Southwest Health and Human Services
Board Agenda
Wednesday, May 16, 2018
Commissioners Room
Government Center, 2nd Floor
Marshall
9:00 a.m.

HUMAN SERVICES

A. Call to order

B. Pledge of Allegiance

C. Consent Agenda
1. Amend/Approval of Agenda
2. Identification of Conflict of Interest
3. Approval of 04/25/18 board minutes

D. Introduce New Staff: None

E. Employee Recognition:
- Loni Eilers, 1 year, Social Worker, Marshall
- Cassandra Hoekstra, 1 year, Office Support Specialist, Marshall
- Brittney Meyer, 1 year, Office Support Specialist, Marshall
- Danielle Ossefoort, 5 years, Social Worker, Pipestone
- John O'Neal, 10 years, Eligibility Worker, Marshall
- Krystal Berentson, 15 years, Eligibility Worker, Pipestone
- Stacy Debates, 15 years, Eligibility Worker, Luverne
- Marlene Erickson, 20 years, Administrative Aid, Marshall
- Patrice Peterson, 30 years, Eligibility Worker, Pipestone

F. Financial

G. E.J. Moberg- Fiscal Agent

H. Caseload

	04/18	04/17	03/18	02/18
Social Service	3,816	3,872	3,749	3,730
Licensing	457	487	455	453
Out-of-Home Placements	190	179	189	188
Income Maintenance	11,985	12,791	12,069	11,999
Child Support Cases	3,277	3,407	3,281	3,257
Child Support Collections	$833,082	$880,091	$822,806	$728,961
Non IV-D Collections	$194,038	$78,140	$178,050	$98,479

I. Discussion/Information
1. Adult Mental Health- Stacy Jorgensen

J. Decision Items
1.

COMMUNITY HEALTH

K. Call to order

L. Consent Agenda
1. Amend/Approval of Agenda
2. Identification of Conflict of Interest
3. Approval of 04/25/18 board minutes

M. Financial

COMMUNITY HEALTH (cont.)

N. Caseload

	04/18	03/18	02/18
WIC	N/A	2177	2166
Family Home Visiting	69	49	42
PCA Assessments	21	23	20
Managed Care	357	378	308
Dental Varnishing	30	35	6
Refugee Health	1	8	7
Latent TB Medication Distribution	10	14	15
Water Tests	96	93	96
FPL Inspections	42	43	46
Immunizations	48	60	70
Car Seats	21	18	13

O. Discussion/Information

1. Planning & Implementation Grant (Alcohol Reduction)- Ann Orren and Steve Beekman

P. Decision Items

1.

GOVERNING BOARD

Q. Call to order

R. Consent Agenda

1. Amend/Approval of Agenda
2. Identification of Conflict of Interest
3. Approval of 04/25/18 board minutes

S. Financial

GOVERNING BOARD (cont.)

T. Discussion/Information
1. HIPAA, Data Privacy and Security- Carol Biren & Karri Harvey
2. SPCC/PrimeWest Update

U. Decision Items

1. County Commissioner/Administrators/Executive Team Meeting Recommendation
2. Administrative Policy 1- Data Privacy Policy and Procedure
3. Administrative Policy 8- Disaster Recovery Plan
4. Administrative Policy 9- Physical and Technical Safeguards
5. Administrative Policy 14- HIPAA
6. Nursing Policy 1, Jail Nursing Policy – Repeal
7. Nursing Policy 2, Family Home Visiting Policy – Repeal
8. Nursing Policy 3, Child and Teen Check-up Outreach Policy - Repeal
9. Administrative Policy 13- Equal Employment Opportunity and Affirmative Action
10. Workforce Development Plan- Carol Biren
11. Public Auction- Obsolete Computers
12. Donations: Milroy Lions Club donated a duffle bag for a child going into foster care
13. Contracts

V. Adjournment

Next Meeting Dates:

- **Wednesday, June 20, 2018 – Marshall**
- **Wednesday, July 18, 2018 – Marshall**
- **Wednesday, July 18, 2018- Annual Planning Meeting immediately following SWHHS Board Meeting**
- **Wednesday, August 15, 2018 – Marshall (meeting location in SWHHS 1 & 2)**

