AITKIN COUNTY HEALTH & HUMAN SERVICES
BOARD MEETING AGENDA
July 28, 2015

9:05 A.M. **I. Attendance**

II. Approval of Health & Human Services Board Agenda

III. Review June 23, 2015 Health & Human Service Board Minutes

IV. Review Bills

V. General/Miscellaneous Information

A. Counties Unique Role in Case Management (A MACSSA Policy Statement)
B. Public Health Nurse Position
C. DHS Bulletin #15-68-09: Child Protection Allocation

VI. Contracts / Resolutions

A. Aitkin-Itasca-Koochiching Community Health Board Joint Powers Agreement

VII. Administrative Reports:

A. Financial & Transportation Reports

VIII. Committee Reports from Commissioners

A. H&HS Advisory Committee – Commissioners Westerlund and/or Marcotte
Committee Members attending today: Holly Bray & Roberta Elvecrog
No minutes as there was no meeting in July.
B. AEOA Committee Update – Commissioner Westerlund
C. NEMOJT Committee Update – Commissioner Napstad
D. CJI (Children's Justice Initiative) – Commissioner Westerlund
E. Lakes & Pines Update – Commissioner Niemi

IX. Break at 9:___ a.m. for _____ minutes **Next Meeting – August 25, 2015**

AITKIN COUNTY HEALTH & HUMAN SERVICES
BOARD MEETING MINUTES
June 23, 2015

I. Attendance

The Aitkin County Board of Commissioners met this 23rd day of June, 2015, at 9:04 a.m. as the Aitkin County Health & Human Services Board, with the following members present: Chairperson Commissioner Mark Wedel; Commissioners, Anne Marcotte, Brian Napstad, Don Niemi, and Laurie Westerlund; and others present included: County Administrator Nathan Burkett; H&HS Staff Members Tom Burke, Director; Sue Tange & Ann Rivas, Social Service Supervisors; Erin Melz, Public Health Supervisor; Eileen Foss and Jessica Goble, Income Maintenance Supervisors; Kathy Ryan, Fiscal Supervisor; Julie Lueck, Clerk to the Health & Human Services Board; and guests; Adam Hoogenakker, Aitkin Independent Age; Holly Bray, Marlene Abear, and Roberta Elvecrog, H&HS Advisory Committee Members; and Amanda Ysen and Melissa Canfield, Support Within Reach.

II. Approval of Health & Human Services Board Agenda

Motion by Commissioner Marcotte, seconded by Commissioner Niemi, and carried; the vote was to approve the Agenda.

III. Review May 26, 2015 Health & Human Service Board Minutes

Motion by Commissioner Westerlund, seconded by Commissioner Nadpstad, and carried; the vote was to approve the Minutes as mailed/posted.

IV. Review Bills

Motion by Commissioner Napstad, seconded by Commissioner Westerlund, and carried; the vote was to approve the Bills as presented this date.

V. General/Miscellaneous Information

A. Support Within Reach - Amanda Ysen / Melissa Canfield – Discussed the Support Within Reach Programs, their advocates, along with some statistical information and a new grant they received.

B. Child Protection Legislative Updates – Tom Burke noted this information is an FYI as the Legislature takes the lead to determine the number of positions each county will need and the fact that by adding one worker in Aitkin County it will reduce caseloads, share the workload and reduce burn out.

VI. Contracts / Resolutions

A. Warming / Cooling Center Site Agreement – LLCC - *Motion by Commissioner Napstad, seconded by Commissioner Westerlund, and carried; the vote was to approve the Warming/Cooling Center Site Agreement between Aitkin County Health & Human Services and the Long Lake Conservation Center.*

B. Resolution – Ann Rivas updated the Board that she has been developing a plan to help reduce the number of people with mental illnesses in the jail and has been collaborating with Sheriff Turner to have voluntary services which would provide a social worker to assist with discharge planning. It was clarified that these services would be provided to the Aitkin County Residents only and the Resolution would reflect that change (from the word "Individuals" to "Aitkin County Residents" in the capitalized paragraph on page one of the Resolution). Following the discharge, the social worker will continue to work with the person for integration back into the community as well as with transportation and other issues.

CERTIFIED COPY OF RESOLUTION OF COUNTY BOARD OF AITKIN COUNTY, MINNESOTA

ADOPTED June 23, 2015

COMMISSIONER Marcotte offered the following resolution and moved for its adoption:

RESOLUTION

Stepping Up Initiative Resolution

"Stepping Up Initiative to Reduce the Number of People with Mental Illnesses in Jails"

WHEREAS, counties routinely provide treatment services to the estimated 2 million people with serious mental illnesses booked into jail each year; and

WHEREAS, prevalence rates of serious mental illnesses in jails are three to six times higher than for the general population; and

WHEREAS, almost three-quarters of adults with serious mental illnesses in jails have co-occurring substance use disorders; and

WHEREAS, adults with mental illnesses tend to stay longer in jail and upon release are at a higher risk of recidivism than people without these disorders; and

WHEREAS, county jails spend two to three times more on adults with mental illnesses that require interventions compared to those without these treatment needs; and

WHEREAS, without the appropriate treatment and services, people with mental illnesses continue to cycle through the criminal justice system, often resulting in tragic outcomes for these individuals and their families; and

WHEREAS, **AITKIN COUNTY** and all counties take pride in their responsibility to protect and enhance the health, welfare and safety of its residents in efficient and cost-effective ways; and

WHEREAS, **AITKIN COUNTY HEALTH AND HUMAN SERVICES IN COLLABORATION WITH THE AITKIN COUNTY SHERIFF DEPARTMENT WILL OFFER VOLUNTARY DISCHARGE PLANNING SERVICES TO INCARCERATED AITKIN COUNTY RESIDENTS WHO LIVE WITH MENTAL ILLNESS. THE GOAL IS TO SUPPORT INCARCERATED AITKIN COUNTY RESIDENTS TO INTERGRATE BACK INTO THE COMMUNITY AND RECEIVE ONGOING SUPPORT SERVICES.**

WHEREAS, through the *Stepping Up* initiative, the National Association of Counties, the Council of State Governments Justice Center and the American Psychiatric Foundation are encouraging public, private and nonprofit partners to reduce the number of people with mental illnesses in jails;

NOW, THEREFORE, LET IT BE RESOLVED, THAT I, J. MARK WEDEL, CHAIR, AITKIN COUNTY BOARD OF COMMISSIONERS, do hereby sign on to the Call to Action to reduce the number of people with mental illnesses in our county jail, commit to sharing lessons learned with other counties in my state and across the country to support a national initiative and encourage all county officials, employees and residents to participate in *Stepping Up*. We resolve to utilize the comprehensive resources available through *Stepping Up* to:

- Convene or draw on a diverse team of leaders and decision makers from multiple agencies committed to safely reducing the number of people with mental illnesses in jails.
- Collect and review prevalence numbers and assess individuals' needs to better identify adults entering jails with mental illnesses and their recidivism risk, and use that baseline information to guide decision making.
- Examine treatment and service capacity to determine which programs and services are available in the county for people with mental illnesses and co-occurring substance use disorders, and identify state and local policy and funding barriers to minimizing contact with the justice system and providing treatment and supports in the community.
- Develop a plan with measurable outcomes that draws on the needs and prevalence assessment data and examination of available treatment and service capacity, while considering identified barriers.
- Implement research-based approaches that advance the plan.
- Create a process to track progress using data and information systems, and to report on successes.

WHICH RESOLUTION, Being seconded by Commissioner Niemi, and it was declared adopted upon the following vote:

Commissioners present: 5 Vote results: All Members Voting "Yes"

(Attest)

_____
Mark Wedel, Chairperson, Aitkin County Board of Commissioners

_____
Anne Marcotte, Aitkin County Commissioner

_____
Brian Napstad, Aitkin County Commissioner

_____
Don Niemi, Aitkin County Commissioner

_____
Laurie Westerlund, Aitkin County Commissioner

Dated at Aitkin, Minnesota, the 23rd day of June 2015.

I, Kirk Peysar, County Auditor of Aitkin County, Minnesota, do hereby certify that the foregoing is a true and correct copy of the Stepping Up Initiative Resolution by the County Board of Aitkin County, Minnesota, at the regular meeting held on the 23rd day of June 2015.
Kirk Peysar
County Auditor, Aitkin County, Minnesota
Dated: June 23, 2015

VII. Administrative Reports:

A. Financial & Transportation Reports – Kathy Ryan informed the Board that as of July 1st, 2015 we will receive the $60,000 of the Governor's Task Force money which cannot supplant any existing worker or program. We will receive an additional $15,000 in February of 2016 based on our outcomes with a new worker.

VIII. Joint Powers Board Reports:

A. Tri-County Community Health Services Board (CHS)
Commissioner Westerlund / Erin Melz / Tom Burke noted that they have had several meetings recently and conducted interviews of five candidates for the Community Health Planner with the hopes of having the person start on July 6th. It was also noted that the Koochiching County Public Health Supervisor resigned.

IX. Committee Reports from Commissioners

A. H&HS Advisory Committee – Commissioners Westerlund and/or Marcotte
Meeting updates from Committee Members: Holly Bray, Roberta Elvecrog, & Marlene Abear
Marlene Abear discussed the interview & hiring practices. The Board was updated on the recent Technology discussion at the meeting and the security measures in place which protects the clients we serve noting that the county IT department is involved with the purchasing of all our equipment which includes I-phones and I-pads.

B. AEOA Committee Update – Commissioner Westerlund updated the Board that they met last week and reviewed their $34 million budget and discussed the Meals on Wheels program, and signed and approved contracts.

C. NEMOJT Committee Update – Commissioner Napstad updated the Board that due to the layoffs on the Iron Range they are looking for emergency grants for these displaced workers.

D. CJI (Children's Justice Initiative) – Commissioner Westerlund noted there was no meeting.

E. Lakes & Pines Update – Commissioner Niemi noted there was no meeting

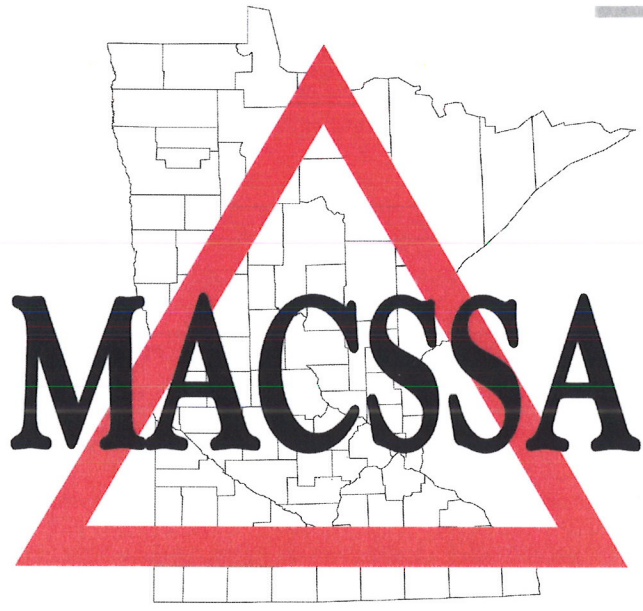
Tom Burke reminded the Board that Eileen Foss' last day of work with Aitkin County is this Friday, June 26th. Tom also introduced Eileen's replacement, Jessica Goble to the Board. Eileen expressed her thanks to the Board for allowing her the opportunity to work with Jess for this past month before her departure. Jess also expressed appreciation for that to happen to make the transition much smoother for everyone.

X. Break at 10:42 a.m. for 15 minutes **Next Meeting – July 28, 2015**

Counties Unique Role in Case Management

A MACSSA Policy Statement

July 2015



Minnesota Association of County
Social Service Administrators

Introduction

In almost every discipline of social services, case management is at the center of the direct services offered to the consumer. Minnesota counties strongly believe that the viability and preservation of our core case management services is of utmost importance as we look to the future. Counties are uniquely positioned to provide effective, high quality case management due to our ability to integrate services at the local level. Above all, it is the investment in the relationship and building a personal connection between the county staff and the consumer that has the greatest impact and provides the most efficacies.

