
Hubbard	10	47	*	42	*	399	502	16
Isanti	*	*	*	13	17	172	208	*
Itasca	8	38	*	71	*	346	481	9
Kanabec	*	*	*	16	8	117	143	*
Kandiyohi	26	*	*	10	16	235	298	129
Kittson	*	*	*	*	*	12	14	*
Koochiching	*	*	*	*	*	62	75	*
Lac qui Parle	*	*	*	*	*	35	39	*
Lake	*	*	*	*	*	58	64	*
Lake of the Woods	*	*	*	*	*	13	14	*
Le Sueur	*	*	*	8	10	132	157	28
McLeod	*	*	*	21	14	266	306	55
Mahnomen	*	17	*	10	*	11	38	*
Marshall	*	*	*	10	*	40	50	*
Meeker	*	*	*	*	12	118	138	14
Mille Lacs	*	126	*	28	19	217	396	15
Morrison	*	*	*	31	*	122	157	*
Mower	53	*	18	33	*	283	399	87
Nicollet	21	*	*	29	*	140	194	36
Nobles	7	*	11	*	14	111	150	70
Norman	*	*	*	*	*	50	62	9
Olmsted	137	*	29	151	*	495	817	91
Otter Tail	15	12	*	47	*	408	523	37

Agency	African American/ black	American Indian	Asian/ Pacific Islander	Two or more races	Unknown/ declined	White	Total alleged victims	Hispanic (any race)
Pennington	11	*	*	*	*	76	94	21
Pine	*	54	*	14	7	228	305	12
Polk	9	15	*	28	*	208	269	79
Pope	*	*	*	*	8	102	121	*
Ramsey	1,458	154	463	507	137	1,027	3,746	443
Red Lake	*	*	*	*	*	13	21	*
Renville	*	*	*	12	*	179	196	47
Rice	53	*	*	29	75	283	447	93
Roseau	*	17	*	*	*	64	88	*
St. Louis	250	329	21	379	69	1,530	2,578	70
Scott	74	33	17	99	72	525	820	114
Sherburne	42	*	*	49	70	364	530	27
Sibley	*	*	*	23	9	123	159	45
Stearns	171	10	*	83	*	637	922	81
Stevens	8	8	*	7	*	64	92	17
Swift	21	*	*	*	*	69	104	14
Todd	*	*	*	7	*	133	145	7
Traverse	*	26	*	*	*	29	58	*
Wabasha	8	*	*	7	9	110	141	22
Wadena	10	*	*	19	10	231	273	11
Washington	125	9	36	96	220	410	896	62
Watonwan	*	*	*	*	*	87	99	45
Wilkin	*	*	*	*	*	59	70	*
Winona	53	*	*	18	18	255	350	19
Wright	45	8	10	73	78	635	849	37

Agency	African American/ black	American Indian	Asian/ Pacific Islander	Two or more races	Unknown/ declined	White	Total alleged victims	Hispanic (any race)
Yellow Medicine	*	21	*	11	*	64	100	15
Southwest HHS	43	64	10	89	49	460	715	108
Des Moines Valley HHS	7	*	11	16	*	151	199	42
Faribault-Martin	*	*	*	45	7	327	383	59
Leech Lake Band of Ojibwe	*	226	*	8	*	*	236	*
White Earth Nation	*	324	*	32	*	*	357	*
MN Prairie	72	*	*	40	9	565	691	108
Minnesota	**7,335**	**2,869**	**1,025**	**5,038**	**1,997**	**20,608**	**38,872**	**4,337**

* 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, 2018

Agency	Unique alleged victims	Unique determined victims	Child pop. est. (2016)	Determined victims per 1,000
Aitkin	128	24	2,654	9
Anoka	1,492	299	84,276	3.5
Becker	291	88	8,350	10.5
Beltrami	589	247	11,777	21
Benton	214	47	10,159	4.6
Big Stone	40	5	1,056	4.7
Blue Earth	422	41	13,265	3.1
Brown	245	21	5,567	3.8
Carlton	350	93	8,017	11.6
Carver	468	38	27,643	1.4
Cass	288	34	6,297	5.4
Chippewa	115	33	2,832	11.7
Chisago	323	62	12,745	4.9
Clay	402	45	15,517	2.9
Clearwater	134	19	2,200	8.6
Cook	43	9	858	10.5
Crow Wing	357	57	14,059	4.1
Dakota	2,205	388	103,532	3.7
Douglas	361	118	8,045	14.7
Fillmore	121	2	5,127	0.4
Freeborn	300	38	6,701	5.7
Goodhue	208	37	10,379	3.6
Grant	107	32	1,351	23.7
Hennepin	8,294	2,068	275,532	7.5
Houston	96	1	4,052	0.2
Hubbard	502	32	4,415	7.2
Isanti	208	64	9,428	6.8
Itasca	481	57	9,446	6
Kanabec	143	35	3,424	10.2
Kandiyohi	298	89	10,417	8.5
Kittson	14	1	887	1.1
Koochiching	75	9	2,313	3.9
Lac qui Parle	39	0	1,337	0
Lake	64	8	1,931	4.1

Agency	Unique alleged victims	Unique determined victims	Child pop. est. (2016)	Determined victims per 1,000
Lake of the Woods	14	0	691	0
Le Sueur	157	10	6,737	1.5
McLeod	306	64	8,355	7.7
Mahnomen	38	1	1,771	0.6
Marshall	50	17	2,137	8
Meeker	138	14	5,655	2.5
Mille Lacs	396	75	6,276	12
Morrison	157	25	7,790	3.2
Mower	399	29	9,848	2.9
Nicollet	194	24	7,487	3.2
Nobles	150	26	5,850	4.4
Norman	62	13	1,565	8.3
Olmsted	817	56	37,946	1.5
Otter Tail	523	104	12,741	8.2
Pennington	94	12	3,264	3.7
Pine	305	35	5,815	6
Polk	269	46	7,653	6
Pope	121	27	2,306	11.7
Ramsey	3,746	1,064	127,779	8.3
Red Lake	21	5	991	5
Renville	196	48	3,377	14.2
Rice	447	70	14,414	4.9
Roseau	88	5	3,728	1.3
St. Louis	2,578	482	38,171	12.6
Scott	820	75	40,626	1.8
Sherburne	530	102	25,132	4.1
Sibley	159	38	3,566	10.7
Stearns	922	174	36,346	4.8
Stevens	92	15	1,985	7.6
Swift	104	38	2,137	17.8
Todd	145	6	5,836	1
Traverse	58	10	682	14.7
Wabasha	141	9	4,724	1.9
Wadena	273	15	3,451	4.3
Washington	896	134	63,271	2.1
Watonwan	99	11	2,633	4.2
Wilkin	70	4	1,436	2.8

Agency	Unique alleged victims	Unique determined victims	Child pop. est. (2016)	Determined victims per 1,000
Winona	350	68	9,231	7.4
Wright	849	124	37,776	3.3
Yellow Medicine	100	13	2,322	5.6
Southwest HHS	715	178	18,148	9.8
Des Moines Valley HHS	199	31	4,899	6.3
Faribault-Martin	383	71	7,344	9.7
Leech Lake Band of Ojibwe†	236	2	1,975	1
White Earth Nation†	357	26	1,981	13.1
MN Prairie	691	51	19,176	2.7
Minnesota	**38,872**	**7,588**	**1,298,657**	**5.8**

† 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, 2018

Agency	Children with a referral	Children required to be referred	Referral rate
Aitkin	1	3	33.3
Anoka	84	88	95.5
Becker	18	28	64.3
Beltrami	71	77	92.2
Benton	10	10	100.0
Big Stone	0	0	--
Blue Earth	9	10	90.0
Brown	0	0	--
Carlton	14	19	73.7
Carver	3	5	60.0
Cass	7	8	87.5
Chippewa	4	5	80.0
Chisago	6	10	60.0
Clay	5	5	100.0
Clearwater	6	7	85.7
Cook	1	2	50.0
Crow Wing	4	6	66.7
Dakota	95	106	89.6
Douglas	21	25	84.0
Fillmore	0	0	--
Freeborn	8	10	80.0
Goodhue	9	9	100.0
Grant	7	7	100.0
Hennepin	503	539	93.3
Houston	1	1	100.0
Hubbard	4	5	80.0
Isanti	13	15	86.7
Itasca	10	13	76.9
Kanabec	7	7	100.0
Kandiyohi	14	15	93.3
Kittson	0	0	--
Koochiching	1	1	100.0
Lac qui Parle	0	0	--
Lake	3	3	100.0
Lake of the Woods	0	0	--
Le Sueur	1	2	50.0
McLeod	9	10	90.0
Mahnomen	0	0	--
Marshall	8	8	100.0
Meeker	3	4	75.0
Mille Lacs	16	24	66.7
Morrison	11	11	100.0
Mower	5	5	100.0

Agency	Children with a referral	Children required to be referred	Referral rate
Nicollet	2	3	66.7
Nobles	2	5	40.0
Norman	0	1	0.0
Olmsted	3	4	75.0
Otter Tail	22	32	68.8
Pennington	4	5	80.0
Pine	9	9	100.0
Polk	9	13	69.2
Pope	4	7	57.1
Ramsey	304	315	96.5
Red Lake	0	0	--
Renville	6	11	54.5
Rice	20	23	87.0
Roseau	0	0	--
St. Louis	63	88	71.6
Scott	12	17	70.6
Sherburne	13	17	76.5
Sibley	5	6	83.3
Stearns	23	30	76.7
Stevens	3	6	50.0
Swift	7	8	87.5
Todd	0	0	--
Traverse	4	5	80.0
Wabasha	1	1	100.0
Wadena	0	2	0.0
Washington	21	26	80.8
Watonwan	0	2	0.0
Wilkin	0	0	--
Winona	0	8	0.0
Wright	14	20	70.0
Yellow Medicine	1	1	100.0
Southwest HHS	33	38	86.8
Des Moines Valley HHS	3	3	100.0
Faribault-Martin	6	11	54.5
Leech Lake Band of Ojibwe	1	1	100.0
White Earth Nation	0	1	0.0
MN Prairie	1	6	16.7
Minnesota	**1,588**	**1,828**	**86.9**

Table 14. Number of assessments/investigations by SDM risk assessment status and by agency, 2018

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	18	2	20	33	7	40	17	15	32
Anoka	351	14	365	483	90	573	93	100	193
Becker	31	2	33	93	17	110	11	70	81
Beltrami	69	7	76	105	74	179	25	85	110
Benton	28	0	28	70	9	79	3	74	77
Big Stone	2	1	3	8	9	17	1	3	4
Blue Earth	108	2	110	131	19	150	41	27	68
Brown	33	0	33	85	15	100	25	32	57
Carlton	77	2	79	90	25	115	17	34	51
Carver	150	4	154	129	28	157	9	47	56
Cass	60	1	61	66	19	85	27	25	52
Chippewa	15	3	18	17	30	47	2	15	17
Chisago	71	3	74	112	20	132	15	32	47
Clay	42	3	45	119	21	140	38	40	78
Clearwater	36	0	36	50	6	56	7	5	12
Cook	3	0	3	14	2	16	11	10	21
Crow Wing	71	6	77	95	16	111	16	35	51
Dakota	681	7	688	826	56	882	61	175	236
Douglas	43	1	44	129	15	144	21	63	84
Fillmore	20	0	20	46	3	49	13	7	20
Freeborn	46	3	49	80	40	120	18	23	41
Goodhue	18	2	20	70	10	80	36	28	64
Grant	12	2	14	37	10	47	7	23	30
Hennepin	1,462	24	1,486	2,512	652	3,165	362	1,320	1,682
Houston	16	0	16	39	5	44	11	12	23
Hubbard	137	5	142	112	24	136	37	36	73
Isanti	29	2	31	61	16	77	7	58	65

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	69	11	80	106	35	141	23	41	64
Kanabec	24	6	30	38	13	51	17	20	37
Kandiyohi	46	1	47	80	19	99	10	37	47
Kittson	5	0	5	4	3	7	0	2	2
Koochiching	16	0	16	26	8	34	19	13	32
Lac qui Parle	6	1	7	11	6	17	1	8	9
Lake	5	0	5	11	11	22	3	18	21
Lake of the Woods	5	3	8	1	3	4	1	0	1
Le Sueur	29	2	31	41	13	54	6	10	16
McLeod	45	2	47	78	22	100	15	31	46
Mahnomen	9	0	9	9	4	13	3	3	6
Marshall	4	0	4	12	6	18	5	5	10
Meeker	29	0	29	47	10	57	14	12	26
Mille Lacs	58	3	61	115	38	153	18	37	55
Morrison	23	1	24	50	15	65	3	25	28
Mower	164	0	164	156	24	180	4	9	13
Nicollet	35	6	41	44	32	76	4	25	29
Nobles	32	6	38	43	21	64	2	12	14
Norman	16	2	18	23	3	26	1	5	6
Olmsted	135	1	136	316	79	396	49	79	128
Otter Tail	127	3	130	149	42	191	36	72	108
Pennington	15	1	16	28	4	32	14	7	21
Pine	65	1	66	92	30	122	14	28	42
Polk	44	0	45	93	13	106	11	28	40
Pope	29	0	29	36	15	51	5	9	14
Ramsey	991	59	1,050	1,157	301	1,458	51	216	267
Red Lake	7	0	7	7	1	8	2	0	2
Renville	34	2	36	58	19	77	13	20	33
Rice	96	2	98	133	28	161	31	33	64

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	19	3	22	14	9	23	7	11	18
St. Louis	592	14	606	957	136	1,093	227	276	503
Scott	269	7	276	270	62	332	23	48	71
Sherburne	157	8	165	162	31	193	23	34	57
Sibley	31	7	38	44	30	74	0	27	27
Stearns	242	10	252	293	61	354	63	68	131
Stevens	13	1	14	36	13	49	4	13	17
Swift	8	0	8	22	8	30	8	33	41
Todd	26	3	29	40	12	52	10	24	34
Traverse	9	0	9	22	13	35	5	4	9
Wabasha	31	0	31	46	8	54	13	15	28
Wadena	49	5	54	87	38	126	15	34	49
Washington	242	7	249	289	55	344	38	58	96
Watonwan	25	1	26	46	6	52	1	20	21
Wilkin	12	0	12	25	14	39	3	8	11
Winona	47	1	48	152	7	159	24	47	71
Wright	269	7	276	241	34	275	38	46	84
Yellow Medicine	18	1	19	24	9	33	4	21	25
Southwest HHS	135	7	142	210	52	262	34	96	130
Des Moines Valley HHS	43	1	44	52	20	72	8	24	32
Faribault-Martin	65	1	66	140	15	155	25	40	65
Leech Lake Band of Ojibwe	43	8	51	62	33	95	13	20	33
White Earth Nation	68	17	85	56	47	103	18	47	65
MN Prairie	122	4	126	243	30	273	50	51	101
Minnesota	**8,327**	**322**	**8,650**	**12,109**	**2,799**	**14,911**	**1,960**	**4,264**	**6,225**

Note: Across all agencies, there were around 900 reports excluded from this table because they did not have an associated SDM Risk Assessment complete

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DEPARTMENT OF HUMAN SERVICES

Minnesota's Out-of-home Care and Permanency Report, 2018

Children and Family Services

December 2019

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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.

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

Out-of-home care and permanency report summary, 2018

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 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 are 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 2018 is as follows:

- There were 16,488 children in 17,137 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 re-entered care.) These figures are similar to 2017 data.
- There was a 10% reduction in the number of children who entered out-of-home care in 2018, from 7,482 to 6,741. There was also a reduction in removals related to alleged neglect and child delinquency. The number of children continuing in out-of-home care (their episode began in a prior year and extended into 2018), continued to increase in 2018, with 10,070 children continuing in care from 2017, a 7% increase from the prior year.
- Parental drug abuse continues to be the most common primary reason for new out-of-home care episodes, accounting for 2,125 new episodes or 31% of all new cases, continuing a trend that started in 2016.
- White children remain the largest group in care, however, disproportionality remains a significant concern.
- American Indian children were 18.2 times more likely, African American children more than 2.9 times, and those identified as two or more races were 5.1 times more likely than white children to experience care, based on Minnesota population estimates from 2017.
- Children under age 2 and those between the ages 15 and 17 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 (87.9% of enterers and 82.4% of continuers). The rest were overseen by corrections (5.1% of enterers, 2.4% of continuers), and tribal social services (7.0% of enterers, 15.1% of continuers).
- The most common settings experienced by children who entered care were family foster homes, with about 75% of children spending time in that type of setting.

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

- There were 7,518 unique children in 7,701 placement episodes that ended in 2018.
- Of placement episodes that ended, 30.7% lasted six months or less.
- Most placements (59.4%) that ended in 2018 were because children were able to safely return home to their parents or other primary caregivers.
- More than one in four (27.3%) continuous placement episodes ended with children being adopted, or transfer of permanent legal and physical custody to a relative.
- There were 3,086 children who spent at least one day under guardianship of the commissioner, an increase of 8% from 2017.
- Adoptions were finalized for 1,268 children under guardianship of the commissioner, a 33% increase from 2017.
- For American Indian children under jurisdiction of tribal court, 64 had a customary tribal adoption.
- Using the federal performance measure, re-entry into foster care in 2018 was 15.9%. While this demonstrates a reduction from 17.2% in 2017, Minnesota's re-entry rate is still much higher than the federal performance standard of 8.3%.

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 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 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

For the first time since 2010, Minnesota saw an overall reduction in the number of children experiencing out-of-home-care, by 0.6% from 2017 to 2018. However, recent increases in children involved in child protection and a growing drug epidemic are contributing to more children staying in care longer.

Minnesota has significant racial disparities in out-of-home care; African American and American Indian children, and children of two or more races, are disproportionately likely to experience out-of-home care.

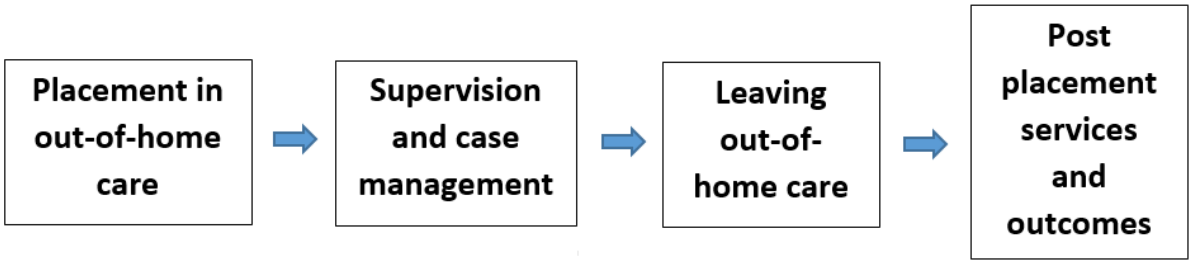
What is out-of-home care?

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 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 safety, permanency, and well-being of children who have experienced out-of-home care. An additional annual report provides information on children who may have been maltreated, "Minnesota's Child Maltreatment Report, 2018." 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. Stats., Chapters 260C and 260D):

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

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, child welfare agencies must have court-approved placement, or parent/s must sign a voluntary placement 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 an out-of-home care placement episode: County social services, corrections, or tribal social services.

There were 16,488 children who experienced 17,137 placements during 2018. Of these placement episodes, 11.3% began as a voluntary or court-reviewed voluntary hold (N = 1,926), and 89.1% began as a court-ordered or protective involuntary hold (N = 15,241). There were 36 episodes with no 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 2018, and continuers are those who were in a placement episode that began prior to 2018 and continued into 2018. As previously stated, the number of placement episodes is higher than the number of children, as a child could have multiple episodes, as follows:

- Of the 16,488 children who experienced 17,137 episodes of out-of-home care in 2018, there were 6,741 children in 7,066 placement episodes who were enterers, and 10,070 who were continuers
- There were 323 children who were continuers and, after returning home in 2018, had a new entry into out-of-home care in 2018 and subsequently categorized as enterers. See Figure 1 for a diagram that shows the overlap in children.