SOUTHWEST HEALTH & HUMAN SERVICES

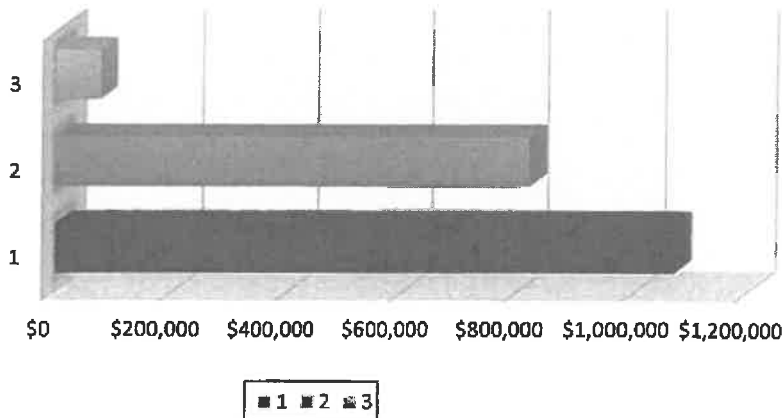
Ivanhoe, Marshall, Slayton, Pipestone, Redwood and Luverne Offices

SUMMARY OF FINANCIAL ACCOUNTS REPORT For the Month Ending: **April 30, 2018**

* Income Maintenance * Social Services * Information Technology * Health *

Description	Month	Running Balance	
BEGINNING BALANCE		**$1,041,171**	
RECEIPTS			
Monthly Receipts	2,475,538		
County Contribution	232,199		
Interest on Savings	1,765		
TOTAL MONTHLY RECEIPTS		2,709,501	
DISBURSEMENTS			
Monthly Disbursements	2,681,586		
TOTAL MONTHLY DISBURSEMENTS		2,681,586	
ENDING BALANCE		**$1,069,086**	
REVENUE			
Checking/Money Market	***$1,069,086***		
Bremer Savings	***$820,868***		
Great Western Bank Savings	***$75,495.09***		**April 2017 Ending Balance**
ENDING BALANCE		**$1,965,450**	**$1,578,173**
DESIGNATED/RESTRICTED FUNDS			
Agency Health Insurance		**$705,227**	
LCTS Lyon Murray Collaborative		**$73,714**	
LCTS Rock Pipestone Collaborative		**$53,962**	
LCTS Redwood Collaborative		**$73,747**	
Local Advisory Council		**$1,216**	
AVAILABLE CASH BALANCE		**$1,057,584**	

REVENUE DESIGNATION



SOUTHWEST HEALTH AND HUMAN SERVICES CHECK REGISTER
APRIL 2018

DATE	RECEIPT or CHECK #	DESCRIPTION	+ DEPOSITS	-DISBURSEMENTS	BALANCE
	BALANCE FORWARD				1,041,171.33
4/2/18	9683	Disb		40,831.83	1,000,339.50
4/3/18	28821-28848	Dep	117,083.78		1,117,423.28
4/6/18	**87702-87725**	Disb		6,879.26	1,110,544.02
4/6/18	**87726-87818**	Disb		226,691.54	883,852.48
4/6/18	**3991-3991 ACH**	Disb		50.60	883,801.88
4/6/18	**3992-4042 ACH**	Disb		52,188.77	831,613.11
4/6/18	9684	Disb		2,808.85	828,804.26
4/6/18	28849-28900,28914-28918	Dep	264,313.75		1,093,118.01
4/9/18	9685	Disb		51,772.62	1,041,345.39
4/10/18	28901-28913,28919-28950	Dep	93,517.71		1,134,863.10
4/12/18	9686	Disb		42,726.56	1,092,136.54
4/12/18	Savings Transfer Bremer	Dep	1,000,000.00		2,092,136.54
4/13/18	8267-8284	Payroll		139,853.11	1,952,283.43
4/13/18	50186-50433 ACH	Payroll		488,915.20	1,463,368.23
4/13/18	**87819-879515**	**Disb**		241,921.54	1,221,446.69
4/13/18	**4043-4065 ACH**	**Disb**		41,824.22	1,179,622.47
4/13/18	**87916-87979**	**Disb**		8,951.42	1,170,671.05
4/13/18	**4066 ACH**	**Disb**		248.40	1,170,422.65
4/13/18	9687	Disb		483.00	1,169,939.65
4/13/18	9688	Disb		25.00	1,169,914.65
4/13/18	28951-29004	Dep	198,066.70		1,367,981.35
4/16/18	9689	Disb		47,419.08	1,320,562.27
4/17/18	29005-29048	Dep	90,003.90		1,410,566.17
4/18/18	9690	Disb		10,313.34	1,400,252.83
4/20/18	**87980-88087**	**Disb**		14,936.80	1,385,316.03
4/20/18	**88088-88260**	**Disb**		77,962.25	1,307,353.78
4/20/18	**4067-4069 ACH**	Disb		1,406.84	1,305,946.94
4/20/18	**88261-88277**	**Disb**		2,005.33	1,303,941.61
4/20/18	**88278-88343**	**Disb**		311,982.93	991,958.68
4/20/18	**4070-4082 ACH**	**Disb**		56,574.10	935,384.58
4/20/18	9691	Disb		8,531.04	926,853.54
4/20/18	29049-29124	Dep	476,094.14		1,402,947.68
4/23/18	9692	Disb		27,881.26	1,375,066.42
4/24/18	9693	Disb		897.80	1,374,168.62
4/24/18	29125-29160	Dep	170,678.05		1,544,846.67
4/27/18	8285-8302	Payroll		139,863.66	1,404,983.01
4/27/18	50434-50682 ACH	Payroll		487,272.90	917,710.11
4/27/18	**88344-88380**	**Disb**		4,337.87	913,372.24
4/27/18	**4083-4084 ACH**	Disb		287.48	913,084.76
4/27/18	**88381-88443**	**Disb**		85,619.97	827,464.79
4/27/18	**4085-4095 ACH**	Disb		17,299.42	810,165.37
4/27/18	29161-29209	Dep	140,069.72		950,235.09
4/30/18	9694	Disb		40,849.82	909,385.27
4/30/18	29210-29227	Dep	159,673.43		1,069,058.70
4/30/18	VOID 88292	Disb		-27.50	1,069,086.20
					1,069,086.20
					1,069,086.20
	Balanced 5/2/18 LMD	**TOTALS**	**2,709,501.18**	**2,681,586.31**	