What is County Case Management?

At a basic level, case management services assist an individual in identifying the individual's goals, strengths and needs; involve planning with the individual what services and community resources might help the individual to accomplish the individual's goals; provide referrals (and often accompany) the individual to obtain services and resources; and monitor and coordinate with those services and resources to assure that the individual is getting the help needed to accomplish the individual's goal and to address the individual needs[1].

In concert with current Legislation and Rules, Minnesota counties invest significant amounts of local levy dollars into programmatic, fiscal, legal, and other administrative aspects of case management services. Given that context, counties consider case management to be at the center of our community-based service system. These services directly impact individuals who are critical to the identity of our communities. County boards have responsibility, under statute, for the development of an affordable system of care serving children, families, and adults that are uninsured or underinsured.

Counties in our combined roles as "payer/purchasers", "developer of integrated services", and "direct care providers", are well positioned to partner with the State and local vendors to continue case management service delivery into the future. Our practice philosophies reflect a holistic framework to promote a consumer-driven, community-based, and recovery-focused system of care.

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[1] Minnesota Department of Human Services. *Case Management Services.* Retrieved on May 7, 2015. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=132311.

These roles are further defined as follows:

Payer and Purchaser

Counties utilize local property tax revenues along with federal and state funding to purchase a broad range of human services for citizens. Counties have an existing infrastructure that ensures access to these needed services, provides contracting protocols, monitors quality, and authorizes payment for services. Even when larger counties have contracted for case management services, the counties have still retained a clear role with the vendor by providing performance oversight, monitoring client access, and streamlining client integration into the local system of care. Regardless of size and population, all counties provide services that are tailored to meet the unique geographical and demographic needs of their communities.

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Counties pay a local funding match for certain Medicaid-covered services including case management. Moreover, counties often pay for services at 100% county cost when services are deemed necessary, and no state, federal, or private funds exist (e.g. mental health hold orders, out of home placements for children, etc.). Counties have been willing to look at the local investment in case management services in terms of "getting the job done." The county case management relationship is based on a long-term commitment with no pre-determined starting or stopping point. The focus is to holistically improve the overall functioning of the client. If case management is ever restructured based only on billable time for defined tasks, the shift away from a long-term relationship model could create significant gaps in the service system for specific duties that no one may be required or resourced appropriately cover (e.g. housing supports, court involvement, transitional care out of residential/inpatient care, etc.).

Developer of Integrated Services

Adults and children in need of case management services typically have complex needs that may include food, clothing, shelter, and access to health care coverage. Counties are in a key position to address the holistic needs of consumers by integrating Social Services, Financial Assistance, and Public Health, with the consumer being the focal point. Consumers seeking case management often have multiple needs that are best served through a county-delivered system that can integrate all public services and internally coordinate the needs of each consumer. Effectiveness of county case management increases as access to all appropriate public services are streamlined.

Because of local contacts and familiarity, counties are well positioned to avoid duplication, navigate jurisdictional nuance, and address issues of diversity. Counties bring passion, commitment, and expertise to the development of an array of embedded services that specifically respond to community needs. Counties, especially in rural Minnesota, are often the sole provider of direct care services which usually require additional efforts (and additional levy resources) to ensure the basic needs of each community member are appropriately met.

Provider (Coordinating with the External Service Network)

Counties offer specialized expertise in serving public consumers. Because of long-standing local reference points, counties are best positioned to link individual citizens with unique local supports (both formal and informal). Counties claim expertise in intensive person-to-person and community-based service delivery. By understanding the integration of funding (Private, County, State, and Federal funding) *and* the available community resources (County, Non-Profit, Private), Counties are uniquely afforded the perspective to provide case management services in a manner that are customized to the individual. Addressing the needs of consumers in this dual manner mitigates the limitations of a model that is based more solely on "funding" as the primary driver of service delivery. Funding defined tasks naturally creates an incentive for "task completion" for all eligible clients, regardless for the individual's need for the specified services.

Counties believe it is critical that individualized care plans are customized to match personal needs with community services. The funding needs to be packaged in a manner that supports customized care plans.

How Can County Case Management Improve into the Future?

Funding, care delivery, increased acuity, data privacy, and liability are all becoming more complex and difficult to manage. There is an ever-growing need for simplification and streamlining of case management services. The overarching goal of county case management is to meet clients at their starting place and then incrementally and purposefully help each individual improve to their highest level of functioning, according to their life goals.

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Focus Points for Improvements:

1. Streamline equitable funding formulas for county case management at sustainable levels to best address the statewide needs for this proven and cost-effective service. Complimentary to this funding reform, there is an imminent need to establish clear practice standards to include: formatted case notes, weighted or tiered caseload targets, standardized assessments, and standardized billing protocols/audits from outside payer sources (e.g. MCOs). There are many unnecessary complexities and incongruent processes when consumers and county case managers try to navigate changes as individuals choose different health care providers, move to a different county, or seek out new programs. This lack of standardization creates functional barriers and personal frustrations as people try to access services.

2. Train both new and experienced county case management staff/vendors under client-centered philosophies that respect individual differences and address issues of diversity (Olmstead).

3. Define meaningful performance measures for county case management that objectively reflect the collective thinking of consumers, county case managers, and others who directly help consumers achieve progress on their life goals. We need measurements to evolve beyond task-performance, and instead measure progress/stability on individualized goals.

Why do Counties want to Continue Providing Case Management Services into the Future?

County case management is a core function interwoven in the fabric of the local community service delivery system. Counties have extensive history and experience providing and contracting for these direct care services. Counties have also learned how to be responsive to the comingling of political, economic, and social forces that impact these subpopulations. This unique skill set and perspective enables county staff to triage real life circumstances with consumers very efficiently and effectively, drawing upon the full continuum of county services. This approach to community-based care would be very hard to replicate outside the public sector.

Foundational Elements for the Future of County Case Management

1. County case managers are directly integrated into the local network of care and are therefore able to offer smooth coordination and seamless handoffs with other community providers. This strength should be maximized into the future. Counties also offer the stability of a governmental infrastructure, which embeds checks and balances and minimizes internal and external gaps, silos, and barriers to consumers. We strive to limit disparities for the people we serve, and through standardization, improve the quality and consistency in how we serve others.

2. Counties should continue to maintain our primary position in providing (or purchasing and overseeing) case management services. Direct connection to the County Attorney, the Courts, and DHS afford counties important systemic advantages. Most critically, counties understand case management is built on establishing a mutual relationship between the case manager and the consumer. As opposed to a system built on funding "tasks", Counties understand we can measure vital rapport in tangible terms of client successes, health, and safety.

3. Counties are able to manage overall revenues and expenses across disciplines to sustain core services through hard economic times. An integrated service model will reduce the impact of volatility in any particular service area, at any given point in time. Counties' role in the community-based network of care, our partnering with consumers to measure individual successes, and our long-standing fiscal commitment to preserving the core mission of county case management over the long term, should be respected and preserved into the future.

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July 2015

MACSSA
Minnesota Association of County Social Service Administrators

Minnesota Association of County Social Service Administrators
125 Charles Avenue, St. Paul, MN 55103-2108
651-789-4340
www.macssa.org

Consideration of Public Health Nurse vs. Social Worker

- Requirement of a Multi-disciplinary Team approach to MNChoices and Assessments/Case Management
  - Currently the only PHN that works with HCBS programs is the PH Supervisor
  - Currently there are 5 Social Workers working with HCBS programs/waivers, they have trained and are currently conducting MNChoices assessments.
- Cases are medically fragile and complex
  - Consistent and ongoing discussion and consultation between SW and nursing staff re: medical needs, devices, prescriptions, co-morbidity, etc.
  - CADI, CAC, BI--all are medical waiver programs
- Ongoing/Back-up/Additional nursing support for PH Team
  - Immunizations/flu shots/outbreaks, etc.
  - Emergency Preparedness
  - When other staff are out--retirement, vacations, medical/family leave, etc.

Consideration of Public Health Nurse vs. Registered Nurse

- Public Health Nurse Credentialing Requirements
  - A Registered Nurse must be licensed and currently registered in MN
  - Have a Baccalaureate or higher degree with a major in nursing
  - Have completed course work which includes theory and clinical practice in public health nursing as outlined in MN statute (not all schools offer this coursework nor do all nursing students choose to complete this option)
  - Submit application and fee and be approved
- The additional education and experiential learning equips and prepares a PHN for the PH philosophy, policy, system and environmental work. PHN's have the educational background to work with groups, community engagement, politics, family and group dynamics, epidemiology and population assessments.
- Staff hired with a PHN certificate will likely undergo less PH orientation due to their ability to better understand basic PH concepts (RN's that have been hired for positions in the past have undergone a significant learning curve)
- PHN's receive education and training to work collaboratively with agencies/departments that RNs trained to work 1-1 with patients are not always likely to collaborate with, i.e. social services, court system, mental health, child protection, etc.
- In HCBS/MNChoices, if we hired an entry level RN, it would take a minimum of 2 years experience before they can be trained and certified as a MNChoices assessor....this is a reimbursable position...with ½ their position doing MNChoices assessment work. A significant portion of the staff's position will be reimbursed with revenue producing work.
- With this particular position, even an entry level PHN is required to have at least 1 year experience before moving on with MNChoices training/assessing capabilities.
- We have already run into issues with PCA assessments, as they MUST be completed by a PHN. Our current HCBS nursing staff is not a PHN. There are cases in which legacy documents must continue to

be completed...we have no HCBS PHN staff other than the PH Supervisor to complete or approve these documents.

- TANF has some language that targeted home visiting requires that a PHN complete an initial family assessment in order to accept TANF FHV funds for those services. If a PHN is not performing those services, MDH wants to know why, the nurse's background, credentials, experience and additional training that qualify them to perform in such a capacity.
- The Minnesota Board of Nursing examination tests the minimum qualifications to conduct Registered Nursing safely in the State of MN. However, that said, it does not account for additional training and experiential learning included and provided by BSN/PHN programs.

Offering a higher wage to candidates

- There have been 5 offers made to date. 2 of those offers were to the same individual. 3 individuals were already making above our current experienced staff and supervisor. To my knowledge, the counter offers were all above current PH staff with the most seniority.
- Offers were made at a level taking into consideration the candidate's education, experience, HCBS experience, ability to be MNChoices Assessor trained and in comparison to where current PH staff are on the wage scale. We did not feel it was justified to offer less experienced staff the same wage as our experienced staff.
- It is a disservice and disrespect to bring new PH staff (yes, many years of nursing experience, however, few to no years of PH experience) in at a wage just under, at or over current PH staff. We have staff that have dedicated their careers to this agency and have gotten no recognition of that or market rate when placed on the new pay scale.
- This practice creates morale issues, distrust, team unrest, agency turmoil and retention issues.

Consideration of Part-Time vs. Full-Time

- We have a caseload supporting full-time
- Reassessments and Managed Care are both set to roll-out and be in full production by the first of the year
- Assessments take on average 10 hours to complete--geography is an issue in Aitkin County, travel time is significant
- Supporting other PH activities by working more than part-time hours is unlikely due to the salaried position.

Shifting Present Staff

- 1 PHN option
    - Considered shifting caseloads/focus area and shadowed Case Manager prior to resignation
    - Has training and background in family health and early intervention
    - Has received specialized cohort infant/child mental health training at U of M
    - Would need to backfill position to manage programs that require additional training, i.e. WIC

- 2 Social Workers
    - Coordinating new initiative and nationally recognized program
    - Obtained credentialing, training and certifications to perform CD assessments and manage MI clients
- Work satisfaction and retention concerns

Additional Eligibility Requirements for Staff (MNChoices Certified Assessors)

Qualified candidates must complete required training and have at least one of the following:

- Bachelor's degree in social work plus at least one year of home and community-based experience
- Bachelor's degree in nursing with current licensure as a registered nurse along with public health certification and at least one year of home and community-based experience
- Bachelor's degree in a closely related field plus at least one year of home and community-based experience
- Current license as a registered nurse with at least two years of home and community-based experience.