Figure 1: Continuers and enterers

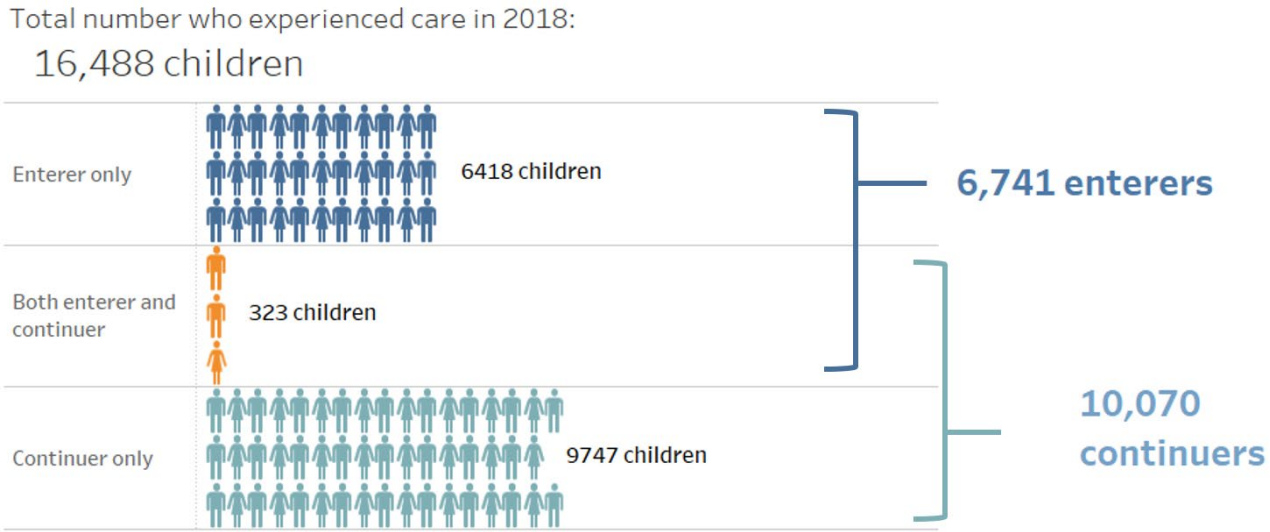
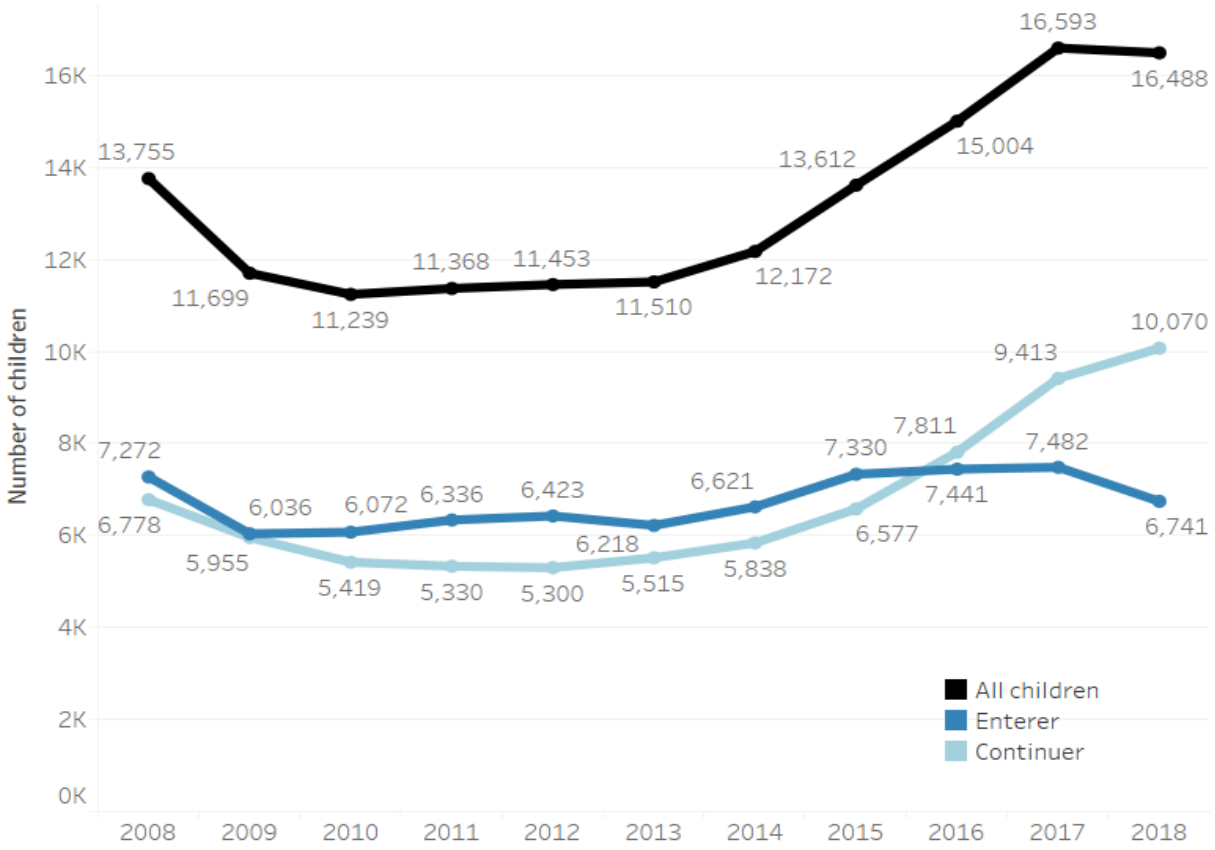


Figure 2: Number of children experiencing care by continuers, enterers and all children, 2008-2018



The figure above shows 11-year trends for the number of children experiencing care, broken down by total numbers of children, enterers and continuers, as follows:

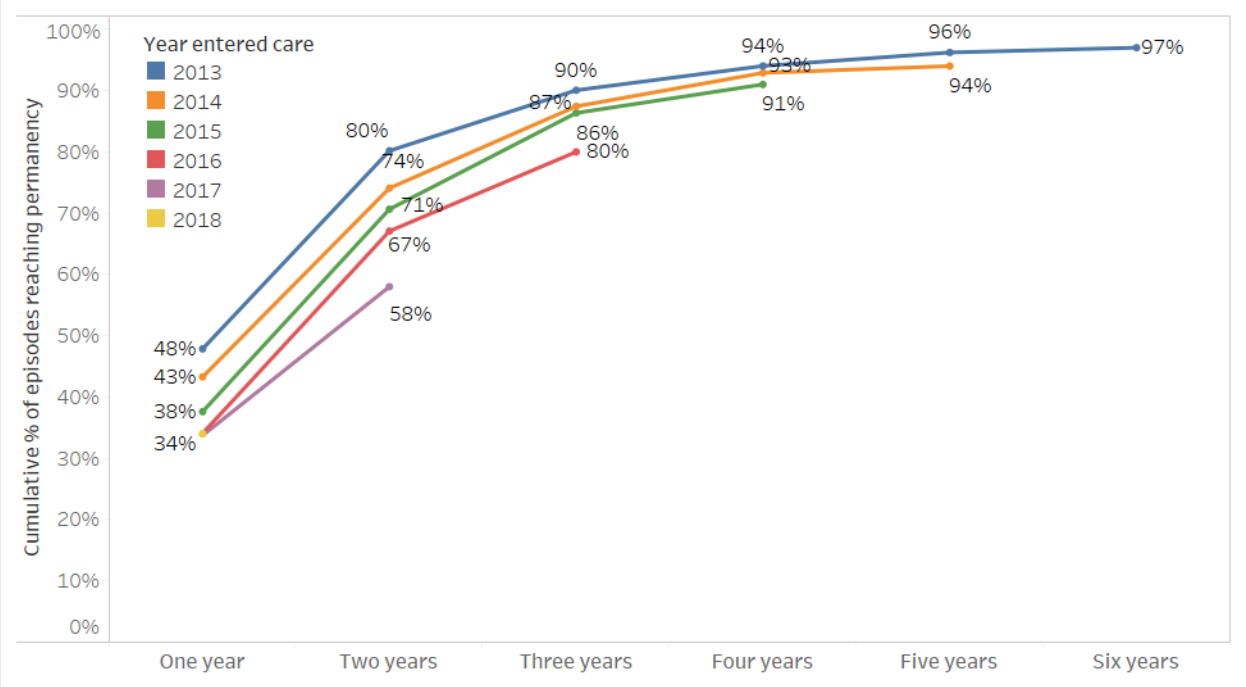
- In 2018, there was a 0.6% decrease in the number of children experiencing care for at least one day from the previous year
- For the second year, more children were continuers than enterers in care, accounting for approximately 61% of children in out-of-home care in 2018
- There was a 7% increase in children continuing in care from the previous year
- The number of children entering care in 2018 decreased by about 10% from the previous year.

Sidebar: Why does there continue to be a high number of children experiencing out-of-home care despite recent decreases in the number entering care?

Over the past five years, Minnesota has seen an increase in the number of children in care across the state (the most recent year showed stabilization of the number of children experiencing care from the previous year's high). There has been a sharper increase in the number of continuers than enterers, which highlights 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. The one-year permanency rates dropped from 48% to 34% from 2013 to 2018, with two-year permanency rates dropping from 80% to 58%.

The median length of time in care for exiters has increased from 175 days in 2013 to 345 days in 2018. 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; 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 2018



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 2018. Disproportionality remains a significant concern for children in out-of-home placement, as indicated below:

- White children remain the largest group, both entering and continuing in care in 2018, accounting for 46.7% of enterers and 40.5% of continuers.
- African American/black children comprised the second largest number and percentage of enterers, at 16.7%, and American Indian children comprised the second largest group of continuers, at 24.2%.

Figure 3: Number and percentage by race/ethnicity of children in care in 2018

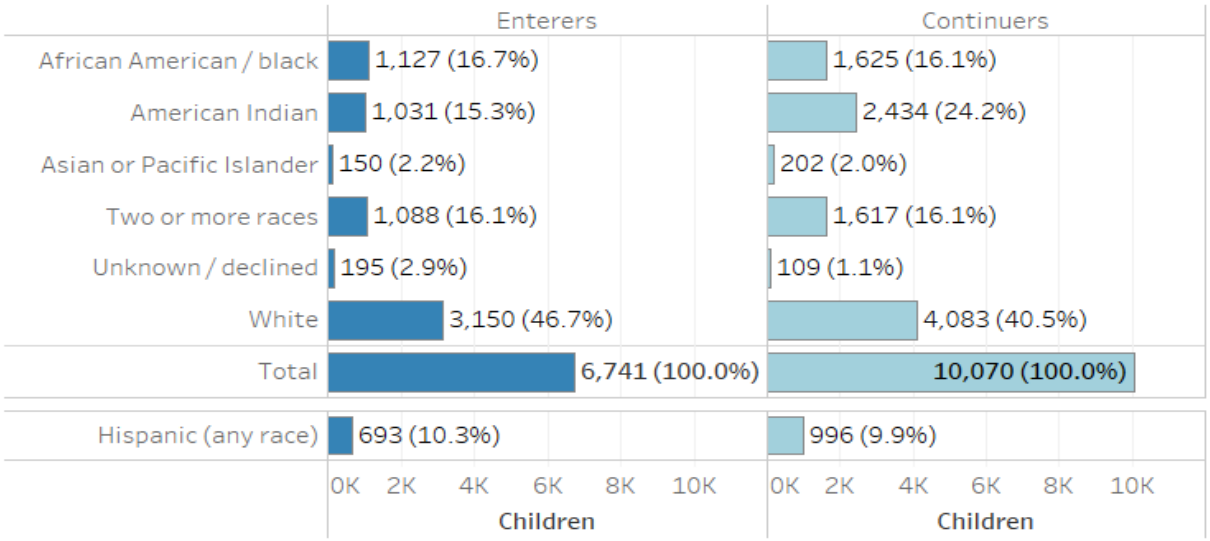
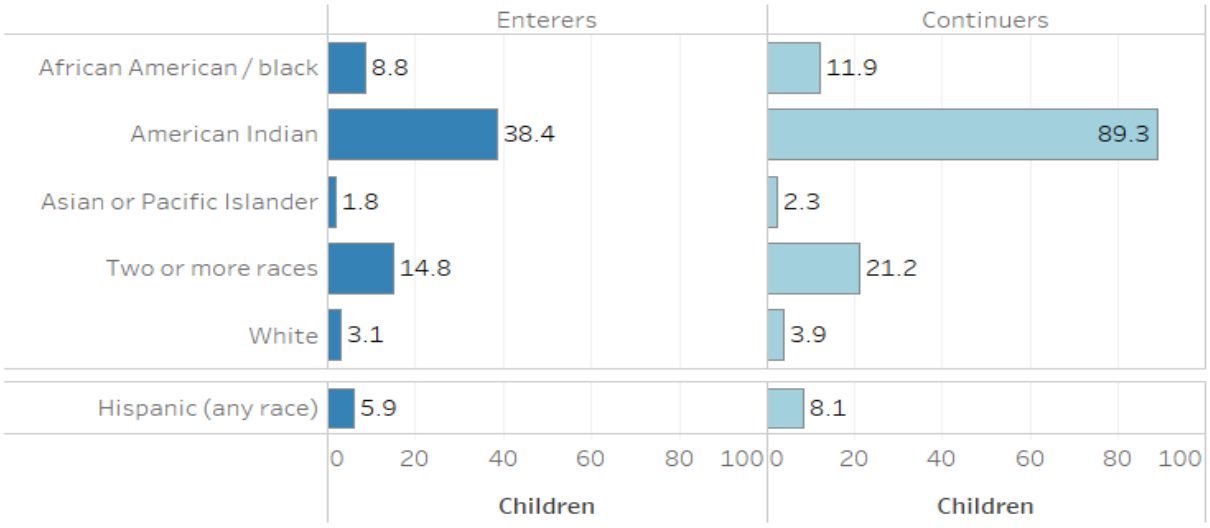


Figure 4: Rate per 1,000 for children in care in 2018



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 2018 and identified as more than one race:

- **86.6**% identified at least one race as white
- **59.7**% identified at least one race as African American/black
- **56.2**% identified at least one race as American Indian
- **4.8**% identified at least one race as Asian
- **1.1**% identified as Pacific Islander.

As shown in Figure 5 below, the rates of children experiencing out-of-home care have increased only for those who identify as two or more races. Rates for American Indian, African American/black, and white children have decreased; the rate for Asian/Pacific Islander children remained the same. American Indian children were 18.2 times more likely, African American children were more than 2.9 times, and those identified as two or more races were 5.1 times more likely than white children to experience care, based on Minnesota population estimates from 2017 (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 – 2018

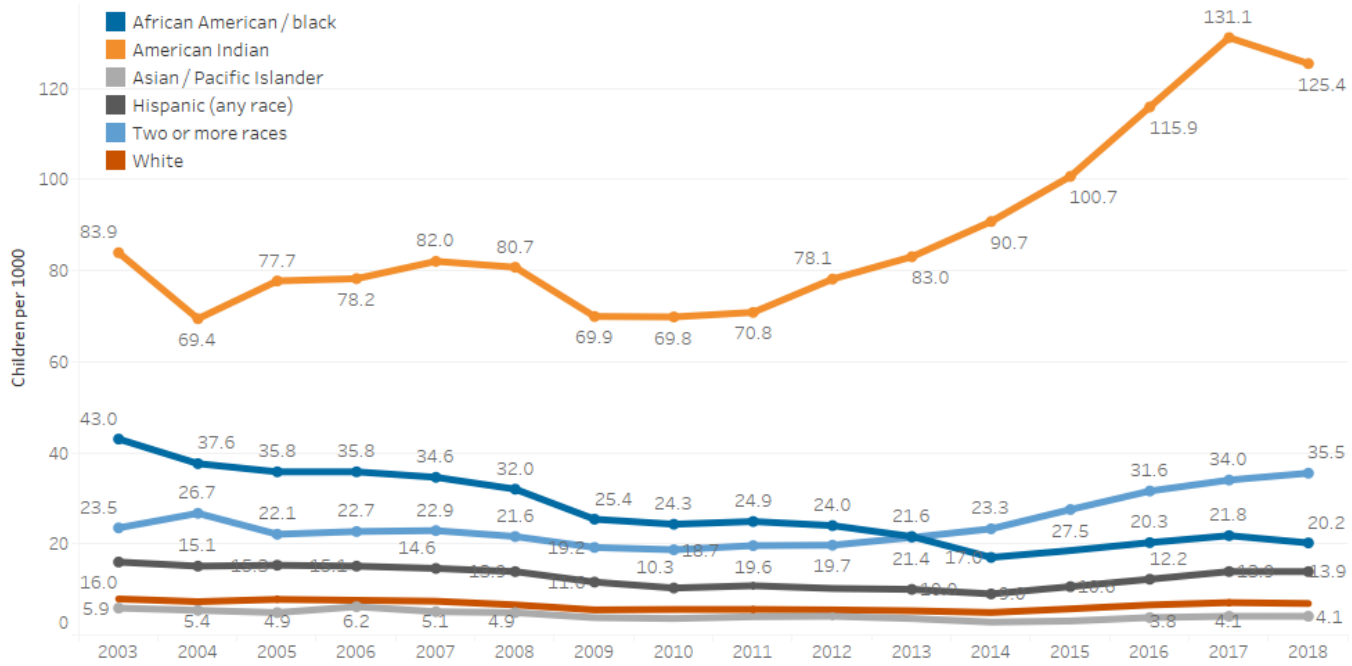


Figure 6: Number of children by age experiencing care in 2018

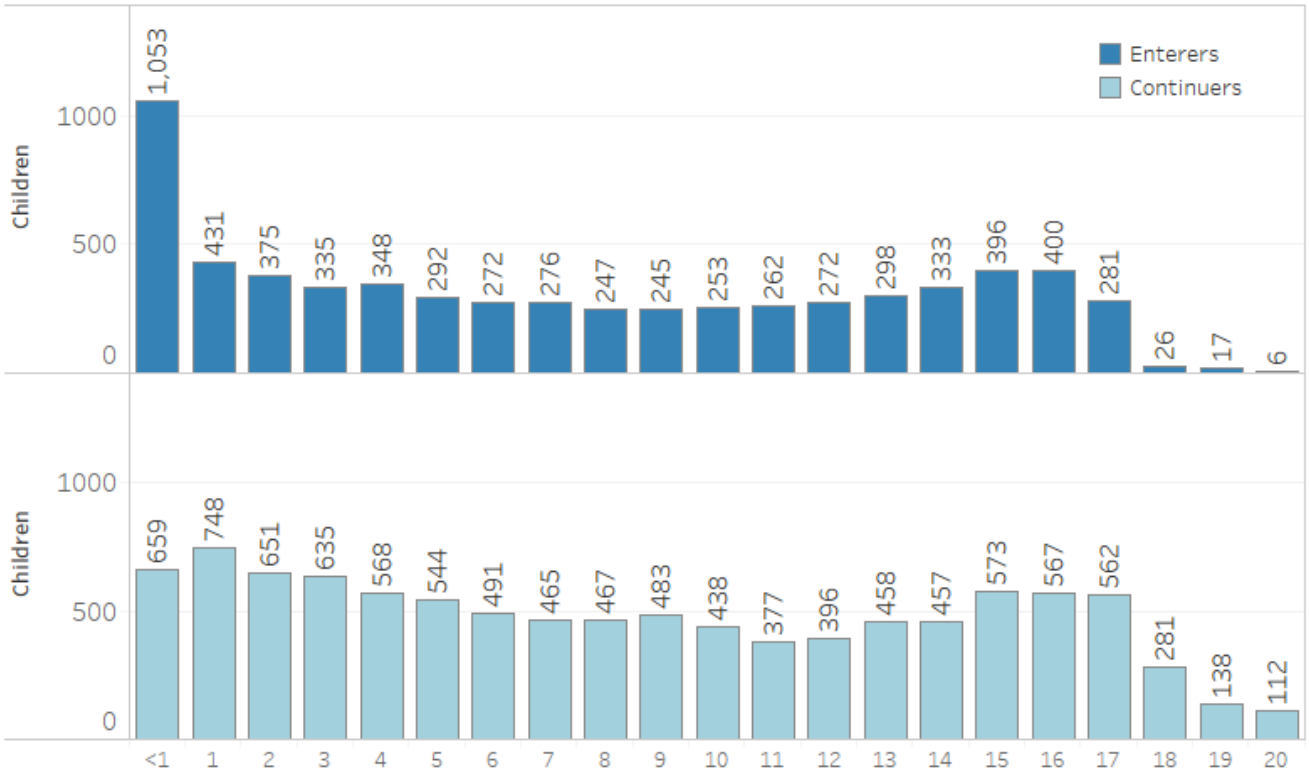
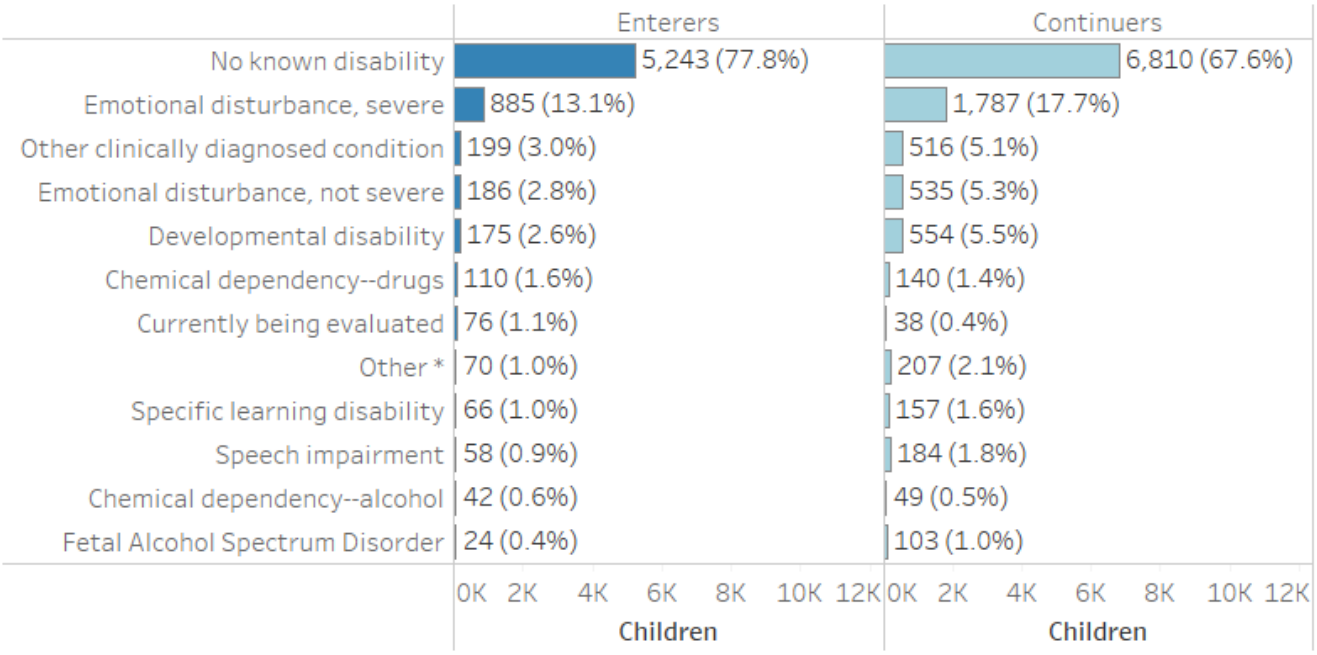


Figure 6 shows the distribution of children experiencing out-of-home care by enterers and continuers by age. Age is calculated at either Jan. 1, 2018, for continuers, or the date of entry into care for those who entered out-of-home care in 2018.

Children under age 2 and those between ages 15 and 17 were more likely to experience out-of-home care.