Savings - Bremer	820,868.33
Savings - Great Western	75,495.09

TOTAL CASH BALANCE	**1,965,449.62**

SOUTHWEST HEALTH AND HUMAN SERVICES BREMER BANK SAVINGS REGISTER

APRIL 2018

DATE	RECEIPT or CHECK #	DESCRIPTION	+ DEPOSITS	-DISBURSEMENTS	BALANCE
	BALANCE FORWARD				1,819,158.24
4/4/2018	34803	Interest	1,710.09		1,820,868.33
4/12/2018	Savings Transfer Bremer	Transfer		1,000,000.00	820,868.33
					820,868.33
					820,868.33
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					820,868.33

SOUTHWEST HEALTH AND HUMAN SERVICES GREAT WESTERN BANK SAVINGS REGISTER
APRIL 2018

DATE	RECEIPT or CHECK #	DESCRIPTION	+ DEPOSITS	-DISBURSEMENTS	BALANCE
	BALANCE FORWARD				75,440.53
4/4/2018	34804	Interest	54.56		75,495.09
					75,495.09
					75,495.09
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					75,495.09
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					75,495.09

Southwest Health and Human Services

Fund			Beginning Balance		This Month	YTD	Current Balance
1	Health Services Fund						
			1,709,545.07				
		Receipts			607,802.92	1,641,593.80	
		Disbursements			143,693.37-	336,301.23-	
		Payroll			221,416.97-	991,608.28-	
		Journal Entries			0.00	86.20	
		Fund Total			242,692.58	313,770.49	2,023,315.56
5	Human Services Fund			410	General Administration		
			189,947.30				
		Receipts			51,703.09	207,616.79	
		Disbursements			25,490.33-	180,285.06-	
		Payroll			15,645.14-	64,899.12-	
		Dept Total			10,567.62	37,567.39-	152,379.91
5	Human Services Fund			420	Income Maintenance		
			2,690,331.05-				
		Receipts			335,897.42	1,573,301.93	
		Disbursements			241,036.41-	1,054,988.29-	
		Payroll			351,376.59-	1,555,754.40-	
		Journal Entries			0.00	30.22-	
		Dept Total			256,515.58-	1,037,470.98-	3,727,802.03-
5	Human Services Fund			431	Social Services		
			8,275,091.90				
		Receipts			487,059.03	3,176,693.34	
		Disbursements			120,711.19-	476,818.50-	
		SSIS			613,247.14-	2,613,176.65-	
		Payroll			641,438.94-	2,904,522.89-	
		Journal Entries			0.00	55.98-	
		Dept Total			888,338.24-	2,817,880.68-	5,457,211.22
5	Human Services Fund			461	Information Systems		
			2,739,744.12-				
		Receipts			3,351.50	16,055.55	
		Disbursements			136.94-	523.77-	