Additional MNChoices Training Requirements

- The MnCAT training consists of four steps. Steps 1, 2 and 3 require you to pass tests with an 80% proficiency or higher before moving to the next course.

- **Steps 1 and 2**
- These MnCAT steps are available in DHS TrainLink. Anyone may take Steps 1 and 2 if they have a TrainLink unique ID (PDF).
    - **Step 1. Foundations = 4 to 5 hours**
        - **Overview**: Online course providing a basic understanding about MnCHOICES
        - **Basics**: Series of open book tests about fundamental information certified assessors need to know that links to online resources

    - **Step 2. Principles = 10 to 12 hours**
        - Consists of seven eLearning program courses
        - Includes key principles about MnCHOICES and attributes of a certified assessor
- **Step 3**
    - This step is also available in TrainLink. DHS will send this link to lead agencies when they are preparing to launch or have launched MnCHOICES. Step 3 requires access to the MnCHOICES Training Zone (MTZ), which is available through a lead agency MnCHOICES Mentor.
    - **Step 3. Application = 7 to 8 hours plus an actual Assessment which = another 10 hours**
        - Access and navigate MnCHOICES and instructed activities in MnCAT Training Zone
        - Increase familiarity with assessment content/functions and instructed activities in MTZ
        - Complete an assessment based on given scenario and participating in a multi-disciplinary learning lab.
- **Step 4**
        - This is continuing education and professional development to support certified assessors to enhance their knowledge and skills.
        - **Recertification**
        - Every three years
        - Professional development that deepens knowledge, skills and abilities of a certified assessor.

Per MACSSA Policy Statement dated July 2015:

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Care Coordination Requirements for Managed Care

- The Care Coordinator will work with the member with support from IHM-GP staff and/or Government Programs staff to assure that the member has access to the following services as needed:
    - 1) Rehabilitative Services. These are services that promote the rehabilitation of members following acute events and for ensuring the smooth transition and coordination of information between acute, sub-acute, rehabilitation, nursing home and community settings.
    - 2) Range of Choices. The care coordinator is key in ensuring access to an adequate range of choices for members by helping the member identify formal as well as informal supports and services, ensuring that the services are culturally sensitive. Interpreter services are available for all BluePlus members.
    - 3) Coordination with Social Services. The Care Coordinator will collaborate with the local Social Service Agency when the member may require any of the following services:
        - Pre-petition Screening
        - OBRA Level II Screening
        - Spousal Impoverishment Assessments
        - Adult Foster Care
        - Group Residential Housing and Board Payments; or
        - Extended Care or Halfway House Services covered by the Consolidated Chemical Dependency Treatment Fund
        - Targeted Mental Health Case Management
        - Adult Protection
    - 4) Coordination with Veteran's Administration (VA). The Care Coordinator shall coordinate services and supports with those provided by the VA if known and available to the member.
    - 5) If the Care Coordinator receives notification of a member's hospital admission, contact will be made with the hospital social worker/ discharge planner, to assist with discharge planning. The Care Coordinator can work with the discharge planner, member or home care nurse (if appropriate) to complete the following:
        - Assess the member's medical condition;
        - Identify any significant health changes;
        - Reassess and revise the CSP for the member to meet their new health needs, if required; and
        - Schedule an interdisciplinary team conference, if needed at this time.

- 6) Identification of Special Needs and Referrals to Specialists. The Care Coordinator should have the ability to identify special needs that are common geriatric medical conditions and functional problems such as poly pharmacy issues, lack of supports, high risk health conditions, cognitive problems, etc. and assist the member in obtaining specialized services to meet identified needs.

Care Plan Service and Guidelines

Delegate staff use professional judgment interpreting the following guidelines to make decisions related to the care and treatment of their Blue Advantage (MSC+) members:

- MN rules and statutes,
- DHS policies and training,
- County program training and guidelines,
- Provider training and guidelines,
- Medicare coverage criteria,
- Long Term Care Screening Document,
- Disease Management protocols,
- Case mix caps/budget, and
- Blue Advantage (MSC+) Certificate of Coverage

Additional MCO Requirements

- Completion of additional forms customized to Managed Care programs
- Adherence to specific guidelines and timelines set forth by Managed Care organizations
- Documented compliance, reviewed during annual audits by Managed Care organizations

HCBS Nurse WORKER SALARY CHART W/BENEFITS

2015		Start	1	2	3	4	6
2015 Wage Scale		**A**	**B**	**C**	**D**	**E**	**F**
GRADE 10		$ 25.30	$ 26.05	$ 26.82	$ 27.62	$ 28.44	$ 29.28
FICA		$ 1.94	$ 1.99	$ 2.05	$ 2.11	$ 2.18	$ 2.24
PERA		$ 1.83	$ 1.89	$ 1.94	$ 2.00	$ 2.06	$ 2.12
Health/Life Single		$ 4.41	$ 4.41	$ 4.41	$ 4.41	$ 4.41	$ 4.41
Total Hourly	**$ -**	**$ 33.48**	**$ 34.34**	**$ 35.23**	**$ 36.14**	**$ 37.08**	**$ 38.05**
Total Salary	**$ -**	**$ 69,637.78**	**$ 71,430.22**	**$ 73,276.43**	**$ 75,178.03**	**$ 77,136.68**	**$ 79,154.08**

CADI Case Manage	$ 24.47	15 min units/Fed and State Share
	$ 240.00	units per month
Monthly CM	$ 5,872.80	
Yearly CM	$ 70,473.60	

**Worker will also bring in SSTS Admin revenue

**ALL MNChoice Assessments are reimbursed by SSTS Admin.

2015						
2015 Wage Scale		**K**	**L**	**M**	**N**	**Maximum/O**
GRADE 10		$ 33.90	$ 34.91	$ 35.94	$ 37.01	$ 37.80
FICA		$ 2.59	$ 2.67	$ 2.75	$ 2.83	$ 2.89
PERA		$ 2.46	$ 2.53	$ 2.61	$ 2.68	$ 2.74
Health/Life Single		$ 4.41	$ 4.41	$ 4.41	$ 4.41	$ 4.41
Total Hourly	**$ -**	**$ 43.36**	**$ 44.52**	**$ 45.71**	**$ 46.94**	**$ 47.84**
Total Salary	**$ -**	**$ 90,186.09**	**$ 92,594.98**	**$ 95,076.14**	**$ 97,631.73**	**$ 99,511.78**

Minnesota Department of Human Services

Bulletin

NUMBER
#15-68-09

DATE
July 8, 2015

OF INTEREST TO
County Directors
Tribal Directors
Social Services Supervisors
Fiscal Supervisors
Financial Assistance Supervisors and Staff

ACTION/DUE DATE
Please read and submit amended plan.

EXPIRATION DATE
July 8, 2017

Child Protection Allocation

TOPIC

Funds allocated by the Minnesota Legislature for child protection staffing and services.

PURPOSE

Notify county agencies of requirements and responsibilities regarding submission of amended plan to Vulnerable Children and Adults Act and use of child protection funds.

CONTACT

Ralph McQuarter, director, Management Operations, Children and Family Services Administration, 651-431-3858, or ralph.mcquarter@state.mn.us

SIGNED

JAMES G. KOPPEL
Assistant Commissioner
Children and Family Services Administration

TERMINOLOGY NOTICE

The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of "People First" language.

I. Child Protection Funding Background

During the 2015 legislative session, $23,350,000 was appropriated annually to the Minnesota Department of Human Services (department) for allocation to county agencies for child protection staffing and services under Minnesota Statutes, section 256M.41. The intent of the legislation is to improve the current child protection worker caseloads so that more timely case work will occur to support children in need of protection.

A. Formula

Allocations to county agencies are shown in Attachment A and are determined as follows:

1. Child population

Fifty percent must be distributed to county agencies based on the child population residing in the county.

2. Screened in reports

Twenty-five percent must be distributed based on the number of screened in reports of child maltreatment in the county.

3. Open child protection case management

Twenty-five percent must be distributed based on the number of open child protection case management cases in the county.

B. Guaranteed Floor

No county will be awarded an allocation less than $75,000 each year.

II. Payments based on Performance

County agencies will receive 80 percent of their full allocation between July 1 and July 10 each year. However, 20 percent of the full allocation will be retained until it is determined in January of the next calendar year that the agency met two requirements in the previous calendar year. If the requirements are met, then the remaining portion will be distributed in February. If requirements are not met, those remaining funds will be re-distributed to county agencies meeting the requirements.

A. Timely Face-to-face Contact with Alleged Child Victims

Ten percent of a county agency's full allocation will be withheld until the department determines if an agency has met the performance outcome threshold of 90 percent based

on face-to-face contact with alleged child victims. To receive the performance allocation, county child protection workers must have timely face-to-face contact with at least 90 percent of all alleged child victims of screened in maltreatment reports. The face-to-face contact with the child and primary caregiver shall occur immediately if sexual abuse or substantial child endangerment is alleged and within five calendar days for all other reports.

B. Monthly Caseworker Visits

Ten percent of a county agency's full allocation will be withheld until the department determines if an agency has met the performance outcome threshold of 90 percent based on face-to-face visits by the case manager. To receive the performance allocation, the total number of visits made by caseworkers on a monthly basis to children in foster care and children receiving child protection services while residing in their home must be at least 90 percent of the total number of such visits that would occur if every child were visited once per month. Note: For 2015 only, the Minnesota Legislature requires that the department apply the standard only to monthly foster care visits, and not to visits to children residing in their home.

III. Non-supplantation

County agencies are prohibited from supplanting existing county funds with the funds appropriated under Minnesota Statutes, section 256M.41. Funds received under this section must be used to address additional staffing for child protection or expand child protection services.

A. Eligible BRASS Codes

The BRASS (Budgeting, Reporting and Accounting for Social Services) codes in the Children's 1000 series have been approved as eligible services for use under 256M.41. The Social Service Information System (SSIS) uses BRASS codes as the basis for tracking county social service activity.

The department will be reviewing each county agency's Social Services Expenditure and Grant Reconciliation (SEAGR) report for eligible Children's 1000 series codes by "Staff Costs" and "Purchased Services Costs" provided in SSIS for the calendar year to determine if the non-supplantation requirements have been met.

Complete descriptions of BRASS services can be found in bulletin #14-32-13, titled "Changes to DHS BRASS Manual for Calendar Year 2015".

B. Amended Vulnerable Children and Adults Services Plan

The 2011 Minnesota Legislature created the Vulnerable Children and Adults Act (VCA). Minnesota Statutes, section 256M.30 requires county agencies to update plans as needed to reflect current county policy and procedures regarding requirements and use of

funds under Minnesota Statutes, chapter 256M. As child protection funding has been incorporated into the Act, agencies are required to submit a revised VCA plan to describe plans for use of the funds, and to certify that these funds will not be used to supplant existing county funds. This information will be provided to the legislature. Plans must be submitted to the Minnesota Department of Human Services by August 31, 2015.

The format for the VCA plan amendment is found in Attachment D. Multi-county consortiums can submit one amendment in lieu of individual county amendments.

Submit plans with signatures electronically to: ralph.mcquarter@state.mn.us.

The department may require revisions to submitted plans if it is determined to be in non-compliance with legislative intent.

IV. Frequently Asked Questions

The following questions have been asked since the Minnesota Legislature enacted Minnesota Statutes, section 256M.41 and appropriated funds.

A. Staffing

1. Can funds be used for staff hired prior to the effective date of the law? **Answer**: No. Only additional positions that increased the county's child protection staff levels hired after June 30, 2015, can be considered new hires.