Figure 7: Number and percentage of children by disability status in 2018



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

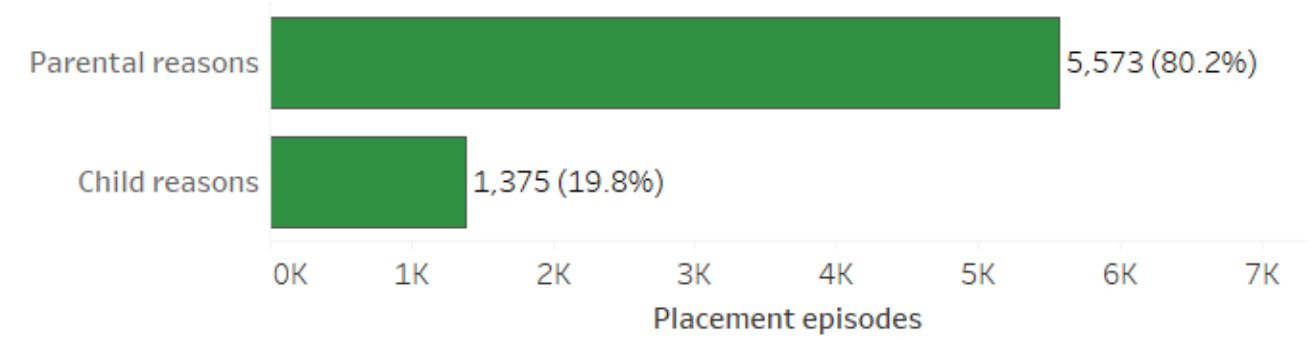
Some children who experienced out-of-home care have disabilities and may need additional support while in out-of-home placement. These range from learning and physical disabilities, emotional disturbances to Fetal Alcohol Spectrum Disorders. Data show that 22.2% of children who entered care in 2018 had an identified disability, while 32.4% who continued in care into 2018 did (see Figure 7).

For those children who entered or continued in care in 2018 with an identified disability, the most common was severe emotional disturbance (13.1% for enterers and 17.7% for continuers).

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 requires specialized treatment. Although children may enter care for multiple reasons, more than three of every four placements (80.2%) had an indicated *primary* removal reason attributed to parents.

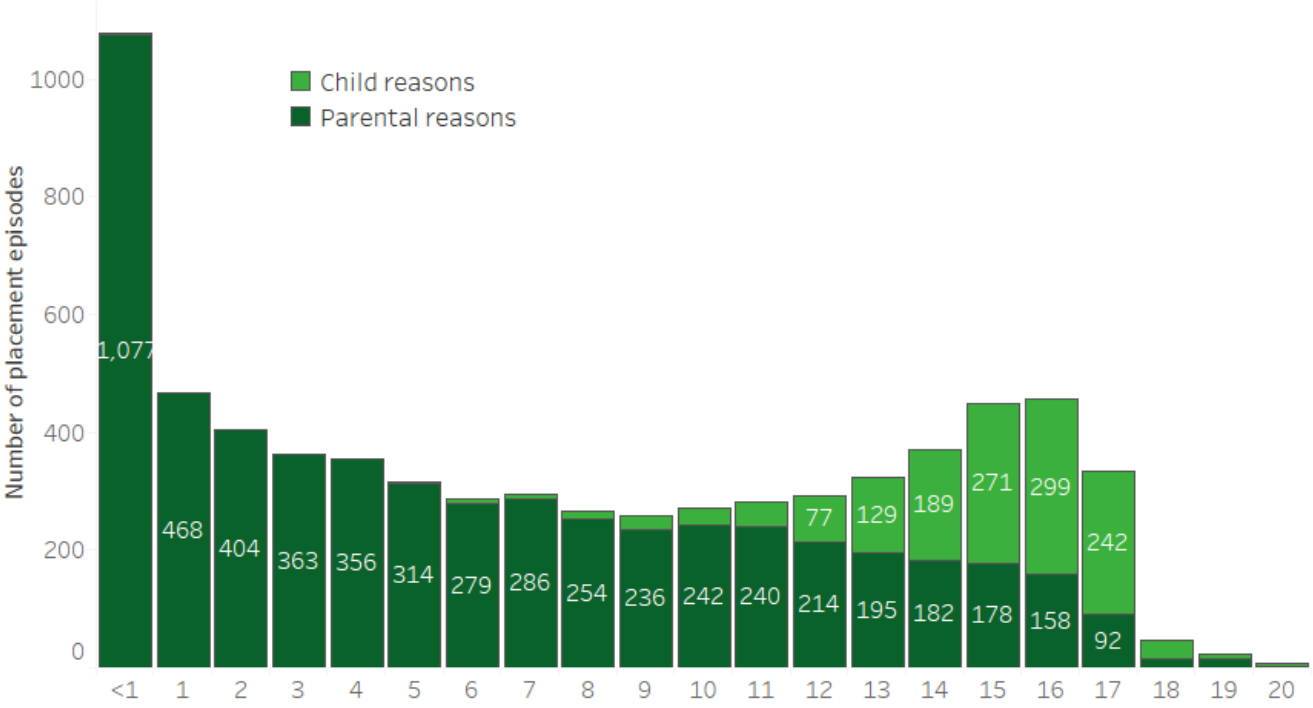
Figure 8*:* Number and percentage of placement episodes with parental and child reasons beginning in 2018



Note: At the time of data analysis, there were 117 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 2018 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 2018 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.

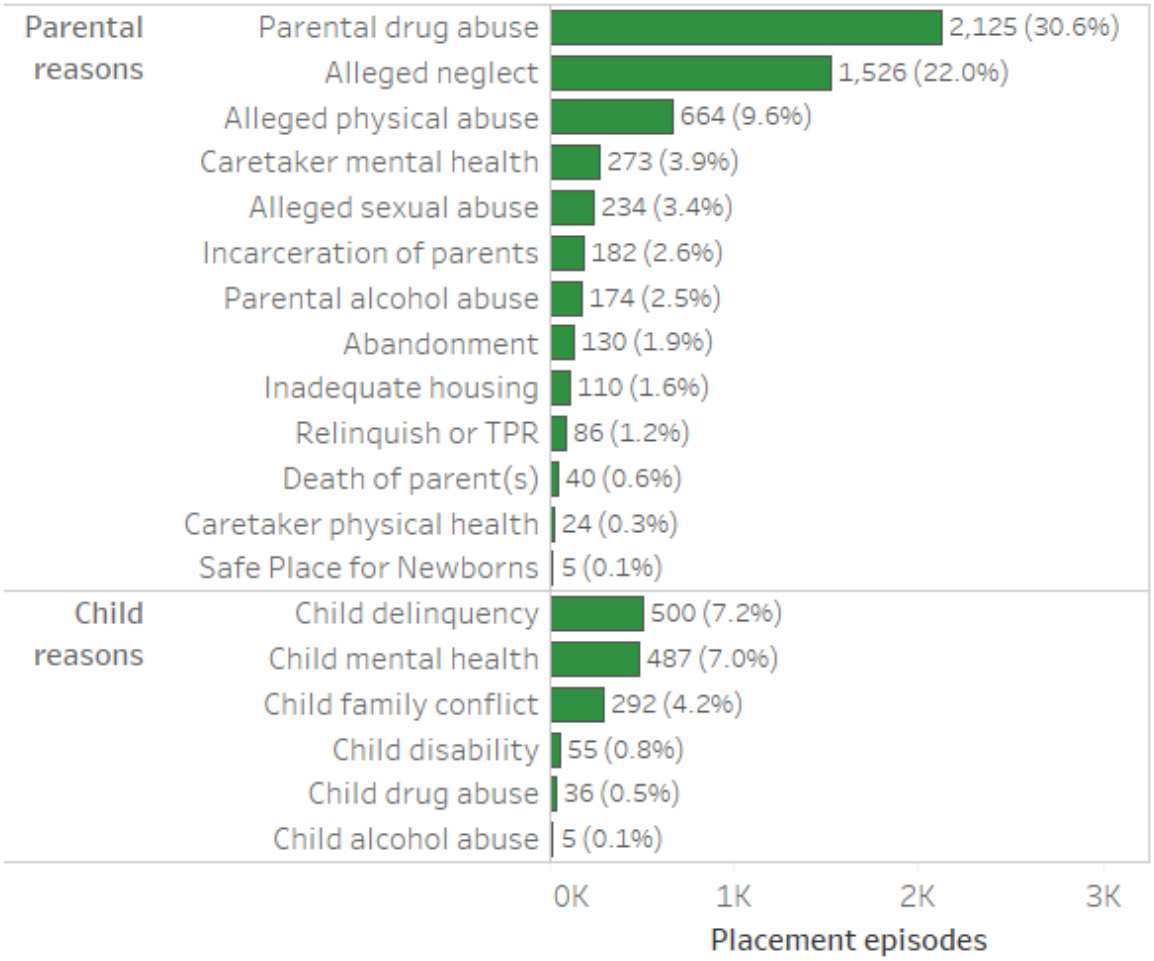
Figure 9*:* Number of placement episodes by age and primary removal reason beginning in 2018



Note: Age is calculated at either Jan. 1, 2018, (for continuers) or the date of entry into care for those whose out-of-home care episode began in 2018.

- Several reasons 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.
    - Are more likely to have diagnosed mental health needs. 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 2018



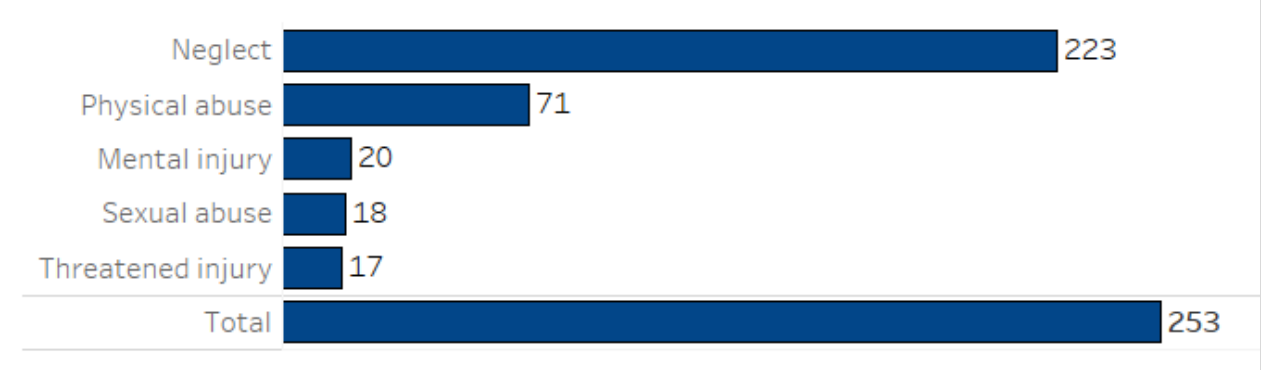
- More than one-quarter (30.6%) of placement episodes had a primary removal reason of parental drug abuse, whereas just less than one-quarter (22 %) had a primary removal reason of alleged neglect. See Figure 10.

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 (1,279 of 1,375, or 93%) had either child delinquency, mental health, or family conflict listed as the primary removal reason.

Sidebar: Neglect removals

While not true for all removals, many placements result from child maltreatment investigations. Of the 1,526 children removed due to alleged neglect in 2018, 253, or approximately 17%, were victims in a maltreatment report completed within 60 days prior to removal. As shown below, the majority of allegations of these reports fell under neglect.

Allegations in previous child protection reports of neglect removals



Supervision and case management

The next section 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

Three different agencies assume, or are delegated by a county or tribal court, responsibility for placement of child/ren in out-of-home care: County and tribal social services, or corrections. These agencies ensure that state and federal laws are followed. Tribal and corrections placements are as follows:

- A high proportion of American Indian children who entered care in 2018 were placed under supervision of tribal social services (44.1%); an even higher proportion of these placements continued in care in 2018 (59.6%)
- 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 (13.2% for enterers and 6.6% for continuers). There has been improvement in recent years, with an overall reduction of African American/black children in care under corrections by about 30% since 2016.

Table 1: Number and percent of placement episodes by race/ethnicity for the three types of supervising agencies in 2018

	Enterers			Continuers			
	County social services	Corrections	Tribal social services	County social services	Corrections	Tribal social services	Total
African American / black	1,049 (86.8%)	159 (13.2%)		1,517 (93.4%)	108 (6.6%)		**2,833** (100.0%)
American Indian	552 (51.5%)	47 (4.4%)	473 (44.1%)	951 (39.1%)	32 (1.3%)	1,452 (59.6%)	**3,507** (100.0%)
Asian / Pacific Islander	153 (96.2%)	6 (3.8%)		197 (97.5%)	5 (2.5%)		**361** (100.0%)
Two or more races	1,091 (94.7%)	39 (3.4%)	22 (1.9%)	1,512 (93.5%)	32 (2.0%)	73 (4.5%)	**2,769** (100.0%)
Unknown / declined	196 (98.0%)	3 (1.5%)	1 (0.5%)	105 (96.3%)	4 (3.7%)		**309** (100.0%)
White	3,167 (96.7%)	108 (3.3%)		4,019 (98.4%)	64 (1.6%)		**7,358** (100.0%)
All races	**6,208** (87.9%)	**362** (5.1%)	**496** (7.0%)	**8,301** (82.4%)	**245** (2.4%)	**1,525** (15.1%)	**17,137** (100.0%)
Hispanic (any race)	683 (93.7%)	32 (4.4%)	14 (1.9%)	922 (92.6%)	19 (1.9%)	55 (5.5%)	**1,725** (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 them, their family, and providers to develop a comprehensive out-of-home placement plan (OHPP). This is the case plan that drives services that child/ren and families receive; it outlines all specific provisions that must be met for child/ren to safely return home. There are often safety requirements that families must meet or exceed for children 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 with court involvement, OHPPs receive court approval and reviewed every 90 days while child/ren remain in care to ensure that adequate and appropriate services are 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:

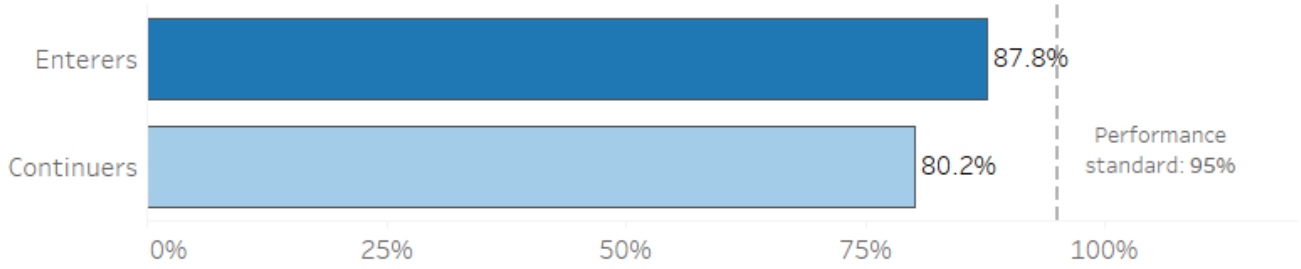
- Support for Emancipation and Living Functionally (SELF) program: Helps youth working with a county or tribal caseworker prepare for successful transition to adulthood, including independent living skills training, housing, transportation, permanent connections, education, and employment services for 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 colleges, universities, 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, who currently or previously, experienced 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 children's safety, stability of placement, progress on services provided, and well-being while in care. Children are often seen more frequently than monthly, depending on the needs of a child, family, or placement provider.

- Of enterers in 2018, for the months where face-to-face visits were required, caseworkers saw children monthly 87.8% of the time; for continuers, these visits dropped to 80.2% (see Figure 11).
- Work continues on improving the frequency with which children are seen by examining barriers to monthly caseworker visits. This rate has steadily increased from 84.8% for enterers and 74.1% for continuers in 2015.

Figure 11: Percent of months in which children received a required monthly caseworker visit (enterers vs. continuers) in 2018



Note: Caseworker visit calculations include only children under age 18.

Placement experiences

Once a child has been removed from their home or prior to removal, whenever possible, child welfare agencies work on locating a safe and stable placement. A variety of out-of-home care settings 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 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 individuals with whom a child may have had significant contact. [see Minn. Stat., 260C.212, subd. 2 (a)] 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.

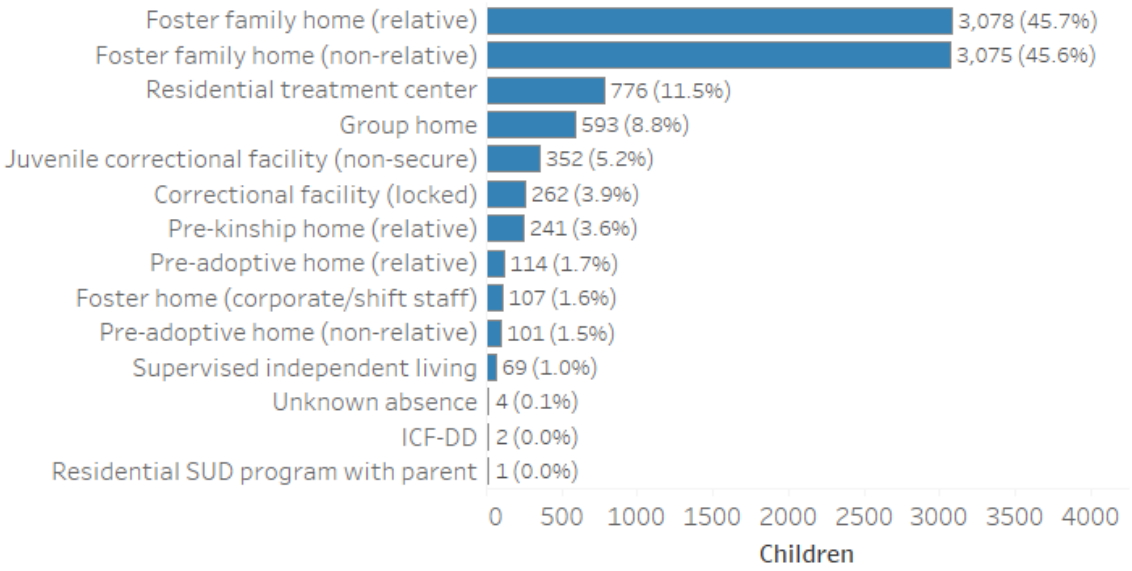
Table 2: Number and percent of foster care homes where at least one caregiver identifies as a specified race/ethnicity in 2018

	Number	Percent
African American / black	1,310	14.8%
American Indian	1,101	12.5%
Asian / Pacific Islander	151	1.7%
Two or more races	484	5.5%
Unknown / declined	393	4.4%
White	6,125	69.3%
Hispanic (any race)	452	5.1%

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 6,741 children who entered care in 2018, more than three-quarters (80.4%) spent some time in either a relative or non-relative foster home setting. About one-third of all children in care (34.1%) spent at least some time in relative family foster care, a decrease of 11.6% from 2017. (Children can spend time in multiple location settings during an episode of out-of-home care, 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 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 2018



Note: This graph shows only children who entered out-of-home care in 2018. ICF-DD stands for intermediate care facilities for persons with developmental disabilities. Residential substance use disorder (SUD) program with parent is a new category added in 2018.

Sidebar: Relative placements

What specific relationships do children have with their relatives when in a relative placement? Below is a breakdown of the percent of placements with relatives, by relative type and child race.

	African American / black	American Indian	Asian / Pacific Islander	Two or more races	Unknown / declined	White	Hispanic (any race)
Grandparent	36%	37%	28%	41%	45%	47%	35%
Aunt/uncle	26%	24%	52%	22%	26%	24%	29%
Other relative	29%	21%	18%	25%	22%	22%	23%
Unknown	0%	0%	0%	0%	0%	0%	6%
Extended family (tribal or ethnic)	8%	17%	3%	12%	7%	7%	10%
Other non-relative	0%	1%		1%	1%	1%	1%
Step-parent	1%	0%		0%		0%	
Former foster parent		0%					

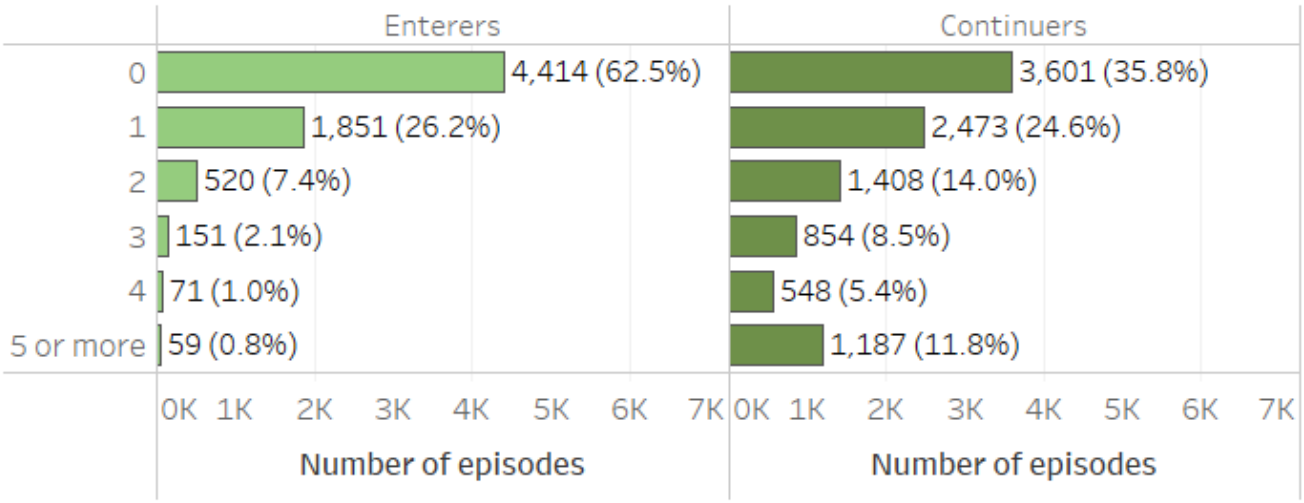
Placement moves

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 child safety, 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 2018 (both enterers and continuers), the majority of placement episodes had between zero and three moves (89.2%). Children who were in care for longer time periods experience more moves. See Figure 13.

The majority of children who entered care in 2018 only experienced one placement location (62.5%). Continuers most commonly experienced one placement location (35.8%).

Figure 13: Number of total moves children experienced while in a placement episode (through 2018)



Leaving out-of-home care

This section focuses on children who left out-of-home care in 2018. The designation of exiters is used for children who were in out-of-home placement and exited during 2018.

Length of time in care

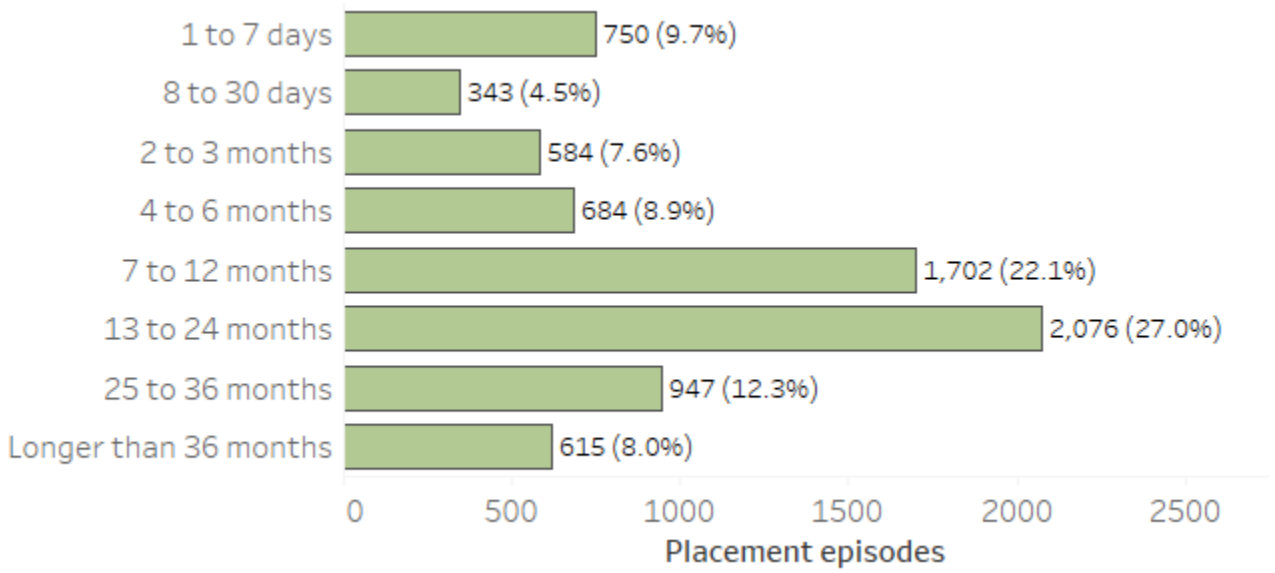
There were 7,518 unique children in 7,701 placement episodes that ended in 2018 (e.g., some children experienced more than one placement episode that ended during the year). Some children were in care for only a few days while others were in care for multiple years. Approximately 30.7% of placements were 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 are discharged 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 1,154 children/youth who experienced extended foster care during 2018. The most common criteria were: Completing high school/GED (54.1%), employed at least 80 hours per month (29.7%), and enrolled in post-secondary or vocational education (21.8%).

Figure 14: Length of stay for placement episodes ending in 2018

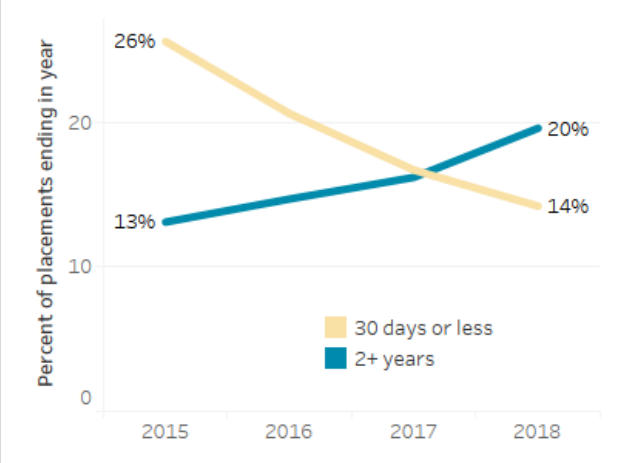


- Length of time in care also varies by race and ethnicity. Table 3 shows the number and percentage of placement episodes by length of stay, race and ethnicity.
- American Indian children have high proportions who stay in care for two years or longer compared to other racial and ethnic groups.

Table 3: Number and percent of placement episodes ending in 2018 by length of time in care and race/ethnicity

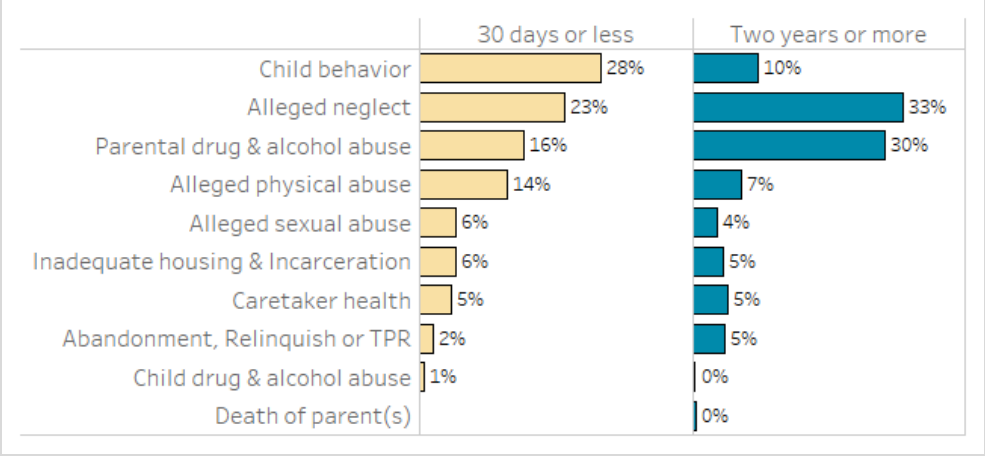
	African American / black	American Indian	Asian / Pacific Islander	Two or more races	Unknown / declined	White	All races	Hispanic (any race)
1 to 7 days	196 (15.0%)	47 (3.6%)	33 (16.5%)	107 (8.8%)	37 (24.0%)	330 (9.4%)	**750** (9.7%)	73 (10.0%)
8 to 30 days	78 (6.0%)	32 (2.5%)	12 (6.0%)	63 (5.2%)	10 (6.5%)	148 (4.2%)	**343** (4.5%)	34 (4.6%)
2 to 3 months	95 (7.3%)	67 (5.2%)	16 (8.0%)	102 (8.4%)	18 (11.7%)	286 (8.1%)	**584** (7.6%)	66 (9.0%)
4 to 6 months	113 (8.6%)	88 (6.8%)	4 (2.0%)	136 (11.2%)	17 (11.0%)	326 (9.2%)	**684** (8.9%)	73 (10.0%)
7 to 12 months	290 (22.2%)	280 (21.6%)	40 (20.0%)	232 (19.0%)	26 (16.9%)	834 (23.7%)	**1,702** (22.1%)	157 (21.4%)
13 to 24 months	269 (20.6%)	395 (30.5%)	49 (24.5%)	321 (26.4%)	32 (20.8%)	1,010 (28.7%)	**2,076** (27.0%)	186 (25.4%)
25 to 36 months	155 (11.9%)	197 (15.2%)	28 (14.0%)	152 (12.5%)	12 (7.8%)	403 (11.4%)	**947** (12.3%)	97 (13.3%)
Longer than 36 months	112 (8.6%)	190 (14.7%)	18 (9.0%)	105 (8.6%)	2 (1.3%)	188 (5.3%)	**615** (8.0%)	46 (6.3%)
Total	**1,308** (100.0%)	**1,296** (100.0%)	**200** (100.0%)	**1,218** (100.0%)	**154** (100.0%)	**3,525** (100.0%)	**7,701** (100.0%)	**732** (100.0%)

Sidebar: Short- and long-term placements

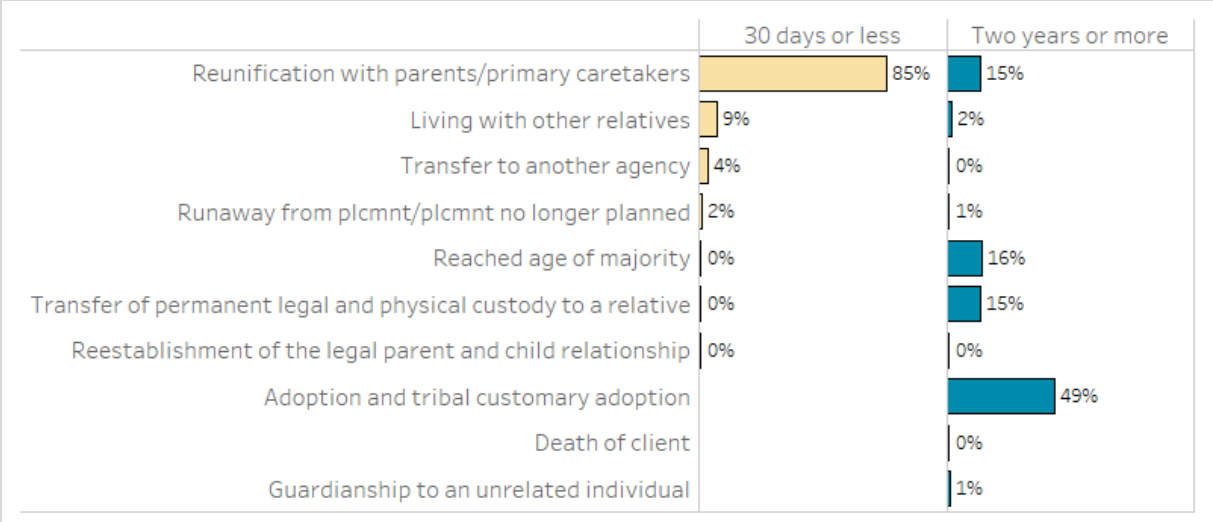


Discharges from care in recent years have shown an increase in the percentage of placements that are two years or longer, and a decrease in those 30 days or less (left). Children in care for less than 30 days are far more likely to enter care as a result of child behavior and alleged physical abuse than are children in care for two or more years; 85% in care for less than 30 days are discharged to reunification with their caregivers, while only 15% in care for two or more years are discharged to reunification.

Percent of placements ending in 2018 lasting 30 days or less vs. two or more years, by removal reason



Percent of placements ending in 2018 lasting 30 days or less vs. two or more years, by discharge reason

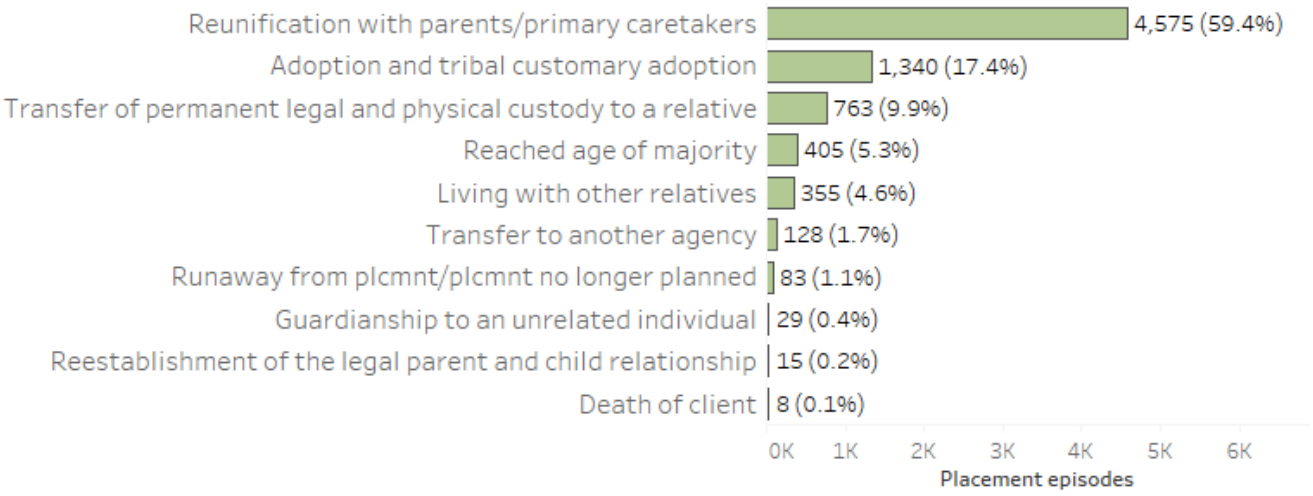


Reasons for leaving out-of-home care

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

- For placement episodes that ended in 2018 (see Figure 15), 59.4% ended because children were able to safely return home to their parents or other primary caregivers, a decrease of 4.7% from 2017.
- The proportion of placement episodes ending with children being adopted, living with relatives (including a non-custodial father), or transfer of permanent legal and physical custody to a relative increased by 5.1%, from 26.8% to 31.9%.
- A small proportion of placements ended because children turned 18, ran away, or transferred to a different agency, such as a correctional facility.
- Eight cases with continuous placement episodes ended because children died while in care. Six instances were due to accidental, natural, or undetermined causes, and two were 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, 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 2018

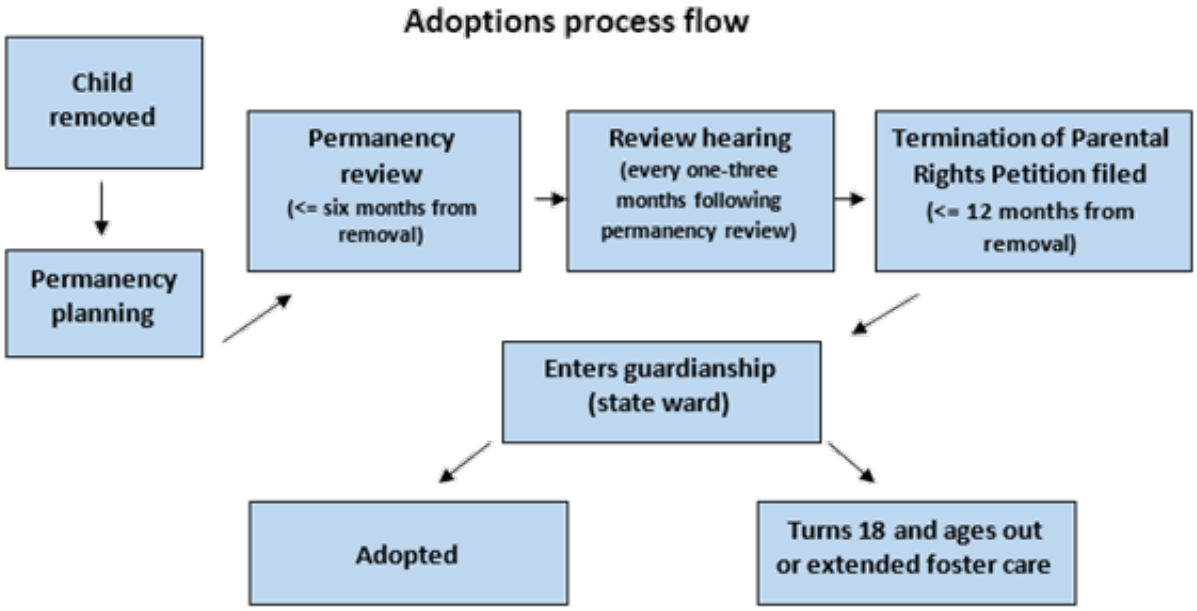


Adoptions

Some children exited out-of-home care in 2018 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 them; 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 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 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 these parents, courts, and others to facilitate the adoption process. This process may be lengthy. Children may remain under guardianship of the commissioner for months or 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.

[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.



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 2018 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 2018 and remained under state guardianship into 2018. During 2018, there were 3,086 children who spent at least one day under guardianship of the commissioner, an 8% increase from 2017. There were 1,253 children who entered guardianship and 1,833 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 2018. White children remain the largest group, both entering and continuing in guardianship in 2018 (see Figure 16). Although white children comprised the greatest number 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 2018