2. What classifications are eligible? **Answer**: Social worker, social worker-child protection specialist, social work team leader; paraprofessional classifications such as case aide or family based services provider; and supervisory job classifications such as social services supervisor or human services supervisor.

3. What costs can be covered under staffing? Can funds be used for staff equipment and set-up of new hires? **Answer**: Eligible staffing costs include staff salaries, overhead, and support costs, such as supplies and equipment.

B. Services

1. During the legislative session, there was discussion about use of the funds for child care, Head Start, and other services for children in need of protection to address waiting lists. Can the funds be used for those purposes? **Answer**: Final legislative action did not include these provisions.

C. Data

1. How will performance be determined and what data will be used? **Answer**: For the remaining 20 percent withheld, in January of 2016 staff will run a data query on county performance for the two performance measures that represents calendar

year 2015 performance. As indicated earlier, for 2015 only, the Minnesota Legislature requires that the department apply the monthly caseworker visits standard only to monthly foster care visits, and not to visits to children residing in their home. Note: The data tables provided in this bulletin are for reference only. The older data will not be used for determination of a withhold.

D. Allocations

1. How will re-distribution occur in February of each year? **Answer**: Withheld funds not released to original county agencies will be re-distributed on a pro-rated basis to county agencies meeting the requirements.

2. Will the allocation formula change over time? **Answer**: Not until and unless the Minnesota Legislature changes the statute. However, the department is required to evaluate the formula and recommend an updated equitable distribution formula beginning in fiscal year 2018. This includes:

- Funding for child protection staffing and expanded services to county agencies and tribes
- Taking into consideration any relief to county agencies and tribes for child welfare and foster care costs
- Additional tribes delivering social services
- Any other relevant information that should be considered in developing a new distribution formula.

The report is due to the Minnesota Legislature by December 15, 2016.

E. Amended VCA Plans

1. How will county agencies know if their submitted amendment is approved? **Answer**: The county contact person submitting an amendment will be contacted with a verification when the plan is approved.

2. How does a county agency obtain a copy of its current VCA plan? **Answer**: Each county agency should be maintaining its current plan but, if necessary, request current plans by contacting: ralph.mcquarter@state.mn.us.

E. Miscellaneous

1. Can county boards choose to use these funds to cover costs of the sheriff's office, county attorney's office, or other areas? **Answer**: During the task force hearings and during the legislative session, there were discussions about the impact on the sheriff's office and county attorney's office, but final legislative action did not include appropriations for these activities.

2. Do the background study requirements passed this session apply to new positions added by county agencies as a result of these allocations? **Answer**: Yes. County employees hired on or after July 1, 2015, who have responsibility for child protection duties or current county employees who are assigned new child protection duties on or after July 1, 2015, are required to undergo a background study. A county may complete these background studies by either use of the Department of Human Services NetStudy 2.0 system, or an alternative process defined by the county.

County social service agencies and local welfare agencies must initiate background studies before an individual begins a position allowing direct contact with persons served by the agency. Contact Jennifer.Henthorne@state.mn.us of the Office of Inspector General for more information.

3. Will tribes receive allocations? **Answer**: As participants in the American Indian Child Welfare Initiative, White Earth and Leech Lake Bands of Ojibwe will each receive $75,000 per a separate statute [Minnesota Statutes, section 256E.28].

In addition, a state allocation of $1,500,000 to address child welfare disparities will be awarded through a request for proposal process; tribes are eligible applicants.

V. Authority for Child Protection Funding

Laws of Minnesota 2015, chapter 71, article 1, section 46.

VI. Attachments

Multiple attachments

- Attachment A: County Staffing/Services Allocation
- Attachment B: Performance Withholds: Timely Face-to-face Contact with Alleged Child Victim
- Attachment C: Performance Withholds: Monthly Face-to-face Visits by Caseworker
- Attachment D: Vulnerable Children and Adults Plan Amendment for Child Protection Funding

Americans with Disabilities Act (ADA) Advisory

This information is available in accessible formats for people with disabilities by calling (651) 431-4670 (voice) or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

Attachment A: County Staffing/Services Allocation

County/County Consortium	Base Allocation (issued in July)	Performance Withhold (issued in February)	Total Allocation	Est. FTEs at Salary Avg ($75,000)
Aitkin	$60,000	$15,000	$75,000	1.0
Anoka	$955,200	$238,800	$1,194,000	15.9
Becker	$172,800	$43,200	$216,000	2.9
Beltrami	$180,800	$45,200	$226,000	3.0
Benton	$138,400	$34,600	$173,000	2.3
Big Stone	$60,000	$15,000	$75,000	1.0
Blue Earth	$162,400	$40,600	$203,000	2.7
Brown	$99,200	$24,800	$124,000	1.7
Carlton	$125,600	$31,400	$157,000	2.1
Carver	$278,400	$69,600	$348,000	4.6
Cass	$108,000	$27,000	$135,000	1.8
Chippewa	$60,000	$15,000	$75,000	1.0
Chisago	$148,000	$37,000	$185,000	2.5
Clay	$205,600	$51,400	$257,000	3.4
Clearwater	$60,000	$15,000	$75,000	1.0
Cook	$60,000	$15,000	$75,000	1.0
Crow Wing	$196,800	$49,200	$246,000	3.3
Dakota	$1,139,200	$284,800	$1,424,000	19.0
Douglas	$117,600	$29,400	$147,000	2.0
Fillmore	$64,000	$16,000	$80,000	1.1
Freeborn	$97,600	$24,400	$122,000	1.6
Goodhue	$126,400	$31,600	$158,000	2.1
Grant	$60,000	$15,000	$75,000	1.0
Hennepin	$4,361,600	$1,090,400	$5,452,000	72.7
Houston	$60,000	$15,000	$75,000	1.0
Hubbard	$116,000	$29,000	$145,000	1.9
Isanti	$131,200	$32,800	$164,000	2.2
Itasca	$156,000	$39,000	$195,000	2.6
Kanabec	$60,000	$15,000	$75,000	1.0
Kandiyohi	$149,600	$37,400	$187,000	2.5
Kittson	$60,000	$15,000	$75,000	1.0
Koochiching	$60,000	$15,000	$75,000	1.0
Lac qui Parle	$60,000	$15,000	$75,000	1.0
Lake	$60,000	$15,000	$75,000	1.0
Lake of the Woods	$60,000	$15,000	$75,000	1.0
Le Sueur	$84,800	$21,200	$106,000	1.4
McLeod	$161,600	$40,400	$202,000	2.7
Mahnomen	$60,000	$15,000	$75,000	1.0
Marshall	$60,000	$15,000	$75,000	1.0
Meeker	$60,000	$15,000	$75,000	1.0
Mille Lacs	$120,800	$30,200	$151,000	2.0
Morrison	$112,800	$28,200	$141,000	1.9
Mower	$148,000	$37,000	$185,000	2.5
Nicollet	$103,200	$25,800	$129,000	1.7
Nobles	$81,600	$20,400	$102,000	1.4
Norman	$60,000	$15,000	$75,000	1.0
Olmsted	$492,800	$123,200	$616,000	8.2
Otter Tail	$188,800	$47,200	$236,000	3.1
Pennington	$60,000	$15,000	$75,000	1.0
Pine	$111,200	$27,800	$139,000	1.9
Polk	$122,400	$30,600	$153,000	2.0
Pope	$60,000	$15,000	$75,000	1.0
Ramsey	$1,608,000	$402,000	$2,010,000	26.8
Red Lake	$60,000	$15,000	$75,000	1.0
Renville	$68,800	$17,200	$86,000	1.1
Rice	$184,000	$46,000	$230,000	3.1
Roseau	$60,800	$15,200	$76,000	1.0
St. Louis	$786,400	$196,600	$983,000	13.1
Scott	$453,600	$113,400	$567,000	7.6
Sherburne	$262,400	$65,600	$328,000	4.4
Sibley	$60,000	$15,000	$75,000	1.0
Stearns	$448,000	$112,000	$560,000	7.5
Stevens	$60,000	$15,000	$75,000	1.0
Swift	$65,600	$16,400	$82,000	1.1
Todd	$86,400	$21,600	$108,000	1.4
Traverse	$60,000	$15,000	$75,000	1.0
Wabasha	$63,200	$15,800	$79,000	1.1
Wadena	$60,000	$15,000	$75,000	1.0
Washington	$582,400	$145,600	$728,000	9.7
Watonwan	$60,000	$15,000	$75,000	1.0
Wilkin	$60,000	$15,000	$75,000	1.0
Winona	$149,600	$37,400	$187,000	2.5
Wright	$383,200	$95,800	$479,000	6.4
Yellow Medicine	$60,000	$15,000	$75,000	1.0
SWHHS: Lincoln, Lyon, Murray, Pipestone, Rock, Redwood	$360,000	$90,000	$450,000	6.0
DVHHS: Cottonwood & Jackson	$120,000	$30,000	$150,000	2.0
Faribault-Martin	$161,600	$40,400	$202,000	2.7
MN Prairie: Dodge, Steele, Waseca	$257,600	$64,400	$322,000	4.3
Total	**$18,680,000**	**$4,670,000**	**$23,350,000**	**311.3**

Attachment B: Performance Withholds: Timely Face-to-face Contact with Alleged Child Victim

	Final CY 2014			CY 2013			CY 2012			Three Year Average (2012-2014)		
	Numerator	Denominator	Results	Numerator	Denominator	Results	Numerator	Denominator	Results	Numerator	Denominator	Results
County/County Consortium	Within time frame	Total child subjects	Percent having contact within time frame	Within time frame	Total child subjects	Percent having contact within time frame	Within time frame	Total child subjects	Percent having contact within time frame	Within time frame	Total child subjects	Percent having contact within time frame
Aitkin	57	102	55.9%	59	111	53.2%	47	87	54.0%	163	300	54.3%
Anoka	805	965	83.4%	737	925	79.7%	862	1,055	81.7%	2,404	2,945	81.6%
Becker	279	328	85.1%	266	361	73.7%	159	223	71.3%	704	912	77.2%
Beltrami	195	278	70.1%	194	287	67.6%	129	209	61.7%	518	774	66.9%
Benton	142	163	87.1%	111	137	81.0%	135	153	88.2%	388	453	85.7%
Big Stone	30	42	71.4%	14	15	93.3%	16	31	51.6%	60	88	68.2%
Blue Earth	171	190	90.0%	154	204	75.5%	195	292	66.8%	520	686	75.8%
Brown	179	206	86.9%	183	200	91.5%	150	167	89.8%	512	573	89.4%
Carlton	209	248	84.3%	177	196	90.3%	201	227	88.5%	587	671	87.5%
Carver	275	302	91.1%	265	317	83.6%	300	339	88.5%	840	958	87.7%
Cass	104	143	72.7%	122	155	78.7%	105	143	73.4%	331	441	75.1%
Chippewa	45	45	100.0%	46	46	100.0%	34	34	100.0%	125	125	100.0%
Chisago	127	154	82.5%	125	154	81.2%	102	133	76.7%	354	441	80.3%
Clay	274	323	84.8%	268	371	72.2%	190	307	61.9%	732	1,001	73.1%
Clearwater	123	133	92.5%	139	182	76.4%	167	207	80.7%	429	522	82.2%
Cook	16	22	72.7%	29	37	78.4%	13	22	59.1%	58	81	71.6%
Crow Wing	279	333	83.8%	216	237	91.1%	198	250	79.2%	693	820	84.5%
Dakota	1,393	1,677	83.1%	1,295	1,518	85.3%	1,385	1,652	83.8%	4,073	4,847	84.0%
Douglas	197	237	83.1%	195	264	73.9%	197	247	79.8%	589	748	78.7%
Fillmore	70	80	87.5%	62	69	89.9%	55	61	90.2%	187	210	89.0%
Freeborn	127	142	89.4%	140	164	85.4%	95	108	88.0%	362	414	87.4%
Goodhue	138	156	88.5%	117	145	80.7%	38	75	50.7%	293	376	77.9%
Grant	49	59	83.1%	63	67	94.0%	52	58	89.7%	164	184	89.1%
Hennepin	3,974	6,701	59.3%	3,751	6,757	55.5%	3,899	6,029	64.7%	11,624	19,487	59.7%
Houston	31	49	63.3%	26	46	56.5%	22	42	52.4%	79	137	57.7%
Hubbard	191	220	86.8%	124	145	85.5%	92	129	71.3%	407	494	82.4%
Isanti	122	160	76.3%	183	233	78.5%	156	185	84.3%	461	578	79.8%
Itasca	194	255	76.1%	211	295	71.5%	151	209	72.2%	556	759	73.3%
Kanabec	54	65	83.1%	45	58	77.6%	97	113	85.8%	196	236	83.1%
Kandiyohi	251	294	85.4%	284	342	83.0%	249	306	81.4%	784	942	83.2%
Kittson	15	16	93.8%	3	5	60.0%	11	16	68.8%	29	37	78.4%
Koochiching	55	70	78.6%	52	61	85.2%	51	68	75.0%	158	199	79.4%
Lac qui Parle	35	40	87.5%	46	56	82.1%	26	26	100.0%	107	122	87.7%
Lake	45	53	84.9%	52	64	81.3%	44	71	62.0%	141	188	75.0%
Lake of the Woods	15	16	93.8%	21	21	100.0%	13	14	92.9%	49	51	96.1%
Le Sueur	98	110	89.1%	67	67	100.0%	90	92	97.8%	255	269	94.8%
McLeod	279	304	91.8%	233	255	91.4%	184	211	87.2%	696	770	90.4%
Mahnomen	18	21	85.7%	7	12	58.3%	4	8	50.0%	29	41	70.7%

	Final CY 2014			CY 2013			CY 2012			Three Year Average (2012-2014)		
	Numerator	Denominator	Results	Numerator	Denominator	Results	Numerator	Denominator	Results	Numerator	Denominator	Results
County/County Consortium	Within time frame	Total child subjects	Percent having contact within time frame	Within time frame	Total child subjects	Percent having contact within time frame	Within time frame	Total child subjects	Percent having contact within time frame	Within time frame	Total child subjects	Percent having contact within time frame
Marshall	56	58	96.6%	50	52	96.2%	52	56	92.9%	158	166	95.2%
Meeker	54	61	88.5%	27	33	81.8%	20	32	62.5%	101	126	80.2%
Mille Lacs	248	280	88.6%	293	329	89.1%	206	229	90.0%	747	838	89.1%
Morrison	164	170	96.5%	125	137	91.2%	126	129	97.7%	415	436	95.2%
Mower	257	317	81.1%	163	238	68.5%	141	179	78.8%	561	734	76.4%
Nicollet	86	89	96.6%	78	78	100.0%	126	140	90.0%	290	307	94.5%
Nobles	144	180	80.0%	93	115	80.9%	67	77	87.0%	304	372	81.7%
Norman	65	67	97.0%	45	58	77.6%	54	59	91.5%	164	184	89.1%
Olmsted	686	775	88.5%	642	709	90.6%	537	613	87.6%	1,865	2,097	88.9%
Otter Tail	255	328	77.7%	223	298	74.8%	241	317	76.0%	719	943	76.2%
Pennington	15	28	53.6%	20	38	52.6%	12	26	46.2%	47	92	51.1%
Pine	167	235	71.1%	114	241	47.3%	125	218	57.3%	406	694	58.5%
Polk	282	299	94.3%	337	352	95.7%	255	286	89.2%	874	937	93.3%
Pope	53	66	80.3%	94	107	87.9%	59	74	79.7%	206	247	83.4%
Ramsey	2,050	2,200	93.2%	1,723	1,865	92.4%	1,659	1,841	90.1%	5,432	5,906	92.0%
Red Lake	7	7	100.0%	2	2	100.0%	4	4	100.0%	13	13	100.0%
Renville	79	114	69.3%	51	92	55.4%	54	71	76.1%	184	277	66.4%
Rice	255	298	85.6%	211	249	84.7%	240	266	90.2%	706	813	86.8%
Roseau	63	67	94.0%	54	63	85.7%	41	50	82.0%	158	180	87.8%
St. Louis	1,270	1,723	73.7%	1,187	1,790	66.3%	1,166	1,663	70.1%	3,623	5,176	70.0%
Scott	493	589	83.7%	539	654	82.4%	452	515	87.8%	1,484	1,758	84.4%
Sherburne	247	278	88.8%	273	302	90.4%	213	239	89.1%	733	819	89.5%
Sibley	79	87	90.8%	76	93	81.7%	65	73	89.0%	220	253	87.0%
Stearns	378	625	60.5%	383	652	58.7%	299	515	58.1%	1,060	1,792	59.2%
Stevens	49	53	92.5%	24	32	75.0%	41	61	67.2%	114	146	78.1%
Swift	137	159	86.2%	59	69	85.5%	85	94	90.4%	281	322	87.3%
Todd	85	119	71.4%	79	129	61.2%	91	118	77.1%	255	366	69.7%
Traverse	64	67	95.5%	39	47	83.0%	35	44	79.5%	138	158	87.3%
Wabasha	91	106	85.8%	56	76	73.7%	54	77	70.1%	201	259	77.6%
Wadena	91	115	79.1%	148	195	75.9%	144	185	77.8%	383	495	77.4%
Washington	514	554	92.8%	533	574	92.9%	511	605	84.5%	1,558	1,733	89.9%
Watonwan	27	32	84.4%	37	49	75.5%	42	60	70.0%	106	141	75.2%
Wilkin	26	32	81.3%	11	15	73.3%	11	19	57.9%	48	66	72.7%
Winona	331	347	95.4%	364	392	92.9%	302	337	89.6%	997	1,076	92.7%
Wright	416	498	83.5%	316	424	74.5%	365	464	78.7%	1,097	1,386	79.1%
Yellow Medicine	66	68	97.1%	87	96	90.6%	58	68	85.3%	211	232	90.9%
SWHHS: Lincoln, Lyon, Murray, Pipestone, Rock, Redwood	305	387	78.8%	288	380	75.8%	277	331	83.7%	870	1,098	79.2%
DVHHS: Cottonwood & Jackson	89	96	92.7%	61	82	74.4%	90	100	90.0%	240	278	86.3%
Faribault-Martin	278	348	79.9%	210	272	77.2%	189	284	66.5%	677	904	74.9%
MN Prairie: Dodge, Steele, Waseca	331	376	88.0%	299	373	80.2%	233	299	77.9%	857	1,048	81.8%
Minnesota (Counties	**21,014**	**27,000**	**77.8%**	**19,496**	**26,331**	**74.0%**	**18,656**	**24,417**	**76.4%**	**59,160**	**77,748**	**76.1%**

Attachment C: Performance Withholds: Monthly Face-to-Face Visits by Caseworker

	Final CY 2014			CY 2013			CY 2012			Three Year Average (2012-2014)		
	Numerator	Denominator	Results	Numerator	Denominator	Results	Numerator	Denominator	Results	Numerator	Denominator	Results
County/County Consortium	Total months that had a visit	Total months requiring visits in care	Percent of months with a social worker visit	Total months that had a visit	Total months requiring visits in care	Percent of months with a social worker visit	Total months that had a visit	Total months requiring visits in care	Percent of months with a social worker visit	Total months that had a visit	Total months requiring visits in care	Percent of months with a social worker visit
Aitkin	175	204	85.8%	182	204	89.2%	140	145	96.6%	497	553	89.9%
Anoka	1,966	2,223	88.4%	1,731	1,968	88.0%	1,531	1,754	87.3%	5,228	5,945	87.9%
Becker	989	1,050	94.2%	1,008	1,041	96.8%	807	814	99.1%	2,804	2,905	96.5%
Beltrami	1,178	5,755	20.5%	1,203	4,456	27.0%	1,202	1,540	78.1%	3,583	11,751	30.5%
Benton	596	639	93.3%	435	440	98.9%	361	367	98.4%	1,392	1,446	96.3%
Big Stone	96	102	94.1%	68	76	89.5%	128	132	97.0%	292	310	94.2%
Blue Earth	611	670	91.2%	607	653	93.0%	649	698	93.0%	1,867	2,021	92.4%
Brown	242	260	93.1%	209	216	96.8%	130	132	98.5%	581	608	95.6%
Carlton	541	583	92.8%	606	670	90.4%	532	583	91.3%	1,679	1,836	91.4%
Carver	411	522	78.7%	422	493	85.6%	331	385	86.0%	1,164	1,400	83.1%
Cass	415	643	64.5%	345	418	82.5%	228	263	86.7%	988	1,324	74.6%
Chippewa	19	19	100.0%	30	30	100.0%	32	32	100.0%	81	81	100.0%
Chisago	401	453	88.5%	300	331	90.6%	138	149	92.6%	839	933	89.9%
Clay	878	972	90.3%	774	863	89.7%	722	769	93.9%	2,374	2,604	91.2%
Clearwater	172	251	68.5%	228	259	88.0%	85	97	87.6%	485	607	79.9%
Cook	70	82	85.4%	70	81	86.4%	73	79	92.4%	213	242	88.0%
Crow Wing	770	1,057	72.8%	617	909	67.9%	769	1,021	75.3%	2,156	2,987	72.2%
Dakota	972	1,088	89.3%	1,143	1,214	94.2%	1,025	1,054	97.2%	3,140	3,356	93.6%
Douglas	220	246	89.4%	274	299	91.6%	306	332	92.2%	800	877	91.2%
Fillmore	175	203	86.2%	139	153	90.8%	129	135	95.6%	443	491	90.2%
Freeborn	335	350	95.7%	307	324	94.8%	250	278	89.9%	892	952	93.7%
Goodhue	448	499	89.8%	330	370	89.2%	189	243	77.8%	967	1,112	87.0%
Grant	81	95	85.3%	122	130	93.8%	73	73	100.0%	276	298	92.6%
Hennepin	9,452	12,187	77.6%	8,872	10,920	81.2%	7,568	8,953	84.5%	25,892	32,060	80.8%
Houston	116	121	95.9%	112	139	80.6%	96	114	84.2%	324	374	86.6%
Hubbard	451	490	92.0%	292	372	78.5%	198	245	80.8%	941	1,107	85.0%
Isanti	517	534	96.8%	450	461	97.6%	260	265	98.1%	1,227	1,260	97.4%
Itasca	682	895	76.2%	510	621	82.1%	494	570	86.7%	1,686	2,086	80.8%
Kanabec	153	172	89.0%	148	164	90.2%	108	113	95.6%	409	449	91.1%
Kandiyohi	581	622	93.4%	476	549	86.7%	490	547	89.6%	1,547	1,718	90.0%
Kittson	66	92	71.7%	125	148	84.5%	80	92	87.0%	271	332	81.6%
Koochiching	116	203	57.1%	180	264	68.2%	111	158	70.3%	407	625	65.1%
Lac qui Parle	192	201	95.5%	134	138	97.1%	63	64	98.4%	389	403	96.5%
Lake	139	160	86.9%	89	99	89.9%	119	136	87.5%	347	395	87.8%
Lake of the Woods	13	13	100.0%	3	4	75.0%			#DIV/0!	16	17	94.1%
Le Sueur	228	228	100.0%	121	123	98.4%	60	62	96.8%	409	413	99.0%
McLeod	420	460	91.3%	337	362	93.1%	309	331	93.4%	1,066	1,153	92.5%
Mahnomen	91	119	76.5%	31	71	43.7%	38	52	73.1%	160	242	66.1%