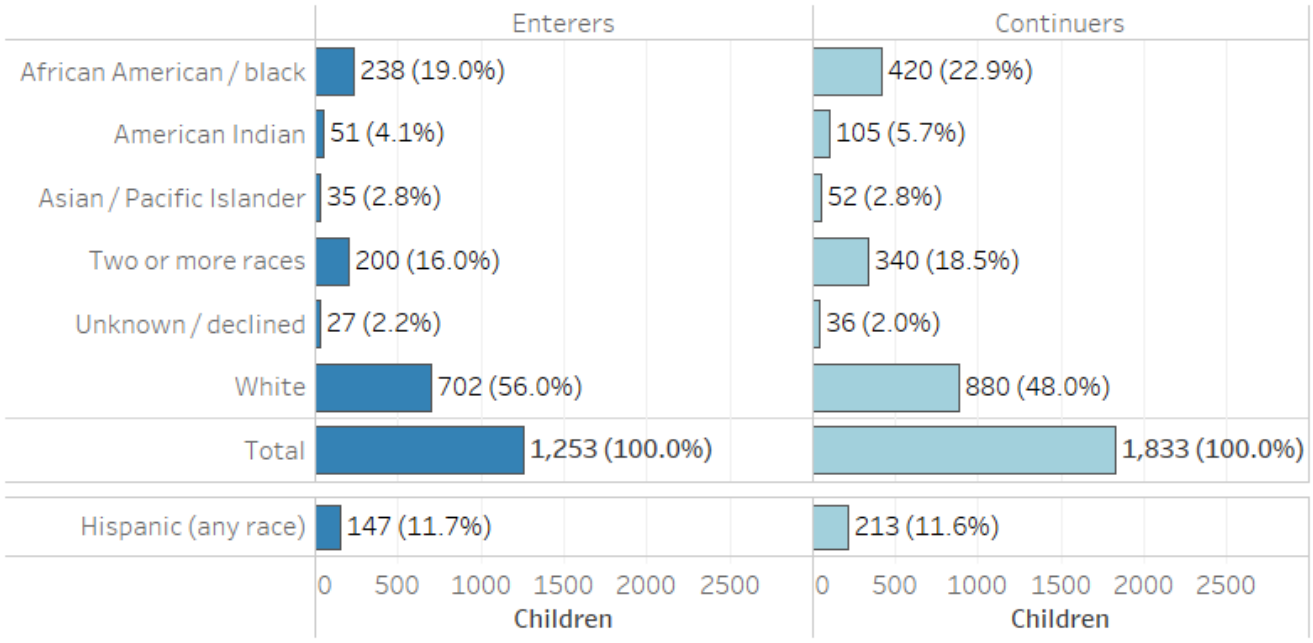


Figure 17: Rate per 1,000 for children under guardianship in 2018

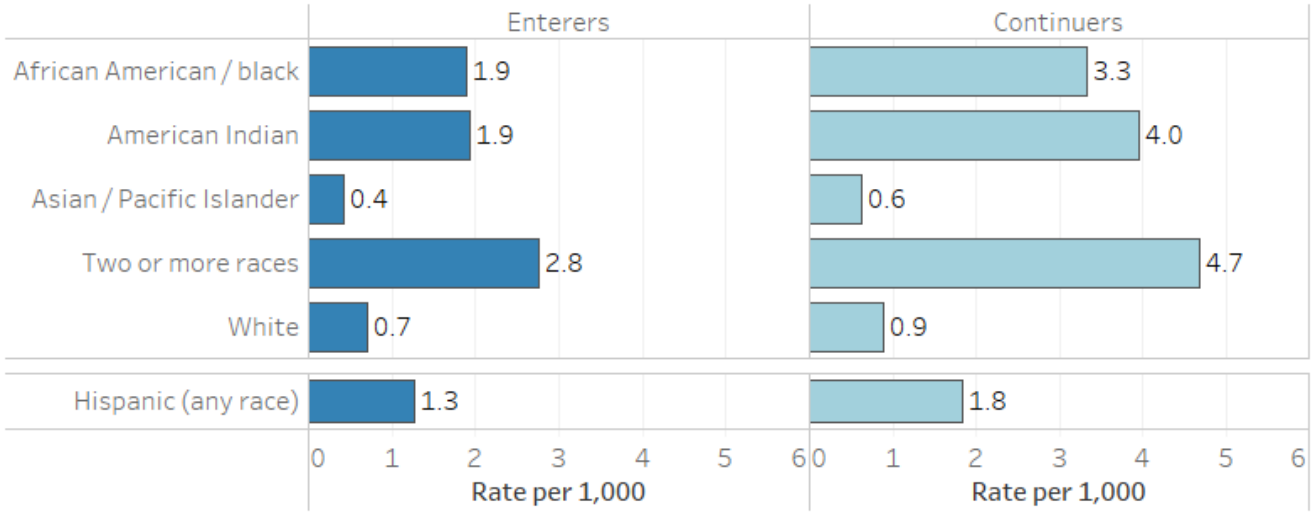
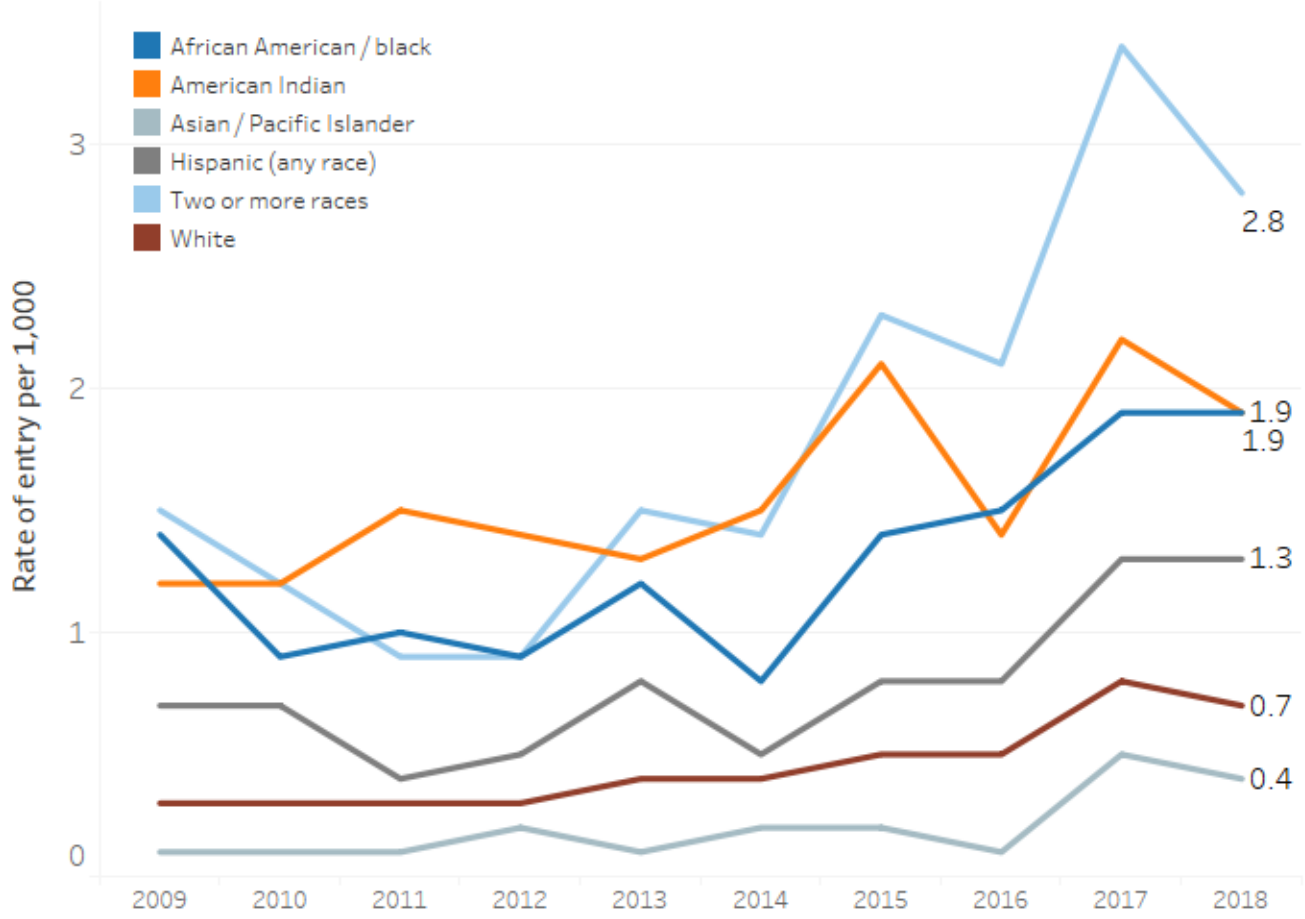
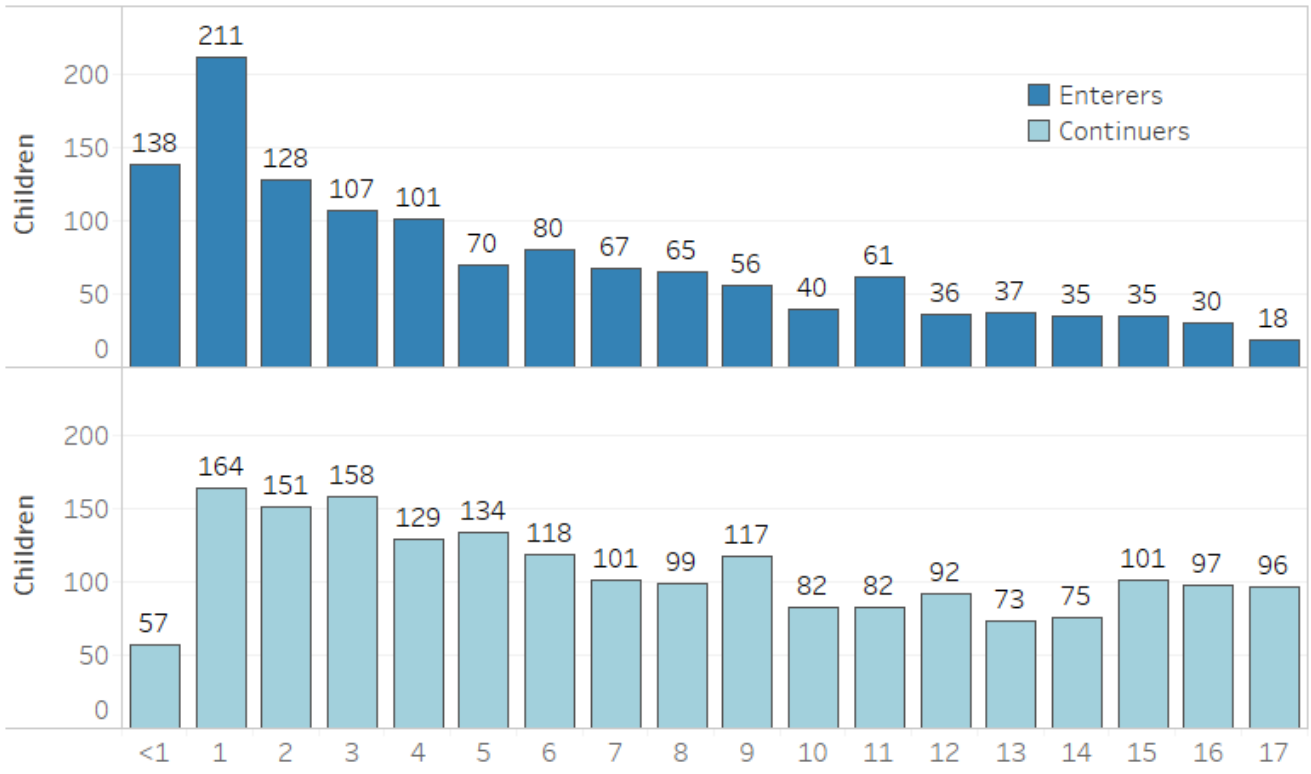


Figure 18: Rate per 1,000 of children entering guardianship by race/ethnicity, 2009 – 2018



- Figure 19 shows the distribution of children entering and continuing guardianship by age
- Children entering guardianship tended to be younger, with a little over 50% age 4 or younger
- Children continuing under guardianship were more evenly distributed across age groups, although approximately 34.6% were also age 4 or younger.

Figure 19. Number of children by age experiencing state guardianship in 2018

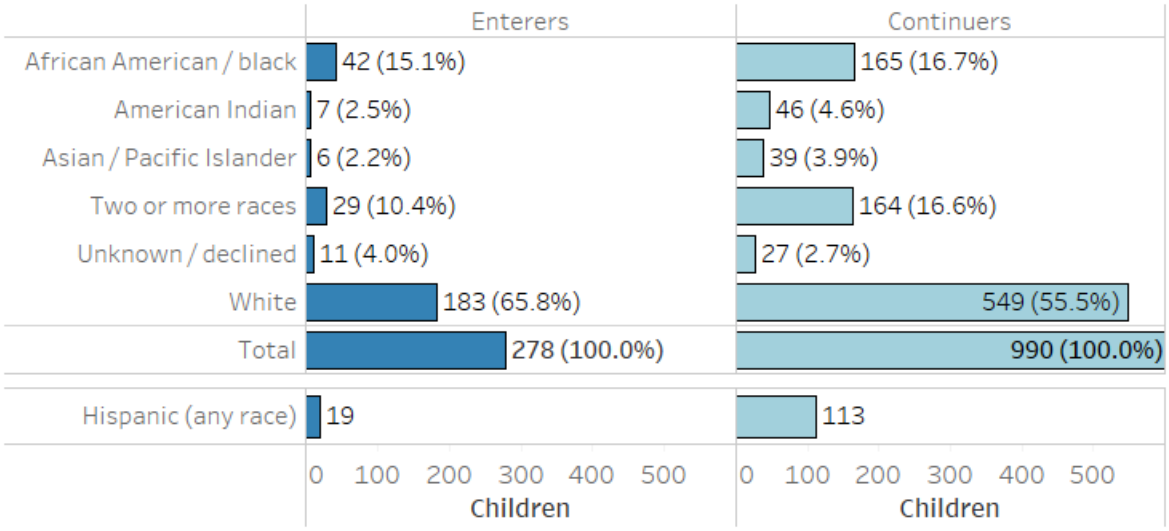


Characteristics of children who were adopted

The following section provides information on the characteristics of children who had been state wards in 2018 and had finalized adoptions during the year. The number adopted included:

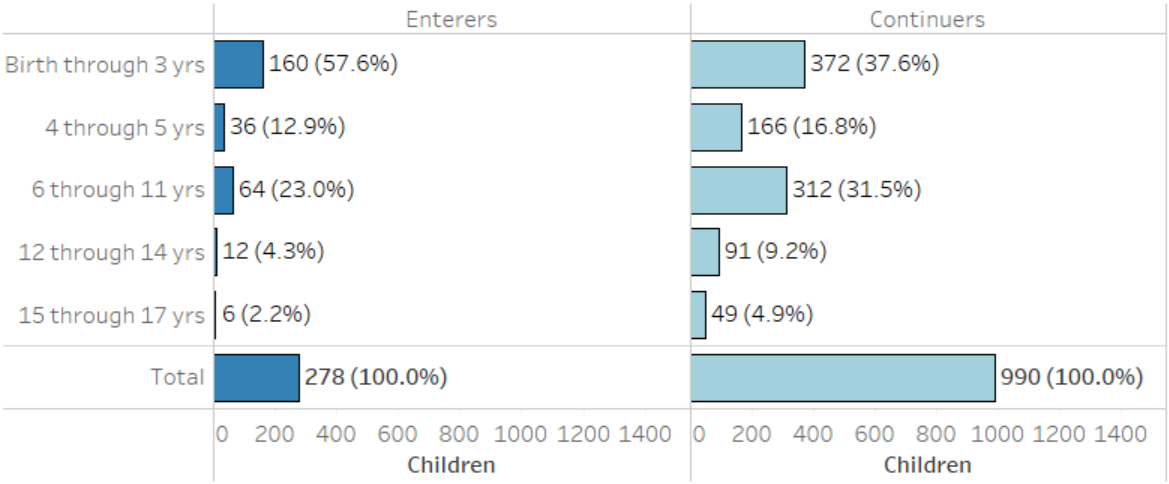
- During 2018, 1,268 children had finalized adoptions, a 28.1% increase from 2017. Of these, 278 became state wards during the same year, and 990 were state wards prior to the beginning of 2018.
- In total, approximately 41.5% of all children under state guardianship in 2018 were adopted.
- White children comprised the largest proportion who were adopted. The racial and ethnic breakdown of all children adopted during 2018 is shown in Figure 20.

Figure 20. Number and percent of children adopted by race/ethnicity in 2018



- Children birth to age 5 comprise the largest proportion of adopted children. This pattern is more pronounced for children who entered guardianship in 2018 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 2018



- As displayed in the next two graphs (Figures 22 and 23), the number of children adopted in all age categories increased in 2018 from 2017. White children continue to comprise the largest group of adopted children; the number adopted increased for all races.

Figure 22. Number of children adopted by age group, 2010 – 2018

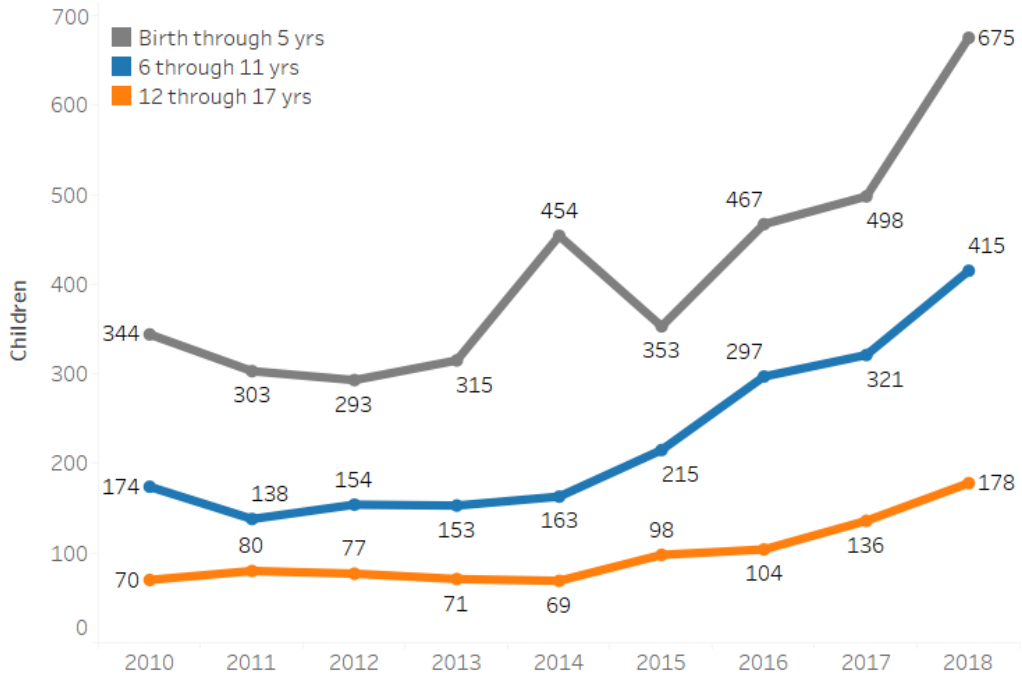
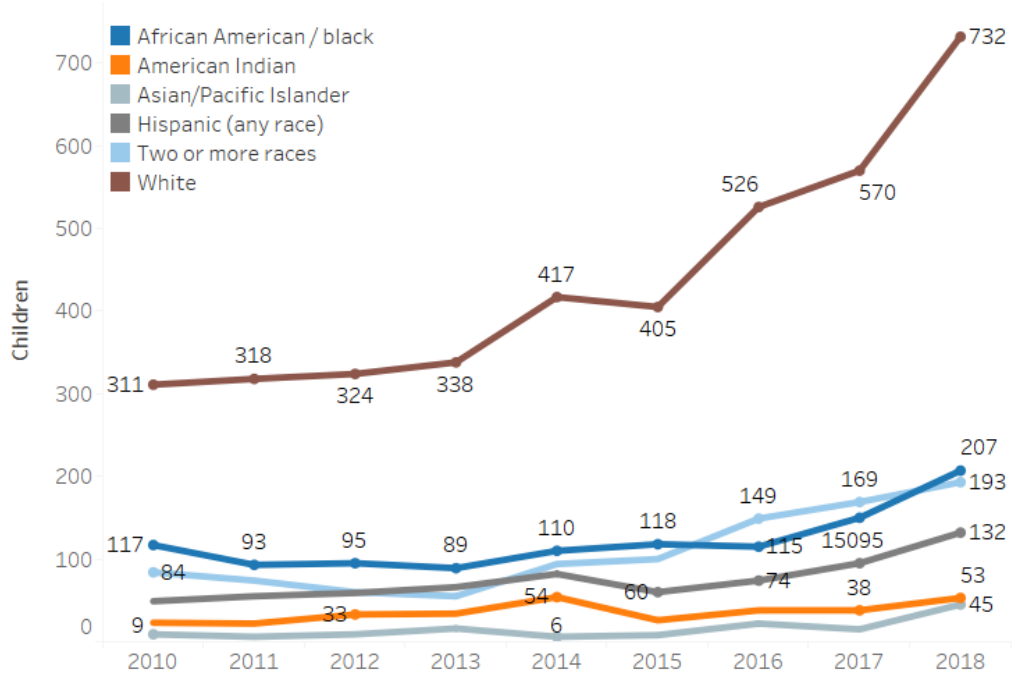


Figure 23. Number of children adopted by race/ethnicity, 2010 – 2018



Children who aged out of guardianship

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

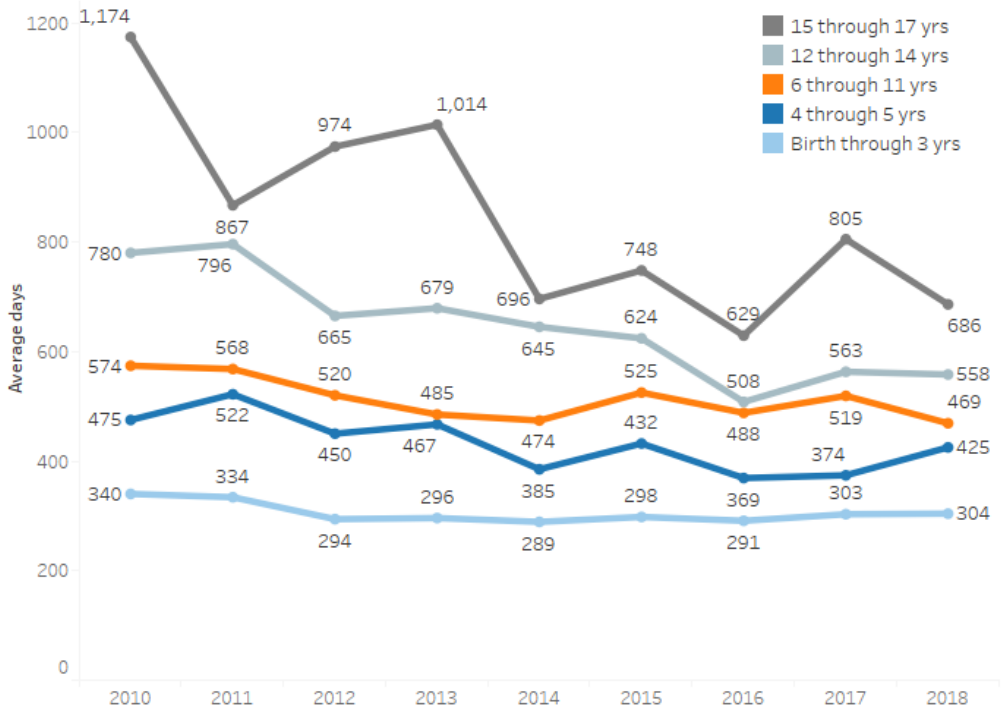
- During 2018, 87 youth who were state wards aged out before being adopted
- Of those who aged out, 28 (32.2%) continued in care after turning 18 through the extended foster care program.

Time to adoption

The average time from entering state guardianship to adoption has improved over the past eight years. Figure 24 shows how long it takes from the date of entering state guardianship to adoption for children who were adopted between 2010 and 2018. The data shows:

- Younger children are typically adopted faster than older children, with those birth - 3 remaining in care for 304 days, on average
- The timeline for children ages 15 - 17 decreased by an average of 119 days in 2018 compared with their length of time in guardianship in 2017
- Older age groups (6 - 17) saw a decrease in time to adoption, while younger age groups (birth - 5) saw an increase.

Figure 24. Days from entering guardianship to adoption by age, 2010 – 2018



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 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 2010–2018. The data shows:

- In 2018, 64.3% of sibling groups were adopted together
- About 78% of sibling groups were adopted either partially or fully intact in 2018.

Table 4. Sibling group preservation in adoptions, 2010 – 2018

	2010	2011	2012	2013	2014	2015	2016	2017	2018
Sibling groups available for adoption with at least one child adopted	153	133	135	135	184	169	237	234	345
Sibling groups adopted fully intact	111	90	97	97	130	118	172	154	222
Sibling groups adopted partially intact	18	14	13	16	22	23	27	36	46
Percent of sibling groups adopted fully intact	72.5%	67.7%	71.9%	71.9%	70.7%	69.8%	72.6%	65.8%	64.3%
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%	77.7%

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

[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. Siblings who are age 18 or older and 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.

jurisdiction and adopted through customary adoption from 2010 – 2018 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 - 2018

	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
2018	24	37.5%	40	62.5%	64

Post placement services and outcomes

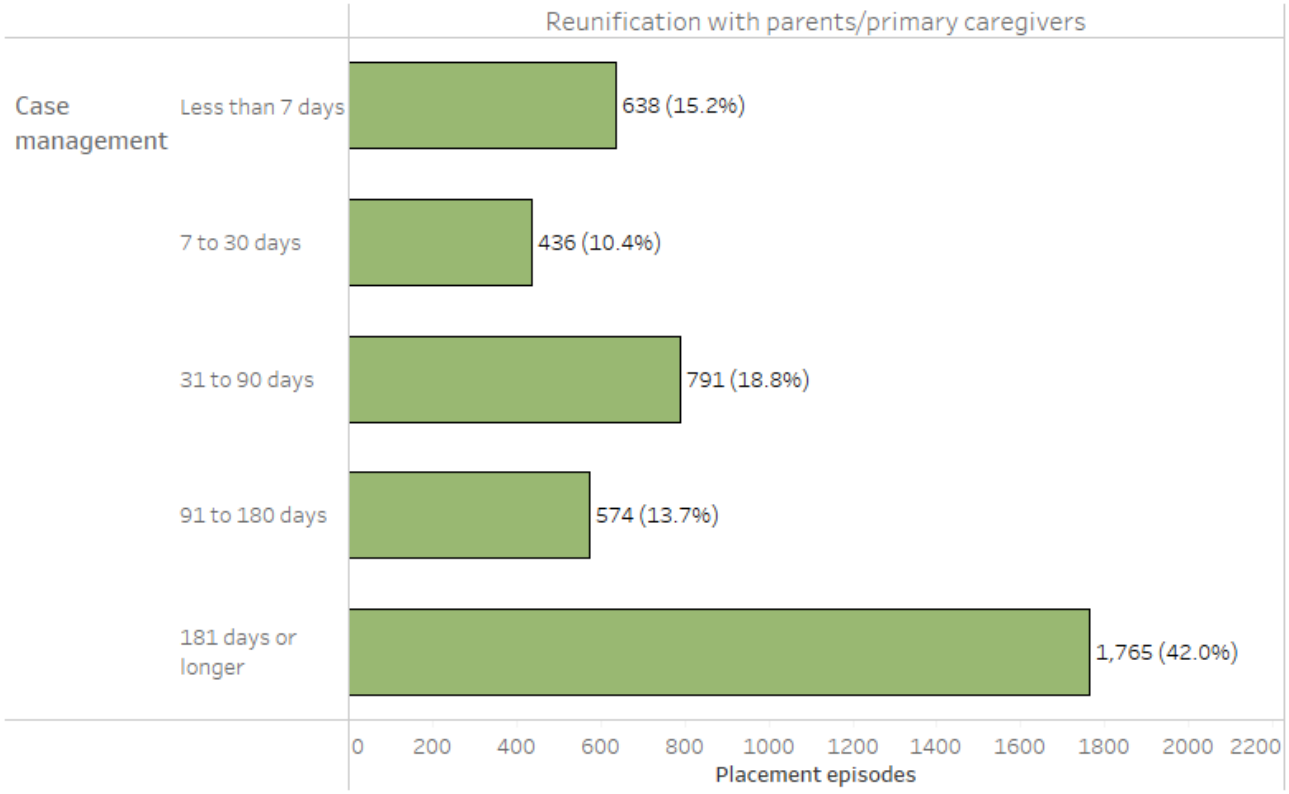
After achieving permanency, either through reunification, adoption, or transfer of permanent legal and physical custody to a relative, a local social services agency or the department may provide services to support families. Some children who achieved permanency may continue to have challenges and re-enter 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% of episodes remained open for three months or more after a child was reunified
- Figure 25 shows episodes that ended with reunification and ongoing case management.

Figure 25. Number and percent of episodes that closed to reunification where ongoing services were provided by length of time in 2018



Adoption and kinship assistance

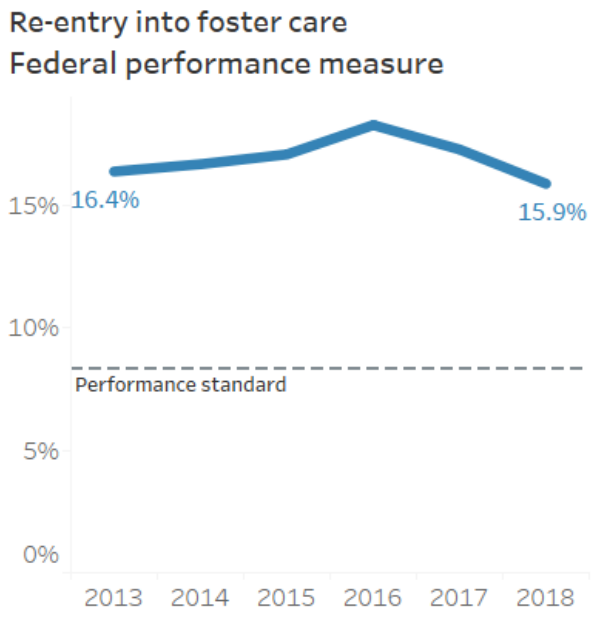
A child and family may receive ongoing support in the form of adoption assistance, available to many adoptive families, or kinship assistance if they meet eligibility criteria. For information on eligibility criteria and the process, see Northstar Adoption Assistance Program. While adoption assistance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

- There were 8,497 children who received payments for adoption assistance in 2018
- Of the 8,497 children, 1,050 were adopted or had a customary tribal adoption finalized in 2018
- There were 3,025 children who received payments from Northstar kinship assistance in 2018.

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 has decreased by 1.7% from 2017, but remains much higher than the federal performance standard of 8.3%.

Figure 26. Re-entry into foster care in 2018



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, 2018

Agency	Under 18 (female)	Under 18 (male)	18 or older (female)	18 or older (male)	Total children / young adults	2017 child population estimate	Child rate per 1,000
Aitkin	16	26	0	0	42	2,654	15.8
Anoka	244	248	7	12	511	84,276	5.8
Becker	91	88	6	1	186	8,350	21.4
Beltrami	529	548	11	7	1095	11,777	91.4
Benton	59	62	3	0	124	10,159	11.9
Big Stone	9	3	0	0	12	1,056	11.4
Blue Earth	80	82	0	0	162	13,265	12.2
Brown	27	40	1	0	68	5,567	12.0
Carlton	79	85	2	1	167	8,017	20.5
Carver	82	72	12	6	172	27,643	5.6
Cass	58	49	2	1	110	6,297	17.0
Chippewa	8	8	0	0	16	2,832	5.6
Chisago	66	78	1	1	146	12,745	11.3
Clay	103	132	5	3	243	15,517	15.1
Clearwater	9	20	0	2	31	2,200	13.2
Cook	9	15	0	1	25	858	28.0
Crow Wing	142	142	1	4	289	14,059	20.2
Dakota	246	270	4	5	525	103,532	5.0
Des Moines Valley HHS	38	59	1	0	98	4,899	19.8
Douglas	44	40	2	0	86	8,045	10.4
Faribault-Martin	68	66	3	1	138	7,344	18.2
Fillmore	9	12	0	1	22	5,127	4.1
Freeborn	49	58	2	0	109	6,701	16.0
Goodhue	49	58	4	0	111	10,379	10.3
Grant	6	10	0	0	16	1,351	11.8
Hennepin	1405	1542	86	74	3107	275,532	10.7
Houston	15	24	0	1	40	4,052	9.6

Agency	Under 18 (female)	Under 18 (male)	18 or older (female)	18 or older (male)	Total children / young adults	2017 child population estimate	Child rate per 1,000
Hubbard	37	43	1	2	83	4,415	18.1
Isanti	45	61	1	3	110	9,428	11.2
Itasca	130	138	5	12	285	9,446	28.4
Kanabec	20	23	2	3	48	3,424	12.6
Kandiyohi	59	60	3	2	124	10,417	11.4
Kittson	7	6	1	1	15	887	14.7
Koochiching	27	41	1	2	71	2,313	29.4
Lac qui Parle	4	2	1	0	7	1,337	4.5
Lake	16	18	0	1	35	1,931	17.6
Lake of the Woods	3	3	0	0	6	691	8.7
Le Sueur	36	23	1	1	61	6,737	8.8
Leech Lake Band of Ojibwe[†]	142	149	3	0	294	1,975	147.3
Mahnomen	8	11	2	1	22	1,771	10.7
Marshall	11	7	1	0	19	2,137	8.4
McLeod	66	61	3	1	131	8,355	15.2
Meeker	22	22	0	2	46	5,655	7.8
Mille Lacs	103	133	4	1	241	6,276	37.6
MN Prairie	119	102	0	1	222	19,176	11.5
Morrison	55	49	0	1	105	7,790	13.4
Mower	42	43	0	2	87	9,848	8.6
Nicollet	46	38	4	1	89	7,487	11.2
Nobles	28	34	4	0	66	5,850	10.6
Norman	9	8	1	0	18	1,565	10.9
Olmsted	77	104	8	5	194	37,946	4.8
Otter Tail	88	119	1	0	208	12,741	16.2
Pennington	20	29	0	0	49	3,264	15.0
Pine	73	70	1	1	145	5,815	24.6
Polk	45	41	0	2	88	7,653	11.2
Pope	11	11	0	3	25	2,306	9.5

Agency	Under 18 (female)	Under 18 (male)	18 or older (female)	18 or older (male)	Total children / young adults	2017 child population estimate	Child rate per 1,000
Ramsey	816	849	43	43	1751	127,779	13.0
Red Lake	6	3	0	0	9	991	9.1
Renville	18	28	0	0	46	3,377	13.6
Rice	96	95	2	4	197	14,414	13.3
Roseau	13	9	1	0	23	3,728	5.9
Scott	111	61	2	2	176	40,626	4.2
Sherburne	62	78	2	0	142	25,132	5.6
Sibley	25	20	0	1	46	3,566	12.6
Southwest HHS	143	131	4	7	285	18,148	15.1
St. Louis	588	621	23	21	1253	38,171	31.7
Stearns	218	207	4	5	434	36,346	11.7
Stevens	14	14	1	0	29	1,985	14.1
Swift	31	30	0	1	62	2,137	28.5
Todd	45	48	0	4	97	5,836	15.9
Traverse	9	11	0	1	21	682	29.3
Wabasha	19	25	1	2	47	4,724	9.3
Wadena	46	57	0	1	104	3,451	29.8
Washington	100	141	12	7	260	63,271	3.8
Watonwan	13	18	2	1	34	2,633	11.8
White Earth Nation†	231	235	1	3	470	1,981	235.2
Wilkin	4	16	0	1	21	1,436	13.9
Winona	87	74	3	0	164	9,231	17.4
Wright	115	113	2	3	233	37,776	6.0
Yellow Medicine	17	22	0	0	39	2,322	16.8
Minnesota	**7,716**	**8,192**	**304**	**276**	**16,488**	**1,302,613**	**12.7**

†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, 2018, or on the day an out-of-home care placement episode began in 2018 for all others.

Table 7. Number of children in out-of-home care by age and agency, 2018

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	11	3	4	10	5	9	0	42
Anoka	121	84	70	69	67	81	19	511
Becker	59	32	26	25	11	26	7	186
Beltrami	247	223	171	173	138	125	18	1,095
Benton	29	23	15	15	22	17	3	124
Big Stone	2	2	0	0	2	6	0	12
Blue Earth	44	34	25	21	27	11	0	162
Brown	17	16	7	12	5	10	1	68
Carlton	34	21	26	22	31	30	3	167
Carver	21	24	24	20	25	40	18	172
Cass	29	12	12	10	15	29	3	110
Chippewa	7	3	2	2	1	1	0	16
Chisago	39	26	23	20	20	16	2	146
Clay	37	27	26	26	44	75	8	243
Clearwater	4	6	5	2	7	5	2	31
Cook	2	5	4	4	5	4	1	25
Crow Wing	78	54	42	32	47	31	5	289
Dakota	150	88	72	70	62	74	9	525
Des Moines Valley HHS	17	14	14	13	20	19	1	98
Douglas	20	19	10	8	14	13	2	86
Faribault-Martin	28	27	17	19	21	22	4	138
Fillmore	3	2	1	2	2	11	1	22
Freeborn	28	24	16	7	14	18	2	109
Goodhue	26	16	15	8	18	24	4	111
Grant	8	3	0	2	2	1	0	16
Hennepin	816	483	363	378	383	524	160	3,107
Houston	11	9	8	0	7	4	1	40
Hubbard	16	17	9	8	14	16	3	83

Agency	Birth - 2 years	3 - 5 years	6 - 8 years	9 - 11 years	12 - 14 years	15 - 17 years	18 or older	Total children
Isanti	16	15	14	18	16	27	4	110
Itasca	53	46	31	27	47	64	17	285
Kanabec	10	4	4	6	7	12	5	48
Kandiyohi	21	19	14	12	27	26	5	124
Kittson	3	0	3	2	1	4	2	15
Koochiching	8	13	14	12	11	10	3	71
Lac qui Parle	3	0	0	0	0	3	1	7
Lake	5	3	4	8	7	7	1	35
Lake of the Woods	0	0	2	1	1	2	0	6
Le Sueur	9	12	9	8	5	16	2	61
Leech Lake Band of Ojibwe	61	78	56	47	29	20	3	294
Mahnomen	6	1	3	0	0	9	3	22
Marshall	4	2	2	1	1	8	1	19
McLeod	29	27	14	16	20	21	4	131
Meeker	11	1	3	8	11	10	2	46
Mille Lacs	64	43	34	27	34	34	5	241
MN Prairie	47	39	40	36	19	40	1	222
Morrison	23	22	8	12	17	22	1	105
Mower	30	10	12	11	14	8	2	87
Nicollet	22	10	13	12	14	13	5	89
Nobles	9	8	9	7	17	12	4	66
Norman	7	0	4	1	3	2	1	18
Olmsted	53	20	19	16	22	51	13	194
Otter Tail	54	36	35	25	29	28	1	208
Pennington	15	6	12	7	4	5	0	49
Pine	40	28	18	16	25	16	2	145
Polk	15	11	9	11	18	22	2	88
Pope	2	8	2	4	3	3	3	25
Ramsey	419	249	222	195	231	349	86	1,751

Agency	Birth - 2 years	3 - 5 years	6 - 8 years	9 - 11 years	12 - 14 years	15 - 17 years	18 or older	Total children
Red Lake	1	3	3	0	1	1	0	9
Renville	8	8	4	6	11	9	0	46
Rice	54	29	27	27	24	30	6	197
Roseau	4	5	1	4	4	4	1	23
Scott	51	30	22	16	22	31	4	176
Sherburne	35	20	18	16	20	31	2	142
Sibley	8	14	9	6	3	5	1	46
Southwest HHS	59	50	39	44	40	42	11	285
St. Louis	307	220	181	170	177	154	44	1,253
Stearns	93	74	68	50	55	85	9	434
Stevens	6	6	5	2	5	4	1	29
Swift	16	10	12	7	7	9	1	62
Todd	21	20	16	23	7	6	4	97
Traverse	4	3	3	0	3	7	1	21
Wabasha	7	10	5	6	4	12	3	47
Wadena	24	17	16	16	13	17	1	104
Washington	42	29	28	29	41	72	19	260
Watonwan	10	4	3	3	2	9	3	34
White Earth Nation	127	89	77	51	55	67	4	470
Wilkin	3	2	2	1	1	11	1	21
Winona	35	29	25	18	24	30	3	164
Wright	51	34	32	33	27	51	5	233
Yellow Medicine	8	8	5	6	6	6	0	39
Minnesota	**3,917**	**2,722**	**2,218**	**2,058**	**2,214**	**2,779**	**580**	**16,488**

Table 8. Number of children in out-of-home care by race, ethnicity and by agency, 2018

Agency	African American/ black	American Indian	Asian or Pacific Islander	Two or more races	Unknown/ declined	White	Grand total	Hispanic (any race)
Aitkin	*	11	*	8	*	22	42	*
Anoka	73	25	*	92	*	302	511	49
Becker	*	59	*	46	*	76	186	15
Beltrami	*	972	*	38	*	73	1,095	24
Benton	24	*	*	25	*	70	124	*
Big Stone	*	*	*	*	*	11	12	*
Blue Earth	21	8	*	22	*	99	162	10
Brown	*	*	*	*	*	59	68	9
Carlton	*	76	*	33	*	58	167	*
Carver	20	*	*	32	*	107	172	21
Cass	*	32	*	*	*	70	110	*
Chippewa	*	*	*	*	*	13	16	*
Chisago	*	*	*	22	*	111	146	9
Clay	20	46	*	58	*	118	243	44
Clearwater	*	15	*	*	*	10	31	*
Cook	*	*	*	*	*	15	25	*
Crow Wing	15	28	*	20	*	223	289	*
Dakota	87	15	9	128	*	251	525	90
Des Moines Valley HHS	*	*	*	*	*	77	98	14
Douglas	*	*	*	20	*	53	86	*
Faribault-Martin	*	*	*	13	*	119	138	14
Fillmore	*	*	*	*	*	20	22	*
Freeborn	*	*	*	13	*	89	109	19
Goodhue	7	*	*	10	*	83	111	15
Grant	*	*	*	*	*	13	16	*
Hennepin	1,258	410	90	743	*	560	3,107	401
Houston	*	*	*	*	*	32	40	7

Agency	African American/ black	American Indian	Asian or Pacific Islander	Two or more races	Unknown/ declined	White	Grand total	Hispanic (any race)
Hubbard	*	19	*	16	*	48	83	8
Isanti	*	*	*	12	*	89	110	*
Itasca	*	37	*	37	*	204	285	*
Kanabec	*	*	*	8	*	39	48	*
Kandiyohi	7	*	*	8	*	104	124	62
Kittson	*	*	*	*	*	11	15	*
Koochiching	*	*	*	7	*	57	71	*
Lac qui Parle	*	*	*	*	*	*	7	*
Lake	*	*	*	*	*	26	35	*
Lake of the Woods	*	*	*	*	*	*	*	*
Le Sueur	*	*	*	10	*	47	61	13
Leech Lake Band of Ojibwe	*	286	*	8	*	*	294	9
Mahnomen	*	14	*	*	*	*	22	*
Marshall	*	*	*	*	*	15	19	*
McLeod	*	*	*	17	*	108	131	22
Meeker	*	*	*	*	*	37	46	*
Mille Lacs	*	179	*	16	*	41	241	11
MN Prairie	22	*	*	19	*	179	222	33
Morrison	*	*	*	19	*	85	105	*
Mower	17	*	9	16	*	44	87	11
Nicollet	14	*	*	18	*	55	89	21
Nobles	*	*	*	*	*	44	66	17
Norman	*	*	*	*	*	15	18	*
Olmsted	29	*	*	43	*	117	194	17
Otter Tail	10	9	*	11	*	168	208	14
Pennington	*	*	*	*	*	43	49	17
Pine	*	61	*	15	*	67	145	*
Polk	*	*	*	11	*	71	88	29
Pope	*	*	*	*	*	16	25	*

Agency	African American/ black	American Indian	Asian or Pacific Islander	Two or more races	Unknown/ declined	White	Grand total	Hispanic (any race)
Ramsey	650	131	182	337	*	433	1,751	199
Red Lake	*	*	*	*	*	7	9	*
Renville	*	8	*	*	*	34	46	14
Rice	26	*	*	19	*	135	197	38
Roseau	*	*	*	*	*	13	23	*
Scott	11	11	7	37	*	100	176	26
Sherburne	9	*	*	38	*	79	142	*
Sibley	*	*	*	7	*	39	46	15
Southwest HHS	*	54	*	55	*	162	285	50
St. Louis	122	333	*	224	*	555	1,253	52
Stearns	69	12	*	69	*	276	434	37
Stevens	*	*	*	*	*	24	29	*
Swift	16	*	*	9	*	35	62	22
Todd	*	*	*	19	*	76	97	*
Traverse	*	8	*	*	*	11	21	*
Wabasha	*	*	*	*	*	37	47	9
Wadena	*	*	*	18	*	80	104	*
Washington	32	11	*	41	*	157	260	39
Watonwan	*	*	*	*	*	30	34	19
White Earth Nation	*	440	*	29	*	*	470	7
Wilkin	*	*	*	*	*	15	21	*
Winona	19	*	*	14	*	124	164	12
Wright	16	*	*	32	*	177	233	13
Yellow Medicine	*	12	*	8	*	18	39	*
Minnesota	**2,686**	**3,400**	**350**	**2,658**	*	**7,094**	**16,488**	**1,661**

* 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, 2018

Agency	Parental drug abuse	Alleged neglect	Alleged physical abuse	Child delinquency	Child mental health	Child family conflict	Caretaker mental health	Alleged sexual abuse	Incarceration of parents	Parental alcohol abuse	Abandonment	Inadequate housing	Relinquish or TPR	Child disability	Death of parent/s	Child drug abuse	Caretaker physical health	Child alcohol abuse	Safe Place for Newborns	Total children
Aitkin	6	1	1	0	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0	11
Anoka	63	44	38	7	9	11	12	6	20	15	7	5	4	1	3	2	0	0	0	247
Becker	8	43	3	11	1	0	0	3	1	1	1	0	2	0	1	0	0	0	0	75
Beltrami	47	223	6	7	4	3	9	7	1	3	2	1	0	0	1	0	0	0	0	314
Benton	18	13	12	1	9	2	1	1	0	0	1	0	0	0	0	0	0	0	0	58
Big Stone	2	0	0	1	4	0	0	0	0	0	1	0	0	0	0	0	0	0	0	8
Blue Earth	32	15	4	3	4	1	7	2	4	4	0	1	2	0	0	0	0	0	0	79
Brown	15	12	3	2	2	3	2	5	0	1	1	0	0	1	0	2	0	0	0	49
Carlton	26	11	4	3	23	2	2	0	0	0	0	0	0	1	0	0	0	0	0	72
Carver	29	8	10	3	0	23	5	0	1	4	0	0	1	0	0	0	0	0	0	84
Cass	19	5	4	1	10	1	0	0	0	0	1	1	1	0	0	0	0	0	0	43
Chippewa	4	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
Chisago	14	16	7	0	5	1	5	0	0	2	4	0	1	3	0	1	0	0	0	59
Clay	32	7	4	44	14	22	8	1	4	1	0	0	1	1	0	0	1	1	0	141
Clearwater	1	4	0	0	0	4	0	0	0	0	1	1	0	0	0	0	0	0	0	11
Cook	8	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	10
Crow Wing	56	14	17	6	0	9	6	0	3	0	0	5	0	3	0	2	2	0	0	123
Dakota	110	64	37	2	3	15	7	7	11	1	16	7	2	12	2	1	2	0	0	299
Des Moines Valley HHS	32	4	4	1	4	6	3	2	0	1	0	0	0	0	0	0	0	0	0	57
Douglas	11	14	6	2	2	0	2	0	1	3	2	0	0	0	0	0	0	0	0	43
Faribault-Martin	25	9	4	0	3	1	2	1	6	2	1	1	0	0	0	0	0	0	0	55

Agency	Parental drug abuse	Alleged neglect	Alleged physical abuse	Child delinquency	Child mental health	Child family conflict	Caretaker mental health	Alleged sexual abuse	Incarceration of parents	Parental alcohol abuse	Abandonment	Inadequate housing	Relinquish or TPR	Child disability	Death of parent/s	Child drug abuse	Caretaker physical health	Child alcohol abuse	Safe Place for Newborns	Total children
Fillmore	1	2	4	1	0	6	2	0	0	0	0	0	0	1	0	0	0	0	0	17
Freeborn	20	13	1	0	4	2	1	0	0	2	0	0	1	0	0	0	0	0	0	44
Goodhue	4	16	6	4	3	4	3	2	1	0	1	0	0	0	3	0	0	1	0	48
Grant	6	1	2	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	10
Hennepin	363	187	163	123	59	22	51	67	30	47	19	7	24	6	5	2	2	0	0	1,177
Houston	4	4	4	1	0	0	2	0	0	0	0	0	0	1	0	0	0	0	0	16
Hubbard	6	14	0	3	5	0	1	2	0	0	1	0	0	0	0	0	0	0	0	32
Isanti	10	10	6	0	3	0	1	3	0	2	0	0	0	1	0	0	0	0	0	36
Itasca	36	31	5	15	25	10	2	2	1	0	2	1	1	1	0	4	1	3	0	140
Kanabec	2	1	1	5	3	1	2	0	0	0	0	1	1	1	0	0	0	0	0	18
Kandiyohi	5	26	6	0	12	11	0	1	3	0	1	0	2	0	0	0	5	0	0	72
Kittson	0	5	0	1	0	1	1	1	0	0	1	0	0	0	0	0	0	0	0	10
Koochiching	22	3	2	3	3	1	0	0	3	0	0	3	0	0	0	0	0	0	0	40
Lac qui Parle	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Lake	3	4	0	2	3	1	1	0	0	0	0	0	0	0	1	0	0	0	0	15
Lake of the Woods	2	0	0	1	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	5
Le Sueur	7	6	0	2	6	1	1	0	1	0	2	1	0	0	0	0	0	0	0	27
Leech Lake Band of Ojibwe	33	12	4	0	1	0	2	0	0	1	0	3	0	0	0	0	0	0	1	57
Mahnomen	1	1	1	2	2	0	0	1	0	0	0	2	0	0	0	0	0	0	0	10
Marshall	5	2	1	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	11
McLeod	30	10	7	2	4	1	0	0	0	2	0	0	0	1	0	0	0	0	0	57
Meeker	8	4	0	0	6	0	1	1	1	0	1	0	0	1	0	0	0	0	0	23
Mille Lacs	25	20	1	6	4	0	4	0	0	1	1	4	0	1	0	3	2	0	0	72