	Final CY 2014			CY 2013			CY 2012			Three Year Average (2012-2014)		
	Numerator	Denominator	Results	Numerator	Denominator	Results	Numerator	Denominator	Results	Numerator	Denominator	Results
County/County Consortium	Total months that had a visit	Total months requiring visits in care	Percent of months with a social worker visit	Total months that had a visit	Total months requiring visits in care	Percent of months with a social worker visit	Total months that had a visit	Total months requiring visits in care	Percent of months with a social worker visit	Total months that had a visit	Total months requiring visits in care	Percent of months with a social worker visit
Marshall	87	97	89.7%	64	73	87.7%	66	69	95.7%	217	239	90.8%
Meeker	209	227	92.1%	319	330	96.7%	269	285	94.4%	797	842	94.7%
Mille Lacs	848	1,101	77.0%	279	326	85.6%	186	190	97.9%	1,313	1,617	81.2%
Morrison	439	447	98.2%	422	427	98.8%	306	307	99.7%	1,167	1,181	98.8%
Mower	475	513	92.6%	490	526	93.2%	423	497	85.1%	1,388	1,536	90.4%
Nicollet	281	285	98.6%	232	235	98.7%	237	240	98.8%	750	760	98.7%
Nobles	318	369	86.2%	269	283	95.1%	173	231	74.9%	760	883	86.1%
Norman	70	71	98.6%	84	90	93.3%	67	77	87.0%	221	238	92.9%
Olmsted	1,085	1,125	96.4%	1,004	1,061	94.6%	973	1,007	96.6%	3,062	3,193	95.9%
Otter Tail	376	412	91.3%	271	294	92.2%	264	303	87.1%	911	1,009	90.3%
Pennington	132	401	32.9%	181	359	50.4%	202	317	63.7%	515	1,077	47.8%
Pine	377	625	60.3%	448	666	67.3%	246	296	83.1%	1,071	1,587	67.5%
Polk	483	492	98.2%	579	584	99.1%	449	456	98.5%	1,511	1,532	98.6%
Pope	122	141	86.5%	152	161	94.4%	144	148	97.3%	418	450	92.9%
Ramsey	5,344	6,749	79.2%	5,837	7,190	81.2%	5,003	5,965	83.9%	16,184	19,904	81.3%
Red Lake	10	11	90.9%	5	5	100.0%	10	10	100.0%	25	26	96.2%
Renville	185	227	81.5%	162	184	88.0%	89	97	91.8%	436	508	85.8%
Rice	529	614	86.2%	448	484	92.6%	428	472	90.7%	1,405	1,570	89.5%
Roseau	46	49	93.9%	51	61	83.6%	49	50	98.0%	146	160	91.3%
St. Louis	3,747	5,720	65.5%	3,663	5,283	69.3%	3,251	4,379	74.2%	10,661	15,382	69.3%
Scott	273	280	97.5%	340	361	94.2%	377	386	97.7%	990	1,027	96.4%
Sherburne	480	498	96.4%	378	396	95.5%	297	301	98.7%	1,155	1,195	96.7%
Sibley	161	180	89.4%	75	93	80.6%	57	64	89.1%	293	337	86.9%
Stearns	1,904	2,077	91.7%	1,548	1,689	91.7%	1,314	1,404	93.6%	4,766	5,170	92.2%
Stevens	56	62	90.3%	87	91	95.6%	47	49	95.9%	190	202	94.1%
Swift	267	278	96.0%	152	163	93.3%	173	187	92.5%	592	628	94.3%
Todd	512	524	97.7%	384	407	94.3%	291	302	96.4%	1,187	1,233	96.3%
Traverse	68	69	98.6%	39	43	90.7%	43	46	93.5%	150	158	94.9%
Wabasha	238	298	79.9%	234	280	83.6%	143	188	76.1%	615	766	80.3%
Wadena	108	117	92.3%	113	118	95.8%	217	223	97.3%	438	458	95.6%
Washington	772	862	89.6%	718	776	92.5%	641	670	95.7%	2,131	2,308	92.3%
Watonwan	92	94	97.9%	127	128	99.2%	145	146	99.3%	364	368	98.9%
Wilkin	44	45	97.8%	41	44	93.2%	54	59	91.5%	139	148	93.9%
Winona	246	278	88.5%	148	195	75.9%	192	225	85.3%	586	698	84.0%
Wright	932	1,026	90.8%	841	977	86.1%	658	768	85.7%	2,431	2,771	87.7%
Yellow Medicine	125	125	100.0%	145	146	99.3%	125	125	100.0%	395	396	99.7%
SWHHS: Lincoln, Lyon, Murray, Pipestone, Rock, Redwood	970	1,056	91.9%	942	998	94.4%	1,076	1,496	71.9%	2,988	3,550	84.2%
DVHHS: Cottonwood & Jackson	292	298	98.0%	443	460	96.3%	333	354	94.1%	1,068	1,112	96.0%
Faribault-Martin	713	758	94.1%	753	801	94.0%	536	557	96.2%	2,002	2,116	94.6%
MN Prairie: Dodge, Steele, Waseca	652	667	97.8%	589	607	97.0%	463	528	87.7%	1,701	1,802	94.4%
Minnesota	**49,046**	**63,731**	**77.0%**	**46,087**	**57,428**	**80.3%**	**39,841**	**46,251**	**86.1%**	**134,971**	**167,410**	**80.6%**

Attachment D: Vulnerable Children and Adult Plan Amendment for Child Protection Funding

County/county consortium submitting amendment: _____

Contact person: _____ Title: _____

Address: _____

Telephone _____ Email address: _____

Assurances

It is understood and agreed by the County Board that any funds granted pursuant to this service agreement amendment will be expended for the purposes outlined in Minnesota Statute 256M.41. It is understood and agreed by the County Board that the commissioner of the Minnesota Department of Human Services has the authority to review and monitor compliance with this amendment and that documentation of compliance will be available to audit.

Budget Plan

Indicate amount and percentage of county's total child protection allocation budget plan for each item listed for calendar year 2015 and 2016. Additional detail may be submitted.

	2015			2016		
Activity	**# of New FTE**	**Budgeted Amount**	**%**	**# of New FTE**	**Budgeted Amount**	**%**
Child protection staff (salaries, overhead, support costs)		$	%		$	%
Child protection services		$	%		$	%
Total		$	100%		$	100%

Certification and Signature

I hereby certify that this amendment to our county's Vulnerable Children and Adults Act plan has been prepared as required and approved by the County Board or its designee under provisions of Minnesota Statute 256M.

County Board representative: _____

Title: _____

Authorized signature: _____ Date: _____

Submit by August 31, 2015 to ralph.mcquarter@state.mn

AN AGREEMENT CREATING THE

AITKIN, ITASCA AND KOOCHICHING COUNTY

COMMUNITY HEALTH BOARD AND ESTABLISHING PARTICIPATION UNDER THE LOCAL PUBLIC HEALTH ACT

This Agreement is renewed and entered into by the participating counties (Aitkin, Itasca, Koochiching) to become effective _____ 2015. In executing this Agreement, the participating counties (hereinafter referred to as "member counties") indicate their joint purpose to develop and implement policies, structures and procedures to more effectively prevent illness and to promote efficiency and economy in the delivery of Public Health services. Without being limited to the purposes and procedures identified herein, the member counties specifically intend that this Agreement permits them through the various boards, committees and structures herein identified and established to participate in the Community Health program established by the Local Public Health Act of 2007 as the same may be amended from time to time.

The member counties are located contiguous to one another, and have an aggregate population in excess of 30,000 persons.

Each of the member counties has participated in the Community Health program under a Joint Powers Agreement since 1977. It is the intent of the member counties to amend this agreement under the provisions of the Local Public Health Act of 2007. (M.S. 145A).

To properly implement the provisions of the Local Public Health Act, the member counties intend to enter into this Agreement establishing the Community Health Board and setting forth certain rights and commitments in relation thereto and to one another. This Agreement is entered into under the authority of the Local Public Health Act and pursuant to the provisions of Minnesota Statutes, Section 471.59.

COMMUNITY HEALTH BOARD

Article 1 - Membership

1.1 Membership: The Aitkin, Itasca and Koochiching Community Health Board (herein referred to as the Community Health Board) is hereby established. The composition of the Board shall be as follows:

A. Except for Itasca County, each member county board of Commissioners shall appoint two members. Itasca County shall be entitled to three members appointed by the county board of commissioners.

B. Of the members appointed by each member county board of commissioners, at least one member shall be a County Commissioner.

C. The remaining members shall be laymen representative of the people in the community and shall include at least one person who is not a member of a county board of commissioners.

1.2 Community Health Board members shall receive such per diem allowance and travel expense allowance as the Community Health Board may determine and which are consistent with Minnesota law.

1.3 Term of Office: All members shall serve three year terms or until a successor has been duly appointed and qualified. A vacancy shall be deemed to exist should any member appointed by virtue of his or her status as a member of a County Board of Commissioners cease to serve as a member of said Board. Any vacancies occurring on the Board shall be filled in the same manner in which the retiring Board member was selected, provided that each member appointed to fill a vacancy shall serve only the remaining balance of the term.

1.4 Officers: There shall be a chairman, vice-chairman and a secretary, each of whom shall be elected for a term of one year. All officers may be removed with or without cause by majority vote of the Board. A vacancy in any office shall be filled promptly by the Board provided that notice of time, place and purpose shall be given to the members by letter at least seven (7) calendar days prior to the meeting to which such action is to take place.

1.5 The chairman shall preside at all Community Health Board meetings. The Chairman may be designated by the Community Health Board to sign applications for funds and other official documents. He/she may sign and execute all contracts authorized by the Community Health Board in furtherance of Community Health Board purposes. He/she shall be responsible for representing official positions and statements formulated by the Board. He/she shall generally perform all duties common to the office of chairman as the Community Health Board may designate.

1.6 The vice-chairman shall assume the powers and duties of the chairman during periods of his absence or incapacity and shall perform such additional duties and functions as the Community Health Board may direct.

1.7 The secretary shall keep the minutes of the meetings of the Community Health Board, and shall attend to the delivery of notices and agenda for all Board meetings. He/she shall perform such additional duties as the Board may direct.

1.8 The Board may establish such other committees as may be deemed necessary or appropriate. The chairman, with the approval of the Community Health Board, shall name the members and chairman of each committee.

Article 2 – Voting and Quorum

2.1 Voting and Quorum: Each Community Health Board member shall be entitled to one vote on the Community Health Board. Votes shall be cast in person, which may include interactive television or telephone conference call, by the member. Voting shall be by voice vote, provided that upon the demand of any member present at the meeting, voting upon any question shall be by signed ballot. A quorum shall consist of at least four members with at least one representative from each county. All Board actions shall be determined by a majority of the votes cast at a meeting of the Community Health Board.

Article 3 – Meetings

3.1 Meetings: The first meeting of each year shall be designated the annual meeting of the Community Health Board, on such dates and at such times and places as the Community Health Board shall determine. Special meetings may be called by the chairman or upon the request of two or more Board members. Notice of meetings shall be emailed or delivered to each Community Health Board member at least seven calendar days prior to the date of the meeting; Notices shall include an agenda. All proceedings of the Community Health Board and any committee or subgroup of the Community Health Board shall be open to the public except as provided for in Minnesota Statutes Chapter 13D, commonly called the Open Meeting Law; all votes taken of members of the Community Health Board shall be recorded and shall become matters of public record. The books and records, including minutes and the original fully-executed Agreement, of the CHB shall be subject to the provisions of the Minnesota Government Data Practices Act, Minnesota Statutes Chapter 13.

Article 4 – Powers and Duties of the Community Health Board

4.1 Powers and Duties of the Community Health Board: The Community Health Board has the powers and duties of a Board of Health as well as the general responsibility for development and maintenance of an integrated system of community health services as prescribed in M.S. 145A.

4.2 The Community Health Board must prepare and submit to the Minnesota Commissioner of Health a written plan under Minnesota Statutes 145A. The Community Health Plan must provide for the assessment of community health status and the integration, development, and provision of community health services that meet the priority needs of the community health service area. The plan must be consistent with the standards and procedures established under M.S. 145A within the limits of available funding.

4.3 The Community Health Board must prepare and submit to the Minnesota Commissioner of Health an annual budget for the expenditure of local match and subsidy funds under M.S. 145A and for other sources of funding for community health services. Budgets must be submitted to the Minnesota Commissioner of Health. The Community Health Board must assure that community health services will comply with applicable state and federal laws.

4.4 The Community Health Board must compile and submit reports to the Minnesota Commissioner of Health on its expenditures and activities as -required under M.S. 145A.

4.5 The Community Health Board may recommend local ordinances pertaining to community health services to any county board within its jurisdiction and advise the Minnesota Commissioner of Health on matters relating to public health that require assistance from the state, or that may be of more than local interest.

4.6 The Community Health Board may appoint a member to serve on the State Community Health Services Advisory Committee as provided in M.S. 145A.

4.7 The Community Health Board must appoint, employ, or contract with a medical consultant to ensure appropriate medical advice and direction for the Community Health Board and assist the Community Health Board and its staff in the coordination of Community Health Services with local medical care and other health services.

4.8 The Community Health Board must appoint, employ or contract with a person or persons to act on its behalf as agent.

4.9 The Community Health Board shall have and exercise all powers that may be necessary and convenient to enable it to perform and carry out the duties and responsibilities conferred on it by this Agreement, or which may hereafter be imposed on it by law or contract. For all accounts, the funds therefore shall be kept in the treasury of Itasca County pursuant to agreement as hereinafter provided. The Itasca County Auditor shall make payments there from on properly authenticated vouchers of the Community Health Board.

4.10 Any programs operated under the jurisdiction of the Board may be extended by contract to counties or other units of government not a party to this Agreement on such terms and conditions as the Community Health Board may deem appropriate. Such contract shall be consistent with the plans and policies established by the Community Health Board.

4.11 The Community Health Board by any lawful means, including gifts, purchase, lease or transfer of custodial control, may acquire and hold the real and personal property necessary and incident to the accomplishment of the purposes of this agreement, and accept gifts, grants and subsidies from any lawful source, apply for and accept state and federal funds, request and accept local tax funds, and establish and collect reasonable fees for community health services provided.

Article 5 – Contract of Employment

5.1 The Community Health Board shall have the power to enter into any contract of employment with a director, staff or other personnel necessary to carry out the purposes of this Agreement and the Local Public Health Act. The Board is authorized to develop personnel policies and procedures as deemed necessary; such policies and procedures may include provisions for contracts for personal service, the establishment of a merit system or such other and further alternatives or combinations thereof as may be determined by the Community Health Board. In the event a State, County or Municipal employee is employed, notwithstanding the provisions of any other law or ordinance to the contrary, and to the extent possible such employment shall be deemed a transfer in grade for such employee with all of the benefits earned and acquired by such employee while in service of his or her previous State, County or Municipal employer.

Article 6 – Civil Rights

6.1 The Community Health Board must insure that Community Health services are accessible to all persons on the basis of need. No one shall be denied services because of race, color, sex, age, language, religion nationality, inability to pay, political persuasion, or place of residence, as provided in State Statute 145A.

COUNTY BOARDS OF HEALTH

Article 7 – County Boards of Health

7.1 Each member county reserves the authority to establish a county board of health and operate under Minnesota Statute 145Aand assigns to those Boards of Health powers and duties under 145A. The County Health Boards shall advise, consult with and make recommendations to the Community Health Board consistent with the provisions of M.S. 145A.

7.2 At the option of each member county, an Advisory Committee to the county's board of health may also be established to provide input to the county board of health. The membership and composition of such an Advisory Committee shall be determined by each member county.

FINANCING

Article 8 - Financing

8.1 – Budget

The Community Health Board shall prepare its annual budget which shall be submitted to each member County Board. The budget shall specify the total amount to be provided by each member county.

8.2 – Community Health Plan

The Community Health Board shall develop and adopt the Community Health Plan as required by the Local Public Health Act. Such Community Health Plan, together with such comments as the Community Health Board may have, shall be submitted to each County Board with the annual budget of the Community Health Board as above provided.

8.3 The Community Health Plan and the budget shall be prepared in such a manner as will provide essential cost information to the member County Boards regarding the items set forth in the Community Health Plan.

8.4 The member counties agree that each county's proportionate share of that portion of the Community Health Budget related to the annual operating costs of the Community Health Board, Committees, their staff and related expenditures shall be equal to each county's proportionate share of the total subsidy funds and/or special project grants available to all member counties through the Local Public Health Act.

8.5 The County Board of each member county shall, upon the approval of the budget and the Community Health Plan, provide by levy or otherwise, its portion of the annual budget.

8.6 The member counties agree that subsidy monies shall be applied for pursuant to the Local Public Health Act. Subsidy funds shall be promptly remitted to the Auditor of Itasca County. The Community Health Board shall negotiate the cost, terms and conditions under which said Auditor will serve as fiscal officer for the Board under the terms hereof.

8.7 The Community Health Board, through its designated agent, shall submit regular program and financial reports to the Commissioner of Health as required pursuant to the Local Public Health Act.

WITHDRAWAL

Article 9 - Withdrawal

9.1 A member county may withdraw from this Joint Power Agreement consistent with the provisions of Minnesota Statute 145A. No withdrawing county shall be entitled to reimbursement of any funds contributed by it during the course of membership on the Community Health Board, except to the extent of any surplus uncommitted monies as may remain in operating accounts (as opposed to capital asset acquisition accounts) upon expiration of the fiscal year of the county's withdrawal. Such surplus shall be distributed in the proportion that the withdrawing member's contribution bears to the aggregate contributions of all member counties for the year of withdrawal.

9.2 No county shall receive any share of surplus funds unless such county has made all back and current contributions required hereunder.

9.3 Funds utilized for capital asset acquisition (e.g., real property) shall be paid to a withdrawing county only at the time of sale of such asset or its diversion to a use inconsistent with the purposes of this Agreement. An inconsistent use shall be deemed to exist in the event said asset or facility is not subject to any provision of the Community Health Plan for three (3) consecutive years. Payments shall be made to such withdrawing county in the same amount or proportion as they are allocated to the account of such county regarding such asset on the books of account maintained by or for the Community Health Board.

Article 10 – Liability Insurance Coverage

10.1 The Community Health Board is a separate and distinct legal entity which shall obtain and maintain general liability and errors and omissions insurance coverage to protect and indemnify its Board, officials or employees in the performance of duties arising from this Agreement and its Members. All policies shall be in an amount at least equal to the maximum liability of a Municipality under Minn. Stat. 466.04 now or as said statute is hereafter amended or as otherwise required by law, statute or rule.

10.2 The Community Health Board shall maintain worker's compensation insurance covering its employees in accordance with Minnesota law now or as said statute is hereafter amended or as otherwise required by law, statute or rule.

10.3 The Community Health Board shall provide certificates of insurance as evidence of such coverage to the other Participating Boards/Counties. Any certificate of insurance shall list each Board/County as a Certificate holder and as an additional insured for all liability coverages except Worker's Compensation and Employer's Liability and Professional Liability, if applicable, and be amended to show that each Certificate Holder will receive thirty (30) days written notice in the event of cancellation, non-renewal or material change in any described policy.

Article 11 – Indemnification and Hold Harmless

11.1 Applicability

The Aitkin, Itasca, and Koochiching Community Health Board shall be considered a separate and distinct public entity to which the parties have transferred all responsibility and control for actions taken pursuant to this Agreement. Aitkin, Itasca and Koochiching Community Health Board shall comply with all laws and rules that govern a public entity in the State of Minnesota and shall be entitled to the protections of M.S. 466.

11.2 Indemnification and Hold Harmless

The Aitkin, Itasca, and Koochiching Community Health Board shall fully defend, indemnify and hold harmless the Parties against all claims, losses, liability, suits, judgments, costs and expenses by reason of the action or inaction of the Board and/or employees and/or the agents of the Aitkin, Itasca, and Koochiching Community Health Board. This Agreement to indemnify and hold harmless does not constitute a waiver by any participant of limitations on liability provided under Minnesota Statutes, Section 466.04.

To the full extent permitted by law, actions by the Parties pursuant to this Agreement are intended to be and shall be construed as a "cooperative activity" and it is the intent of the Parties that they shall be deemed a "single governmental unit" for the purpose of liability, as set forth in Minnesota Statutes, Section 471.59, subd. 1a(a); provided further that for purposes of that Statute, each Party to this Agreement expressly declines responsibility for the acts or omissions of the other Party.

The Parties of this Agreement are not liable for the acts or omissions of the other participants to this Agreement except to the extent to which they have agreed in writing to be responsible for acts or omissions of the other Parties.

REVIEW OF AGREEMENT

The Community Health Board shall review and make recommendations to the member counties regarding the status of the Joint Powers Agreement at its annual meeting.

EXECUTION

This Agreement shall be executed pursuant to resolution adopted by the participating County Boards.

IN WITNESS WHEREOF, the following counties by appropriate resolution have authorized the execution of this Agreement, said Agreement to be effective as of the

_____ day of _____, 2015.

By _____ Dated: _____
Chairperson - Aitkin County Board of Commissioners

By _____ Dated: _____
Aitkin County Attorney

By _____ Dated: 6/9/2015
Chairperson - Itasca County Board of Commissioners

By _____ Dated: 6/24/15
Itasca County Attorney

By _____ Dated: _____
Chairperson - Koochiching County Board of Commissioners

By _____ Dated: _____
Koochiching County Attorney

REVIEW OF AGREEMENT

The Community Health Board shall review and make recommendations to the member counties regarding the status of the Joint Powers Agreement at its annual meeting.

EXECUTION

This Agreement shall be executed pursuant to resolution adopted by the participating County Boards.

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_____ day of _____, 2015.

By _____ Dated: _____
Chairperson - Aitkin County Board of Commissioners

By _____ Dated: _____
Aitkin County Attorney

By _____ Dated: 6/9/2015
Chairperson - Itasca County Board of Commissioners

By _____ Dated: 6/24/15
Itasca County Attorney

By _____ Dated: _____
Chairperson - Koochiching County Board of Commissioners

By _____ Dated: _____
Koochiching County Attorney

REVIEW OF AGREEMENT

The Community Health Board shall review and make recommendations to the member counties regarding the status of the Joint Powers Agreement at its annual meeting.

EXECUTION

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_____ day of _____, 2015.