Agency	Parental drug abuse	Alleged neglect	Alleged physical abuse	Child delinquency	Child mental health	Child family conflict	Caretaker mental health	Alleged sexual abuse	Incarceration of parents	Parental alcohol abuse	Abandonment	Inadequate housing	Relinquish or TPR	Child disability	Death of parent/s	Child drug abuse	Caretaker physical health	Child alcohol abuse	Safe Place for Newborns	Total children
MN Prairie	34	18	6	7	13	2	3	2	0	6	1	1	4	2	1	0	0	0	0	100
Morrison	33	4	1	1	5	0	1	0	0	0	0	4	1	4	0	0	0	0	0	54
Mower	14	10	8	0	0	2	3	0	3	0	1	0	0	0	0	0	0	0	0	41
Nicollet	1	15	1	1	5	1	0	3	1	3	0	1	0	1	0	0	0	0	0	33
Nobles	10	3	5	7	4	1	1	7	4	0	0	0	1	0	0	0	1	0	0	44
Norman	4	2	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	8
Olmsted	27	8	7	5	8	7	0	3	0	5	2	0	1	1	0	0	2	0	0	76
Otter Tail	24	13	15	1	8	2	3	2	11	3	1	3	4	1	0	2	0	0	1	94
Pennington	8	6	0	1	0	0	0	0	4	0	0	1	1	0	0	0	0	0	0	21
Pine	28	12	5	2	5	2	1	0	0	1	0	0	1	0	0	0	0	0	0	57
Polk	7	11	2	6	7	3	0	1	1	0	0	2	0	0	0	2	2	0	0	44
Pope	4	2	7	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0	0	16
Ramsey	86	207	57	132	15	28	28	42	9	6	16	8	11	1	15	6	0	0	1	668
Red Lake	1	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Renville	12	3	1	1	5	0	0	0	3	0	0	0	0	0	0	0	0	0	0	25
Rice	42	28	7	4	6	1	7	4	0	5	2	7	0	0	3	0	0	0	0	116
Roseau	7	1	0	3	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14
Scott	28	19	9	4	5	15	10	6	2	4	1	0	1	0	0	1	0	0	0	105
Sherburne	31	17	8	6	3	0	1	0	2	2	0	1	0	1	0	0	0	0	0	72
Sibley	5	5	2	1	1	0	0	3	5	0	0	2	0	0	2	0	0	0	1	27
Southwest HHS	52	21	6	9	8	9	1	3	4	0	2	11	0	0	0	0	0	0	0	126
St. Louis	222	48	34	5	62	8	39	21	19	16	6	8	10	2	2	0	2	0	1	505
Stearns	43	85	39	2	23	5	6	12	7	6	8	0	2	0	0	0	0	0	0	238

Agency	Parental drug abuse	Alleged neglect	Alleged physical abuse	Child delinquency	Child mental health	Child family conflict	Caretaker mental health	Alleged sexual abuse	Incarceration of parents	Parental alcohol abuse	Abandonment	Inadequate housing	Relinquish or TPR	Child disability	Death of parent/s	Child drug abuse	Caretaker physical health	Child alcohol abuse	Safe Place for Newborns	Total children
Stevens	3	1	1	1	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	9
Swift	8	8	12	1	4	1	1	0	7	0	0	0	1	1	0	0	0	0	0	44
Todd	25	4	0	0	2	0	3	1	0	2	0	3	1	0	0	0	0	0	0	41
Traverse	1	0	0	2	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	6
Wabasha	7	3	6	1	2	1	0	0	0	2	0	1	0	0	0	1	0	0	0	24
Wadena	8	16	5	6	1	1	0	0	1	1	1	8	1	0	0	0	0	0	0	49
Washington	35	8	13	9	23	15	3	1	3	12	7	1	0	2	1	3	0	0	0	136
Watonwan	5	11	1	1	3	1	1	0	0	0	2	0	0	0	0	0	0	0	0	25
White Earth Nation	97	17	12	4	4	5	3	3	3	2	8	3	1	0	0	2	0	0	0	164
Wilkin	6	2	0	3	1	4	0	0	0	0	0	0	0	0	0	0	0	0	0	16
Winona	22	18	7	5	2	7	7	0	0	1	0	0	1	0	0	0	0	0	0	70
Wright	25	18	2	3	8	2	4	3	0	2	2	1	0	2	0	1	2	0	0	75
Yellow Medicine	9	2	2	0	3	1	0	0	0	0	0	0	0	0	0	0	0	0	0	17
Minnesota	**2,125**	**1,526**	**664**	**500**	**487**	**292**	**273**	**234**	**182**	**174**	**130**	**110**	**86**	**55**	**40**	**36**	**24**	**5**	**5**	**6,948**

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, 2018

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)	ICF-DD	Residential SUD program with parent	Total children
Aitkin	13	13	2	3	1	1	12	1	0	0	2	0	0	42
Anoka	245	150	41	34	13	42	58	5	13	18	42	1	0	511
Becker	90	39	14	25	3	12	21	10	4	5	16	0	0	186
Beltrami	450	496	64	196	75	18	12	25	9	25	30	0	0	1,095
Benton	54	32	15	3	11	10	24	0	2	3	6	0	0	124
Big Stone	1	2	6	0	2	4	0	0	0	0	0	0	0	12
Blue Earth	62	49	4	18	4	32	12	0	2	0	4	1	0	162
Brown	29	21	4	7	4	8	4	0	3	1	4	2	0	68
Carlton	51	39	44	53	26	9	6	3	6	2	1	0	0	167
Carver	50	60	13	26	10	4	6	1	3	17	25	0	0	172
Cass	34	36	22	9	12	7	6	2	2	5	7	0	0	110
Chippewa	6	9	0	0	1	0	2	1	0	0	1	0	0	16
Chisago	68	30	12	9	3	21	17	1	2	2	1	0	0	146
Clay	93	27	10	9	17	34	13	0	8	5	89	0	0	243
Clearwater	6	5	3	7	2	2	0	0	3	2	2	0	0	31
Cook	10	10	1	3	1	0	0	1	1	0	0	0	0	25
Crow Wing	114	92	24	35	22	41	30	0	8	2	9	0	0	289

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)	ICF-DD	Residential SUD program with parent	Total children
Dakota	208	219	33	44	9	47	24	2	24	8	8	1	0	525
Des Moines Valley HHS	36	26	13	2	7	8	13	1	6	2	8	0	0	98
Douglas	34	37	5	6	6	8	3	1	0	2	0	0	0	86
Faribault-Martin	56	50	4	9	4	12	14	0	0	5	2	2	0	138
Fillmore	5	8	5	1	4	0	0	2	5	1	1	0	0	22
Freeborn	37	36	11	3	9	12	21	0	1	6	0	0	0	109
Goodhue	42	37	17	12	5	8	5	2	2	7	0	0	0	111
Grant	10	3	2	0	0	3	1	0	0	0	0	0	0	16
Hennepin	1,103	1,182	448	224	229	210	270	133	59	124	26	1	1	3,107
Houston	20	1	6	4	1	13	1	1	1	3	1	0	0	40
Hubbard	27	21	8	21	4	12	4	1	2	2	7	0	0	83
Isanti	33	43	15	16	8	10	7	1	5	2	4	0	0	110
Itasca	114	85	58	19	6	21	13	6	10	4	21	0	0	285
Kanabec	14	6	9	6	6	2	8	2	0	2	3	0	0	48
Kandiyohi	52	33	11	3	10	9	10	1	6	6	11	0	0	124
Kittson	10	0	2	1	0	0	1	0	0	2	2	0	0	15
Koochiching	19	31	9	8	3	3	0	1	1	3	2	0	0	71
Lac qui Parle	3	2	1	0	0	0	1	0	1	1	0	0	0	7
Lake	15	5	3	11	4	3	0	0	1	1	1	0	0	35

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)	ICF-DD	Residential SUD program with parent	Total children
Lake of the Woods	0	3	1	0	0	0	0	0	1	0	1	0	0	6
Le Sueur	20	18	8	8	4	4	4	2	1	2	6	0	0	61
Leech Lake Band of Ojibwe	107	91	10	73	7	16	11	0	1	3	5	0	0	294
Mahnomen	8	8	5	0	1	0	2	2	0	2	3	0	0	22
Marshall	1	10	6	1	0	0	2	1	1	2	3	0	0	19
McLeod	49	56	10	4	5	3	14	0	2	4	2	0	0	131
Meeker	9	14	7	3	3	0	0	0	6	1	2	0	0	46
Mille Lacs	74	82	17	50	13	18	4	7	4	4	9	0	0	241
MN Prairie	73	78	26	14	6	22	40	5	7	1	4	0	0	222
Morrison	44	34	9	2	0	8	24	0	5	2	0	0	0	105
Mower	31	14	9	7	5	24	8	1	0	2	3	0	0	87
Nicollet	25	9	11	6	3	21	5	0	5	6	4	1	0	89
Nobles	33	11	13	0	2	3	0	6	4	3	5	0	0	66
Norman	7	6	0	0	2	1	4	1	1	0	2	0	0	18
Olmsted	66	40	18	7	9	31	33	5	3	10	17	1	0	194
Otter Tail	68	63	24	27	6	20	19	5	11	0	8	0	0	208
Pennington	21	18	5	4	0	3	3	1	1	1	1	0	0	49
Pine	53	44	14	21	2	11	13	0	3	4	1	0	0	145

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)	ICF-DD	Residential SUD program with parent	Total children
Polk	38	14	18	1	5	11	5	2	2	3	17	0	0	88
Pope	11	3	2	4	0	3	0	0	0	3	0	0	0	25
Ramsey	556	680	144	96	157	88	168	141	49	78	7	0	0	1,751
Red Lake	1	6	1	2	0	0	2	0	1	0	0	0	0	9
Renville	8	14	7	7	10	1	10	1	0	0	3	0	0	46
Rice	87	67	11	14	9	7	20	0	3	7	3	0	0	197
Roseau	5	8	5	1	2	0	0	1	0	0	6	0	0	23
Scott	60	58	4	12	2	29	20	2	7	6	30	0	0	176
Sherburne	40	45	11	18	14	18	16	0	10	2	3	0	0	142
Sibley	13	24	3	2	1	7	4	0	2	1	2	0	0	46
Southwest HHS	79	109	18	46	20	18	21	4	7	14	13	2	0	285
St. Louis	407	403	126	214	195	99	85	19	28	37	2	0	0	1,253
Stearns	175	163	35	24	39	37	29	9	14	11	13	0	0	434
Stevens	7	10	4	0	3	2	8	2	1	1	3	0	0	29
Swift	38	16	5	12	3	3	0	0	1	1	0	1	0	62
Todd	34	42	6	15	3	16	15	0	1	3	3	0	0	97
Traverse	8	0	4	1	0	4	0	3	2	2	1	0	0	21
Wabasha	15	15	6	1	4	7	3	0	0	2	0	1	0	47
Wadena	39	46	9	13	5	2	1	9	2	1	2	0	0	104

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)	ICF-DD	Residential SUD program with parent	Total children
Washington	67	81	44	19	19	13	25	3	17	12	12	0	0	260
Watonwan	16	8	9	0	1	2	0	0	0	3	1	0	0	34
White Earth Nation	228	122	22	58	14	29	35	11	3	4	23	0	0	470
Wilkin	11	0	2	0	3	2	1	1	0	2	3	0	0	21
Winona	53	56	10	16	22	15	24	1	2	5	4	1	0	164
Wright	68	79	20	25	8	29	47	1	7	4	3	0	0	233
Yellow Medicine	3	16	2	7	6	1	6	0	0	0	0	0	0	39
Minnesota	**5,970**	**5,619**	**1,660**	**1,662**	**1,135**	**1,254**	**1,350**	**450**	**405**	**517**	**566**	**15**	**1**	**16,488**

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

Residential substance use disorder program with parent is a new location setting added in 2018.

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, 2018

Agency	African American/ black	American Indian	Asian or Pacific Islander	Two or more races	Unknown/ declined	White	Total families	Hispanic (any race)
Aitkin	*	*	*	*	*	22	27	*
Anoka	32	7	*	*	*	254	291	13
Becker	*	15	*	*	11	102	123	*
Beltrami	7	343	*	29	*	190	530	10
Benton	*	*	*	*	*	65	71	*
Big Stone	*	*	*	*	*	*	*	*
Blue Earth	*	*	*	*	*	86	94	*
Brown	*	*	*	*	*	33	34	*
Carlton	*	23	*	7	*	30	53	*
Carver	11	*	*	*	*	89	104	7
Cass	*	11	*	*	11	51	70	*
Chippewa	*	*	*	*	*	13	13	*
Chisago	*	*	*	*	*	90	93	*
Clay	*	*	*	*	*	93	100	*
Clearwater	*	*	*	*	*	12	13	*
Cook	*	*	*	*	*	8	11	*
Crow Wing	*	*	*	*	*	180	190	*
Dakota	19	*	*	16	67	215	292	13
Des Moines Valley HHS	*	*	*	*	*	44	44	*
Douglas	*	*	*	*	*	59	62	*
Faribault-Martin	*	*	*	*	*	72	75	*
Fillmore	*	*	*	*	*	17	19	*
Freeborn	*	*	*	*	*	57	58	*
Goodhue	*	*	*	*	7	58	66	*
Grant	*	*	*	*	*	12	12	*
Hennepin	738	187	47	128	38	863	1,840	106
Houston	*	*	*	*	*	23	27	*

Agency	African American/ black	American Indian	Asian or Pacific Islander	Two or more races	Unknown/ declined	White	Total families	Hispanic (any race)
Hubbard	*	*	*	*	*	43	51	*
Isanti	*	*	*	*	*	74	77	*
Itasca	*	*	*	9	*	106	119	*
Kanabec	*	*	*	*	*	28	29	*
Kandiyohi	*	*	*	*	*	60	62	14
Kittson	*	*	*	*	*	7	7	*
Koochiching	*	*	*	*	*	31	32	*
Lac qui Parle	*	*	*	*	*	*	*	*
Lake	*	*	*	*	*	23	23	*
Le Sueur	*	*	*	*	*	38	38	*
Leech Lake Band of Ojibwe	*	78	*	15	7	45	128	*
Mahnomen	*	7	*	*	*	8	15	*
Marshall	*	*	*	*	*	*	8	*
McLeod	*	*	*	*	*	69	73	*
Meeker	*	*	*	*	*	22	22	*
Mille Lacs	*	58	*	19	*	69	127	*
MN Prairie	9	*	*	*	*	136	145	14
Morrison	*	*	*	*	*	70	72	*
Mower	*	*	*	*	*	44	48	*
Nicollet	*	*	*	*	*	27	30	*
Nobles	*	*	*	*	*	22	23	*
Norman	*	*	*	*	*	7	7	*
Olmsted	9	*	*	*	*	121	129	8
Otter Tail	*	*	*	*	*	114	115	*
Pennington	*	*	*	*	*	21	21	*
Pine	*	18	*	7	*	67	88	*
Polk	*	*	*	*	*	36	38	*
Pope	*	*	*	*	*	8	9	*
Ramsey	372	45	63	83	47	485	1,026	100

Agency	African American/ black	American Indian	Asian or Pacific Islander	Two or more races	Unknown/ declined	White	Total families	Hispanic (any race)
Red Lake	*	*	*	*	*	*	*	*
Renville	*	*	*	*	*	27	28	*
Rice	7	*	*	*	*	100	109	12
Roseau	*	*	*	*	*	13	16	*
Scott	*	*	*	*	19	72	95	*
Sherburne	7	*	*	*	12	70	86	*
Sibley	*	*	*	*	*	35	37	*
Southwest HHS	*	24	*	*	*	134	153	10
St. Louis	39	115	*	48	*	498	687	20
Stearns	15	*	*	*	*	221	242	*
Stevens	*	*	*	*	*	16	16	*
Swift	*	*	*	*	*	28	30	*
Todd	*	*	*	*	*	75	75	*
Traverse	*	*	*	*	*	9	10	*
Wabasha	*	*	*	*	*	24	25	*
Wadena	*	*	*	*	*	63	64	*
Washington	12	*	*	7	36	104	148	*
Watonwan	*	*	*	*	9	12	17	*
White Earth Nation	*	121	*	30	7	71	180	*
Wilkin	*	*	*	*	*	11	12	*
Winona	*	*	*	*	8	96	109	*
Wright	*	*	*	*	*	157	166	*
Yellow Medicine	*	*	*	*	*	19	27	*
Minnesota	**1,310**	**1,101**	**151**	**484**	**393**	**6,125**	**8,835**	**452**

*If the number of families is less than seven it 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 2018. 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 tribal affiliation, 2018

State where the Tribe is primarily located	Tribe	American Indian children, ICWA indicated	American Indian children, ICWA not indicated, but tribally affiliated	Total
Minnesota	Bois Forte Band of Chippewa	167	50	217
	Fond du Lac Band of Lake Superior Chippewa	210	105	315
	Grand Portage Band of Lake Superior Chippewa	35	22	57
	Leech Lake Band of Ojibwe	780	65	845
	Lower Sioux Indian Community of Minnesota	84	11	95
	Mille Lacs Band of Ojibwe	395	48	443
	Minnesota Chippewa tribe (cannot identify specific band)	7	6	13
	Minnesota Dakota tribe (cannot identify specific tribe)	1	0	1
	Prairie Island Indian Community	17	5	22
	Red Lake Nation	1,082	105	1,187
	Shakopee Mdewakanton Sioux Community	15	9	24
	Upper Sioux Community of Minnesota	19	6	25
	White Earth Nation	910	172	1,082
Iowa	Meskwaki Nation	1	0	1
Michigan	Bay Mills Indian Community	1	12	13
	Grand Traverse Band of Ottawa and Chippewa Indians	2	2	4
	Hannahville Indian Community of Michigan	11	0	11
	Keweenaw Bay Indian Community	2	1	3
	Lac Vieux Desert Band of Lake Superior Chippewa	2	8	10
	Little Traverse Bay Bands of Odawa Indians	3	0	3
	Saginaw Chippewa Tribe of Michigan	3	13	16
	Sault Ste. Marie Tribe of Chippewa Indians of Michigan	3	13	16
Nebraska	Fort Peck Assiniboine and Sioux Tribes	6	3	9
	Omaha Tribe of Nebraska	4	3	7
	Ponca Tribe of Nebraska		2	2
	Santee Sioux Nation	5	9	14

State where the Tribe is primarily located	Tribe	American Indian children, ICWA indicated	American Indian children, ICWA not indicated, but tribally affiliated	Total
Nebraska	Winnebago Tribe of Nebraska	9	6	15
North Dakota	Eastern Band of Cherokee Indians	25	20	45
	Mandan, Hidatsa & Arikara Nation	26	6	32
	Spirit Lake Tribe	48	8	56
	Standing Rock Sioux Tribe	78	36	114
	Turtle Mountain Band of Chippewa Indians	61	48	109
South Dakota	Cheyenne River Sioux Tribe	20	16	36
	Crow Creek Sioux Tribe	13	4	17
	Flandreau Santee Sioux Tribe	2	5	7
	Lower Brule Sioux Tribe	6	8	14
	Oglala Sioux Tribe	61	8	69
	Rosebud Sioux Tribe	46	23	69
	Sisseton Wahpeton Oyate	86	32	118
	Yankton Sioux Tribe of South Dakota	28	14	42
Wisconsin	Bad River Band of the Lake Superior Tribe of Chippewa Indians	28	14	42
	Forest County Potawatomi Community	13	2	15
	Ho-Chunk Nation	14	13	27
	Lac Courte Oreilles Band (LCO)	41	22	63
	Lac du Flambeau Band of Lake Superior Chippewa Indians	6	15	21
	Menominee Indian Tribe of Wisconsin	8	7	15
	Oneida Nation of Wisconsin	21	3	24
	Red Cliff Band of Lake Superior Chippewa	23	13	36
	Sokaogon Chippewa Community	4	13	17
	St. Croix Chippewa Indians of Wisconsin	18	16	34
Other unknown	Canadian tribe	7	15	22
	Other foreign tribe	1	5	6
	Other US tribe	151	163	314
	Unknown Dakota, Lakota or Nakota (Sioux)	3	14	17

State where the Tribe is primarily located	Tribe	American Indian children, ICWA indicated	American Indian children, ICWA not indicated, but tribally affiliated	Total
Other unknown	Unknown Ojibwe, Ojibwa or Chippewa	7	18	25
	Unknown tribe	110	176	286
Total	**Any Tribe**	**3,920**	**961**	**4,881**