By _____ Dated: _____
Chairperson - Aitkin County Board of Commissioners

By _____ Dated: _____
Aitkin County Attorney

By _____ Dated: 6/9/2015
Chairperson - Itasca County Board of Commissioners

By _____ Dated: 6/24/15
Itasca County Attorney

By _____ Dated: _____
Chairperson - Koochiching County Board of Commissioners

By _____ Dated: _____
Koochiching County Attorney

Aitkin County Health & Human Services

Financial Statement

	Actual Jan-15	Actual Feb-15	Actual Mar-15	Actual Apr-15	Actual May-15	Actual Jun-15	Actual Jul-15
Income:							
Tax Levy						1,133,384.45	
CPA and In Lieu						2,591.32	
State Revenue	1,939.91	40,539.90	105,579.99	22,407.63	77,415.42	107,442.28	
Federal Revenue	74,142.95	239,019.53	228,357.04	105,297.74	244,877.96	203,055.99	
Revenue From Third Party	10,836.27	20,079.03	25,971.09	21,408.59	27,152.59	20,038.25	
Misc. Revenue	24,781.43	20,058.61	19,601.81	15,277.69	16,245.43	10,730.78	(57.26)
Total:	**111,700.56**	**319,697.07**	**379,509.93**	**164,391.65**	**365,691.40**	**1,477,243.07**	**(57.26)**
Expenditures:							
Payments to Recipients	108,337.55	151,614.51	121,965.73	190,417.54	118,409.50	136,146.50	153,546.18
Salaries and Fringes	346,067.82	301,340.14	304,812.06	315,453.61	434,268.87	315,075.06	326,794.82
Services, Charges and Fees	34,946.78	31,070.50	24,034.29	28,148.57	30,348.07	16,650.61	32,616.17
Travel and Insurance	46,931.08	3,721.12	6,403.80	6,475.62	5,068.18	3,584.84	4,215.89
Supplies and Small Equipment	2,089.92	3,019.98	2,988.67	13,267.81	8,759.37	3,835.32	2,194.09
Capital Outlay	-	-	-	-	735.63	4,155.77	2,098.22
Misc Expense, Pass Thru	3,564.28	36,736.35	5,999.28	35,049.48	4,801.98	8,047.75	26,747.65
Total:	**541,937.43**	**527,502.60**	**466,203.83**	**588,812.63**	**602,391.60**	**487,495.85**	**548,213.02**
Final Totals:	(430,236.87)	(207,805.53)	(86,693.90)	(424,420.98)	(236,700.20)	989,747.22	(548,270.28)

Cash Balance as of 07/2014

5,024,834.88

Cash Balance as of 07/2015

4,013,235.58

	YTD 2015	ACTUAL 2014	ACTUAL 2013	ACTUAL 2012	ACTUAL 2011	ACTUAL 2010	ACTUAL 2009	ACTUAL 2008
Income:								
Tax Levy	1,133,384.45	1,888,236.54	2,470,279.73	2,445,757.88	2,345,969.16	2,333,865.63	2,340,935.73	2,409,856.71
CPA and In Lieu	2,591.32	270,042.48	314,823.94	131,275.60	236,240.57	235,223.92	321,690.72	303,462.53
State Revenue	355,325.13	881,136.72	686,350.95	723,462.02	736,864.33	611,120.93	632,506.88	936,661.64
Federal Revenue	1,094,751.21	2,168,615.65	2,136,553.41	2,161,389.09	2,120,681.67	2,225,918.50	2,266,036.42	2,031,189.00
Revenue From Third Party	125,485.82	207,345.61	216,749.43	204,217.36	163,265.77	126,077.60	-	-
Misc. Revenue	106,638.49	315,012.26	359,291.46	451,663.65	446,320.68	541,300.99	575,677.90	608,372.74
Total:	**2,818,176.42**	**5,730,389.26**	**6,184,048.92**	**6,117,765.60**	**6,049,342.18**	**6,073,507.57**	**6,136,847.65**	**6,289,542.62**
Expenditures:								
Payments to Recipients	980,437.51	1,635,620.50	1,417,258.22	1,604,608.63	1,729,427.71	1,862,889.86	1,818,277.01	1,729,049.89
Salaries and Fringes	2,343,812.38	3,664,934.15	3,425,848.90	3,516,455.12	3,602,677.75	3,585,784.86	3,658,299.47	3,300,291.25
Services and Charges	197,814.99	336,723.19	423,064.32	397,600.22	271,548.15	305,453.93	295,501.81	327,685.72
Travel and Insurance	76,400.53	143,562.07	89,679.42	87,885.39	96,969.42	107,221.46	125,924.90	125,736.88
Office Supplies	36,155.16	73,198.58	61,402.17	33,369.33	61,209.60	56,501.21	52,262.98	79,742.17
Capital Outlay	6,989.62	31,266.36	52,492.10	120,759.15	23,482.25	33,649.79	68,997.74	35,484.07
Misc Expense & Pass Thru	120,946.77	180,413.58	184,722.83	168,640.01	96,521.72	123,123.15	142,355.79	133,526.22
Total:	**3,762,556.96**	**6,065,718.43**	**5,654,467.96**	**5,929,317.85**	**5,881,836.60**	**6,074,624.26**	**6,161,619.70**	**5,731,516.20**
Final Totals:	(944,380.54)	(335,329.17)	529,580.96	188,447.75	167,505.58	(1,116.69)	(24,772.05)	558,026.42

ACTUAL 2007	ACTUAL 2006
2,303,196.53	1,817,723.90
389,866.09	312,877.69
790,366.43	905,921.06
2,013,560.50	1,993,226.16
-	-
568,060.27	484,763.05
6,065,049.82	**5,514,511.86**
1,827,333.49	1,858,630.93
3,091,358.49	2,911,440.42
271,589.87	281,345.91
91,625.96	96,293.29
63,677.05	65,267.30
24,380.79	40,048.96
148,157.71	145,866.15
5,518,123.36	**5,398,892.96**
546,926.46	115,618.90

2010 Foster Care Breakdown

	Total	Social Service	Corrections	ICWA
Child Shelter	$9,488.00	$0.00	$9,488.00	$0.00
Treatment Foster	$56,083.53	$33,226.63	$22,856.90	$0.00
Child Foster Care	$476,817.55	$346,845.36	$18,694.69	$111,277.50
Rule 8 FC	$76,179.08	$14,709.60	$13,372.90	$48,096.58
Corrections	$170,224.47	$0.00	$66,820.90	$103,403.57
Home Monitoring/Spec. Equip	$1,201.39	$721.39	$480.00	$0.00
Rule 5	$140,169.52	$103,209.65	$0.00	$36,959.87
Respite	$34,850.93	$34,065.68	$0.00	$785.25
Child Care	$1,579.00	$1,579.00	$0.00	$0.00
Health Services	$81.56	$81.56	$0.00	$0.00
Transportation	$9,584.21	$9,584.21	$0.00	$0.00
Total	$976,259.24	$544,023.08	$131,713.39	$300,522.77
Total	$976,259.24			

2011 Foster Care Breakdown

	Total	Social Service	Corrections	ICWA
Child Shelter	$2,832.90	$177.00	$2,655.90	$0.00
Treatment Foster	$101,130.13	$101,130.13	$0.00	$0.00
Child Foster Care	$317,597.09	$167,153.57	$11,627.25	$138,816.27
Rule 8 FC	$79,291.48	$45,321.48	$17,569.80	$16,400.20
Corrections	$316,273.71	$0.00	$208,352.80	$107,920.91
18-21	$1,228.00	$1,228.00	$0.00	$0.00
Rule 5	$70,889.29	$70,889.29	$0.00	$0.00
Respite	$8,645.32	$7,336.52	$0.00	$1,308.80
Child Care	$1,166.65	$1,166.65	$0.00	$0.00
Health Services	$193.65	$193.65	$0.00	$0.00
Transportation	$10,267.87	$10,267.87	$0.00	$0.00
Total	$909,516.09	$404,864.16	$240,205.75	$264,446.18
Total	$909,516.09			

2012 Foster Care Breakdown

	Total	Social Service	Corrections	ICWA
Child Shelter	$8,847.10	$2,696.30	$6,150.80	$0.00
Treatment Foster	$96,215.62	$96,215.62	$0.00	$0.00
Child Foster Care	$276,532.46	$174,297.88	$9,783.11	$92,451.47
Rule 8 FC	$76,095.10	$7,061.90	$43,317.20	$25,716.00
Corrections	$245,552.59	$0.00	$188,861.99	$56,690.60
Electronic Monitoring	$352.00	$0.00	$352.00	$0.00
Rule 5	$99,575.24	$99,575.24	$0.00	$0.00
Respite	$9,183.36	$7,811.86	$0.00	$1,371.50
Child Care	$0.00	$0.00	$0.00	$0.00
Health Services	$382.00	$382.00	$0.00	$0.00
Transportation	$7,187.58	$7,187.58	$0.00	$0.00
Total	$819,923.05	$395,228.38	$248,465.10	$176,229.57
Total	$819,923.05			

2013 Foster Care Breakdown

	Total	Social Service	Corrections	ICWA
Child Shelter	$4,194.22	$2,816.72	$1,377.50	$0.00
Treatment Foster	$79,138.00	$79,138.00	$0.00	$0.00
Child Foster Care	$252,908.55	$241,526.46	$0.00	$11,382.09
Rule 8 FC	$7,305.55	$0.00	$0.00	$7,305.55
Corrections	$188,405.85	$24,953.28	$142,441.58	$21,010.99
Electronic Monitoring	$2,904.00	$2,596.00	$308.00	$0.00
Rule 5	$58,405.55	$21,834.76	$0.00	$36,570.79
Respite	$2,358.48	$2,258.48	$0.00	$100.00
Child Care	$718.00	$718.00	$0.00	$0.00
Health Services	$110.87	$110.87	$0.00	$0.00
Transportation	$14,128.68	$14,128.68	$0.00	$0.00
Total	$610,577.75	$390,081.25	$144,127.08	$76,369.42
Total	$610,577.75			

2014 Foster Care Breakdown

	Total	Social Service	Corrections	ICWA
Child Shelter	$1,968.00	$0.00	$1,968.00	$0.00
Treatment Foster	$35,417.88	$35,417.88	$0.00	$0.00
Child Foster Care	$185,255.82	$158,688.03	$1,998.00	$24,569.79
Rule 8 FC	$987.57	$99.57	$0.00	$888.00
Corrections	$360,963.39	$0.00	$292,192.98	$68,770.41
Extended Foster Care	$100.00	$100.00	$0.00	$0.00
Rule 5	$119,466.26	$119,466.26	$0.00	$0.00
Respite	$918.50	$918.50	$0.00	$0.00
Child Care	$591.50	$591.50	$0.00	$0.00
Health Services	$2,606.51	$2,606.51	$0.00	$0.00
Transportation	$9,790.44	$9,790.44	$0.00	$0.00
Total	$718,065.87	$327,678.69	$296,158.98	$94,228.20
Total	$718,065.87			

2015 Foster Care Breakdown Year to Date

	Total	Social Service	Corrections	ICWA
Child Shelter	$0.00	$0.00	$0.00	$0.00
Treatment Foster	$18,757.24	$18,757.24	$0.00	$0.00
Child Foster Care	$125,537.51	$88,205.47	$6,119.04	$31,213.00
Rule 8 FC	$12,548.97	$12,548.97	$0.00	$0.00
Corrections	$116,334.75	$0.00	$90,352.39	$25,982.36
Extended Foster Care	$0.00	$0.00	$0.00	$0.00
Rule 5	$97,193.13	$78,246.20	$0.00	$18,946.93
Respite	$1,425.34	$1,425.34	$0.00	$0.00
Child Care	$1,679.00	$1,679.00	$0.00	$0.00
Health Services	$153.99	$153.99	$0.00	$0.00
Transportation	$4,128.03	$4,128.03	$0.00	$0.00
Total	$377,757.96	$205,144.24	$96,471.43	$76,142.29
Total	$377,757.96			

AITKIN COUNTY VOLUNTEER DRIVER TRANSPORTATION

MONTH	MEDICAL TRANSPORTS COMPLETED	OTHER TRANSPORTS COMPLETED*	TRANSPORTS CANCELED OR NO SHOWS	TOTAL TRANSPORTS ARRANGED	COUNTY EXPENSE FOR MEDICAL TRANSPORTS
JULY	49	23	13	85	$351.16
AUGUST	57	16	22	95	$475.16
SEPT	60	0	25	85	$503.16
OCT	75	1	13	89	$373.80
NOV	61	O	9	70	$211.44
DEC	59	2	9	70	$394.82
JAN '15	57	2	7	66	$131.75
FEB '15	39	3	10	52	$217.92
MARCH	54	0	6	60	$79.85
APRIL	63	0	4	67	$395.43
MAY	41	5	0	46	$404.58
JUNE	55	13	12	80	$148.01
JULY					$165.48

*COURT, MEDICAL W/NO TRANSPORTATION (SUCH AS MN CARE), VISITATION, ETC.