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, 2018

Agency	1 to 7 days	8 to 30 days	2 to 3 months	4 to 6 months	7 to 12 months	13 to 24 months	25 to 36 months	Longer than 36 months	Total
Aitkin	3	0	0	0	12	8	1	2	26
Anoka	41	8	17	26	56	60	45	17	270
Becker	2	1	8	6	23	33	4	4	81
Beltrami	0	8	3	26	112	130	43	54	376
Benton	4	4	5	9	8	16	9	4	59
Big Stone	1	0	2	1	0	1	0	1	6
Blue Earth	10	0	3	7	18	29	9	13	89
Brown	13	2	2	2	5	10	1	0	35
Carlton	2	2	20	3	24	40	1	1	93
Carver	6	4	13	9	16	29	10	6	93
Cass	0	2	9	3	14	11	3	7	49
Chippewa	0	0	0	0	4	1	1	0	6
Chisago	3	6	6	10	9	39	7	1	81
Clay	51	12	9	4	11	19	20	7	133
Clearwater	0	2	0	0	1	3	2	0	8
Cook	2	2	1	0	7	6	2	0	20
Crow Wing	5	4	7	11	23	40	37	4	131
Dakota	46	13	31	37	56	51	20	9	263
Des Moines Valley HHS	8	0	7	4	3	13	4	0	39
Douglas	1	4	8	4	19	7	1	1	45
Faribault-Martin	9	2	2	7	22	16	6	4	68
Fillmore	1	1	2	1	5	1	0	0	11
Freeborn	0	1	7	3	3	6	12	6	38
Goodhue	7	0	2	4	14	15	6	4	52
Grant	1	0	0	2	1	0	0	0	4
Hennepin	112	59	71	108	287	366	198	136	1,337
Houston	0	0	0	1	2	3	5	1	12

Agency	1 to 7 days	8 to 30 days	2 to 3 months	4 to 6 months	7 to 12 months	13 to 24 months	25 to 36 months	Longer than 36 months	Total
Hubbard	5	1	1	1	4	19	6	6	43
Isanti	6	0	0	2	9	19	9	2	47
Itasca	10	17	19	8	45	42	12	10	163
Kanabec	1	0	4	8	12	6	6	1	38
Kandiyohi	9	1	7	3	15	24	0	2	61
Kittson	0	2	5	0	2	0	0	1	10
Koochiching	4	1	3	2	20	6	0	0	36
Lac qui Parle	0	0	0	1	1	1	0	1	4
Lake	0	0	0	1	4	5	1	2	13
Lake of the Woods	0	0	0	3	2	0	0	0	5
Le Sueur	0	1	3	2	8	8	1	1	24
Leech Lake Band of Ojibwe	0	0	0	1	9	24	12	33	79
Mahnomen	0	1	2	1	3	2	1	1	11
Marshall	3	0	1	2	1	3	0	1	11
McLeod	1	1	3	0	18	24	4	2	53
Meeker	0	0	0	1	11	5	0	0	17
Mille Lacs	2	2	8	7	13	21	16	19	88
MN Prairie	0	5	6	15	30	58	6	0	120
Morrison	1	3	2	1	17	15	1	1	41
Mower	6	1	0	5	10	13	7	1	43
Nicollet	4	14	2	8	5	14	6	0	53
Nobles	6	0	3	2	7	2	1	3	24
Norman	0	0	0	4	0	5	2	0	11
Olmsted	4	2	10	7	24	39	12	8	106
Otter Tail	4	3	2	9	15	40	4	4	81
Pennington	12	1	2	9	11	11	2	0	48
Pine	3	2	3	2	16	25	4	4	59
Polk	1	4	12	8	13	14	5	1	58

Agency	1 to 7 days	8 to 30 days	2 to 3 months	4 to 6 months	7 to 12 months	13 to 24 months	25 to 36 months	Longer than 36 months	Total
Pope	7	2	0	0	3	6	1	1	20
Ramsey	119	56	57	69	180	135	116	69	801
Red Lake	0	0	0	1	2	2	0	0	5
Renville	3	2	1	4	6	4	3	4	27
Rice	11	1	12	29	22	13	17	2	107
Roseau	1	0	1	3	2	3	1	0	11
Scott	18	12	6	7	18	33	3	2	99
Sherburne	7	0	6	17	19	19	9	2	79
Sibley	2	3	2	3	5	7	0	0	22
Southwest HHS	24	3	5	12	28	32	26	12	142
St. Louis	42	25	95	53	108	171	91	65	650
Stearns	37	3	20	20	70	58	14	8	230
Stevens	0	0	0	2	1	2	0	1	6
Swift	15	2	2	2	6	8	0	1	36
Todd	0	0	2	1	17	8	9	5	42
Traverse	0	2	2	2	1	8	0	1	16
Wabasha	5	1	1	3	6	6	5	3	30
Wadena	10	6	5	6	8	15	0	2	52
Washington	24	8	12	12	36	45	9	7	153
Watonwan	0	1	3	1	4	1	0	2	12
White Earth Nation	3	1	6	15	47	47	44	22	185
Wilkin	0	1	3	1	1	0	0	2	8
Winona	4	12	5	6	10	22	6	5	70
Wright	8	2	4	10	16	24	24	13	101
Yellow Medicine	0	1	1	4	6	9	4	0	25
Minnesota	**750**	**343**	**584**	**684**	**1,702**	**2,076**	**947**	**615**	**7,701**

Table 14. Number of children under state guardianship by agency, 2018

Agency	Entered guardianship prior to 2018	Entered guardianship in 2018	Total children
Aitkin	7	7	14
Anoka	50	61	111
Becker	24	16	40
Beltrami	17	12	29
Benton	22	16	38
Big Stone	2	2	4
Blue Earth	20	26	46
Brown	5	14	19
Carlton	10	8	18
Carver	10	8	18
Cass	9	7	16
Chippewa	1	2	3
Chisago	23	21	44
Clay	53	3	56
Cook	1	0	1
Crow Wing	40	30	70
Dakota	44	37	81
Des Moines Valley HHS	3	13	16
Douglas	5	7	12
Faribault-Martin	20	12	32
Freeborn	26	7	33
Goodhue	7	8	15
Grant	0	4	4
Hennepin	429	261	690
Houston	7	7	14
Hubbard	16	4	20
Isanti	11	8	19

Agency	Entered guardianship prior to 2018	Entered guardianship in 2018	Total children
Itasca	22	15	37
Kanabec	10	3	13
Kandiyohi	9	11	20
Kittson	0	2	2
Koochiching	4	1	5
Lac qui Parle	2	0	2
Lake	2	1	3
Le Sueur	5	5	10
Mahnomen	1	1	2
Marshall	1	1	2
McLeod	16	8	24
Meeker	0	2	2
Mille Lacs	11	10	21
MN Prairie	28	48	76
Morrison	18	15	33
Mower	22	16	38
Nicollet	9	18	27
Nobles	3	0	3
Norman	4	0	4
Olmsted	33	31	64
Otter Tail	11	19	30
Pennington	5	1	6
Pine	12	9	21
Polk	10	10	20
Pope	2	0	2
Ramsey	289	141	430
Red Lake	0	2	2
Renville	6	6	12

Agency	Entered guardianship prior to 2018	Entered guardianship in 2018	Total children
Rice	16	13	29
Scott	33	14	47
Sherburne	26	11	37
Sibley	7	3	10
Southwest HHS	27	13	40
St. Louis	113	81	194
Stearns	53	27	80
Stevens	2	13	15
Swift	2	3	5
Todd	21	14	35
Traverse	4	0	4
Wabasha	12	3	15
Wadena	3	4	7
Washington	27	17	44
Watonwan	2	5	7
Wilkin	2	0	2
Winona	24	25	49
Wright	58	27	85
Yellow Medicine	4	3	7
Minnesota	**1,831**	**1,253**	**3,084**

Table 15. Number of children adopted by age at adoption and by agency, 2018

Agency	Birth through 3 yrs	4 through 5 yrs	6 through 11 yrs	12 through 14 yrs	15 through 17 yrs
Aitkin	3	0	4	1	0
Anoka	22	8	20	4	2
Becker	5	2	2	1	1
Beltrami	5	2	4	1	0
Benton	4	6	5	2	1
Big Stone	1	0	0	0	0
Blue Earth	6	4	14	1	1
Brown	2	2	1	1	1
Carlton	1	0	1	0	0
Carver	4	0	3	0	0
Cass	2	4	0	0	0
Chippewa	0	1	0	0	0
Chisago	13	8	4	2	1
Clay	10	6	13	1	1
Clearwater	1	1	0	0	0
Crow Wing	18	13	14	2	1
Dakota	16	6	9	2	5
Des Moines Valley HHS	2	0	0	0	0
Douglas	1	0	0	0	1
Faribault-Martin	6	1	3	1	1
Freeborn	5	6	5	2	0
Goodhue	2	0	1	0	2
Hennepin	111	32	63	21	8
Houston	3	0	0	1	0
Hubbard	0	1	3	4	1
Isanti	2	0	2	0	0
Itasca	6	4	6	0	2
Kanabec	4	1	5	0	0

Agency	Birth through 3 yrs	4 through 5 yrs	6 through 11 yrs	12 through 14 yrs	15 through 17 yrs
Kandiyohi	8	2	1	1	0
Koochiching	1	0	1	0	0
Lac qui Parle	1	0	0	0	0
Lake	0	0	1	1	0
Le Sueur	1	0	0	0	0
Leech Lake Band of Ojibwe	2	3	5	0	0
Mahnomen	1	0	1	0	0
Marshall	0	1	0	0	0
McLeod	4	2	6	2	0
Mille Lacs	10	2	1	0	0
MN Prairie	17	4	15	3	1
Morrison	9	5	0	1	3
Mower	4	1	6	3	0
Nicollet	7	0	4	1	0
Nobles	0	0	0	1	0
Norman	2	0	2	0	0
Olmsted	18	4	9	5	3
Otter Tail	9	2	1	2	1
Pennington	3	0	0	0	0
Pine	5	1	3	0	1
Polk	2	4	1	0	1
Pope	2	0	0	0	0
Ramsey	37	15	41	12	3
Red Lake	0	2	0	0	0
Renville	2	0	1	0	0
Rice	9	2	6	2	1
Scott	17	3	6	2	0
Sherburne	8	2	7	2	1
Sibley	2	1	2	0	0

Agency	Birth through 3 yrs	4 through 5 yrs	6 through 11 yrs	12 through 14 yrs	15 through 17 yrs
Southwest HHS	12	5	6	2	1
St. Louis	37	11	36	9	1
Stearns	17	4	13	2	1
Stevens	1	1	0	0	0
Todd	6	5	5	0	1
Traverse	0	1	2	0	0
Wabasha	3	2	2	0	1
Wadena	0	0	0	0	1
Washington	5	2	7	4	1
Watonwan	1	0	0	0	0
White Earth Nation	12	2	14	8	3
Wilkin	1	0	1	0	0
Winona	3	3	0	0	1
Wright	14	7	13	4	3
Yellow Medicine	2	1	1	0	0
Minnesota	**550**	**208**	**402**	**114**	**58**

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GOODHUE COUNTY
FOLLOW ALONG PROGRAM (FAP)
2019 ANNUAL REPORT

January 31, 2020

Goodhue County Health & Human Services' Follow Along Program began in 1998. This program identifies areas of developmental concern for children up to 3 years of age and provides support, information and resources to parents. This program is free and available to all Goodhue County families. The 2018/19 goal to increase screener return was met thanks to additional funding! An additional goal for 2019 was to assure that all families who were referred for further evaluation were connected with the referral source within two weeks of the referral. This goal was also met!

As we know, the first years of children's lives are so important in their social, emotional, and educational development. The Follow Along Program uses a validated screening tool called Ages & Stages Questionnaire (ASQ) to assist in monitoring children's development and indicate if early intervention is needed when screened at 2, 4, 8, 16, 20, 24, 30, and 36 months. In-between screeners are utilized when closer monitoring is indicated.

By the Numbers:

- 497 active participants ~ 9% increase
- 186 new enrollees ~ 7% increase
- 1585 questionnaires provided ~ 23% increase
- 114 children had concerns in one or more areas of development requiring monitoring ~ 259% increase
- 13 children had serious concerns in one or more areas requiring referrals for appropriate follow up ~ remains stable

Outreach

Our goal to reach all families throughout Goodhue County is obtained in a variety of ways. Internally, we ensure all divisions within Goodhue County Health & Human Services understand FAP and encourage coworkers to talk to families about enrolling in the program, including those we work with through Family Home Visiting and WIC.

Externally, we talked with families at the following community events: Goodhue County Fair, Project Community Connect, Zumbrota Family Expo, Lake City & Cannon Falls Baby Cafes, Beyond Birth Classes, Lake City School Wellness Expo, Make It OK event, Kenyon Community Event, and the Prairie Island Health Fair. Another piece of our outreach efforts is making sure brochures and enrollment information are available at places where families frequent. For example, FAP brochures and enrollment information are available at Goodhue County Mayo Health Systems and Olmsted Medical Center clinics.

Collaborating with Early Childhood Special Education and Early Childhood Family Education is vital in fostering success of children throughout the county. With the appropriate releases in place, screeners can be shared and this information is used to better meet children's needs in the classroom, as well as at home.

Success Stories

"Thanks to the Follow Along Program, my child was flagged and we were connected with the school district's birth to three program for some developmental and physical therapy to get my child back on track."

A family with 4 children has noted developmental concerns with 3 of the 4 children. Using the FAP screeners, the family is reassured that their 4th child is staying on track developmentally. Activities from FAP are used by the family to foster the child's development.

A family working with a home visiting nurse enrolled their baby in FAP. Screeners at 4 and 6 months showed developmental areas to monitor. The 8 month screener showed 3 developmental areas that needed a referral for the school district's birth to three program. Schools are providing the services needed. The child is also receiving further evaluation medically, based on screener information. The child is now 16 months old and well involved with services. Mom is grateful for screenings, especially since early intervention was needed.

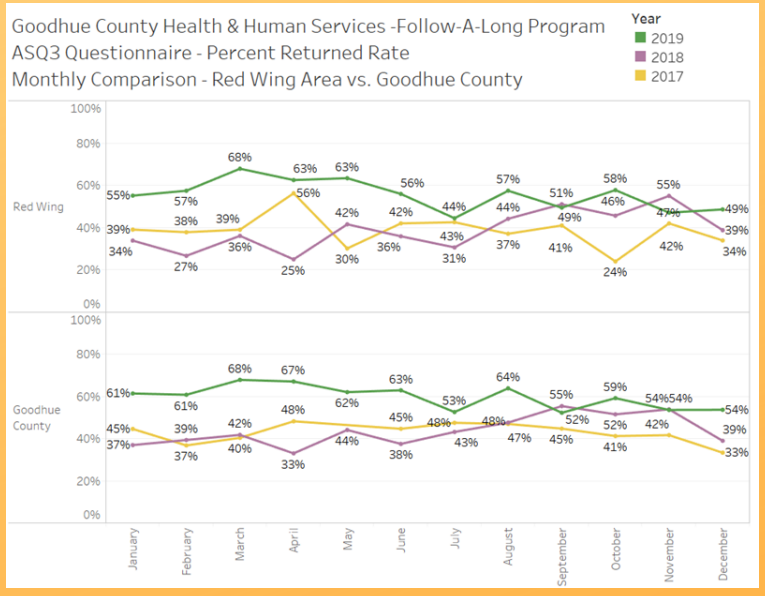
Funding:

Historically, the Follow Along Program is funded through the Goodhue County Child & Family Services Collaborative. Additional funding was procured for April 2018 - December 2019 through our collaboration with Every Hand Joined (EHJ). Our focus for this additional funding was to increase screener returns and to provide data feedback to EHJ regarding services for birth to three population.

Follow Along Program Enhancements

As a result of the collaboration with Every Hand Joined and the additional funding it provided, we were able to:

- give additional support to children who scored in the monitoring range
- maintain the 2018 increased questionnaire return rate
- increased school collaborations by ensuring families and school personnel connected after referrals were made
- increased county wide outreach
- branded our envelopes with FAP's duck image to help families identify mailings



This graph provided through Every Hand Joined collaboration.

DEPARTMENT OF HUMAN SERVICES

Goodhue County Health & Human Services

Goodhue County – Recipients by Program

Program	Recipients	Time Period
Medicaid	7,061 individuals	Calendar Year 2018
MinnesotaCare	514 individuals	Calendar Year 2018
Nursing Facilities & ICF/DD	151 individuals	January 2018 Snapshot
Disability Waivers & Home Care	696 individuals	January 2018 Snapshot
Minnesota Family Investment Program (MFIP)	110 cases (125 adults and 212 children)	July 2019 Snapshot
Child Care Assistance Program (CCAP)	238 children from 137 families	State Fiscal Year 2019
Supplemental Nutrition Assistance Program (SNAP)	3,294 individuals	Federal Fiscal Year 2017

Medicaid & MinnesotaCare Enrollment

- 15% of Goodhue County population is enrolled in Medicaid
- 1% of Goodhue County population is enrolled in MinnesotaCare

Recipients	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
0-19 years	2,900	3,172	3,266	3,356	3,308
20-64 years	3,109	3,393	3,332	3,298	3,167
65+ years	574	573	586	581	586
Medicaid	**6,583**	**7,138**	**7,184**	**7,234**	**7,061**
MinnesotaCare	**531**	**825**	**709**	**547**	**514**

Medicaid Enrollment by Eligibility Type

Eligibility Type	Persons Ever Eligible During CY2018	% Eligible
Families with Children	5,650	65%
People with Disabilities	836	10%
Older Adults	573	7%
Adults without Kids	1,632	19%
Total	**8,691**	100%

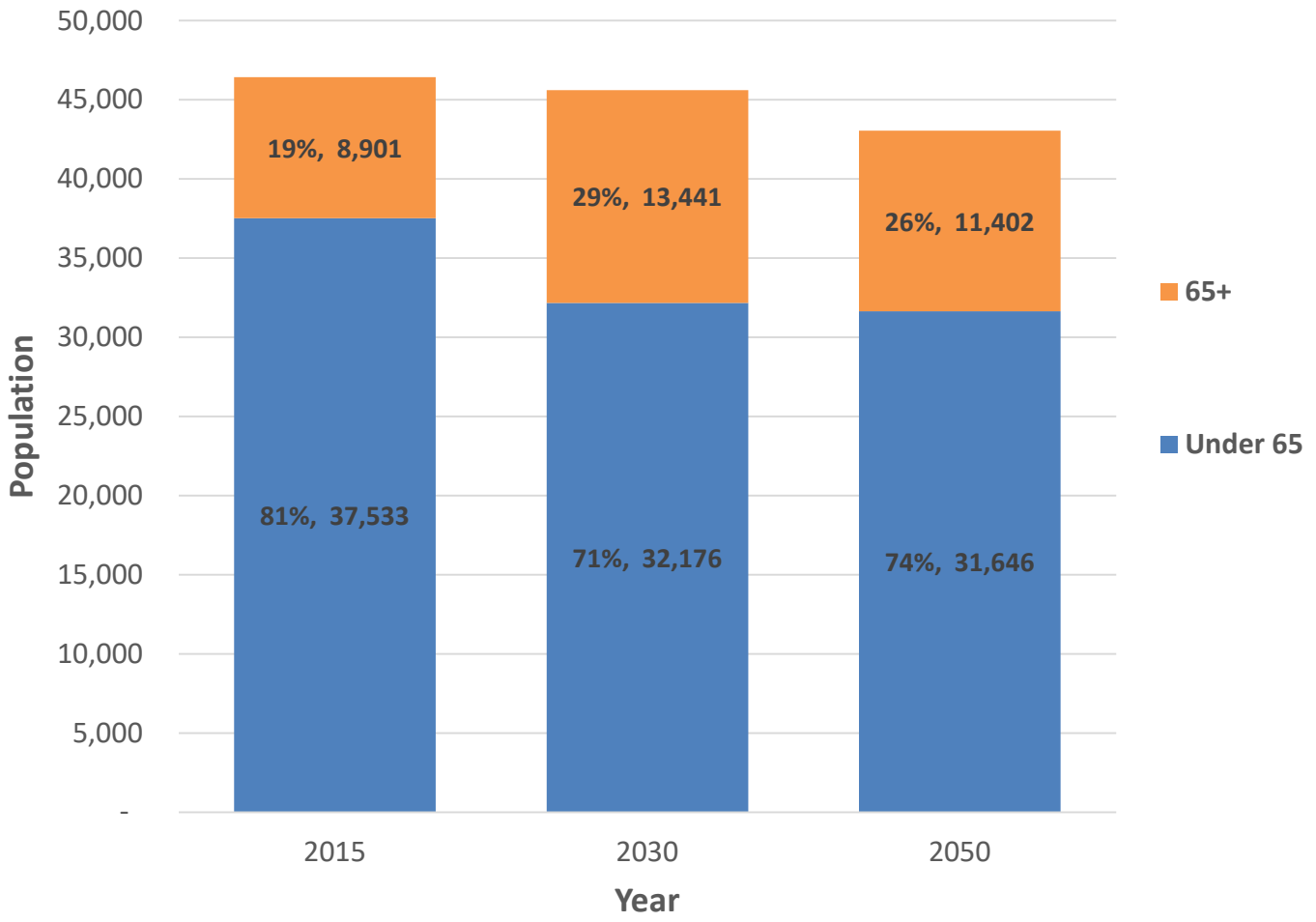
Medicaid Enrollment by Race/Ethnicity – CY 2018 Monthly Average

Race/Ethnicity	MA Recipients	Percentage
African American/Black	217	3%
American Indian/Alaska Native	86	1%
Asian/Pacific Islander	57	1%
Hispanic	192	3%
White	4,008	57%
Multirace	188	3%
Unknown (Missing/Not Reported)	2,307	33%
Total	**7,055**	100%

Long-Term Services & Supports Population by Race/Ethnicity
January 2018 Snapshot

LTSS Population	# of People	% of People
African American/Black	30	4%
American Indian	14	2%
Asian or Pacific Islander	<6	N/A
Hispanic	7	1%
White	764	90%
Multirace	<6	N/A
Unknown	23	3%
Total	**846**	100%

Goodhue Population Projections



DEPARTMENT OF HUMAN SERVICES

Questions? Email Tom.Carr@State.MN.US