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Fund		Beginning Balance		This Month	YTD	Current Balance
	Payroll			26,027.23-	123,308.73-	
	Dept Total			22,812.67-	107,776.95-	2,847,521.07-
5	Human Services Fund		471	LCTS Collaborative Agency		
		0.00				
	Receipts			0.00	69,331.00	
	Disbursements			0.00	69,331.00-	
	Dept Total			0.00	0.00	0.00
	Fund Total	3,034,964.03		1,157,098.87-	4,000,696.00-	965,731.97-
61	Agency Health Insurance					
		753,857.36				
	Receipts			225,451.87	1,141,191.69	
	Disbursements			254,816.06-	1,189,822.41-	
	Fund Total			29,364.19-	48,630.72-	705,226.64
71	LCTS Lyon Murray Collaborative Fund		471	LCTS Collaborative Agency		
		93,353.73				
	Receipts			0.00	31,035.00	
	Disbursements			26,550.00-	50,675.00-	
	Dept Total			26,550.00-	19,640.00-	73,713.73
	Fund Total	93,353.73		26,550.00-	19,640.00-	73,713.73
73	LCTS Rock Pipestone Collaborative Fund		471	LCTS Collaborative Agency		
		44,725.46				
	Receipts			0.00	11,871.00	
	Disbursements			0.00	2,634.00-	
	Dept Total			0.00	9,237.00	53,962.46
	Fund Total	44,725.46		0.00	9,237.00	53,962.46
75	Redwood LCTS Collaborative		471	LCTS Collaborative Agency		
		46,722.12				

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Fund		Beginning Balance	This Month	YTD	Current Balance
	Receipts		0.00	27,025.00	
	Dept Total		0.00	27,025.00	73,747.12
	Fund Total	46,722.12	0.00	27,025.00	73,747.12
77	Local Advisory Council 477 Local Advisory Council				
		1,398.86			
	Disbursements		0.00	182.78-	
	Dept Total		0.00	182.78-	1,216.08
	Fund Total	1,398.86	0.00	182.78-	1,216.08
All Funds		5,684,566.63			
	Receipts		1,711,265.83	7,895,715.10	
	Disbursements		812,434.30-	3,361,562.04-	
	SSIS		613,247.14-	2,613,176.65-	
	Payroll		1,255,904.87-	5,640,093.42-	
	Total		970,320.48-	3,719,117.01-	1,965,449.62

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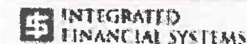
Southwest Health and Human Services



RM-Stmt of Revenues & Expenditures

As Of 04/2018 Report Basis: Cash

DESCRIPTION	CURRENT MONTH	YEAR TO-DATE	2018 BUDGET	% OF BUDG	% OF YEAR
FUND 1 HEALTH SERVICES FUND					
REVENUES					
CONTRIBUTIONS FROM COUNTIES	232,198.72-	464,397.50-	928,795.00-	50	33
INTERGOVERNMENTAL REVENUES	5,554.24-	173,359.99-	187,300.00-	93	33
STATE REVENUES	158,842.90-	357,699.65-	855,647.00-	42	33
FEDERAL REVENUES	173,085.81-	488,174.10-	1,362,742.00-	36	33
FEES	37,779.39-	147,487.12-	454,980.00-	32	33
EARNINGS ON INVESTMENTS	282.34-	1,566.50-	1,600.00-	98	33
MISCELLANEOUS REVENUES	59.52-	8,862.28-	8,900.00-	100	33
TOTAL REVENUES	607,802.92-	1,641,547.14-	3,799,964.00-	43	33
EXPENDITURES					
PROGRAM EXPENDITURES	0.00	0.00	0.00	0	33
PAYROLL AND BENEFITS	221,416.97	991,522.08	2,907,719.00	34	33
OTHER EXPENDITURES	143,693.37	336,254.57	892,245.00	38	33
TOTAL EXPENDITURES	365,110.34	1,327,776.65	3,799,964.00	35	33

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Southwest Health and Human Services

RM-Stmt of Revenues & Expenditures

As Of 04/2018 Report Basis: Cash

DESCRIPTION	CURRENT MONTH	YEAR TO-DATE	2018 BUDGET	% OF BUDG	% OF YEAR
FUND 5 HUMAN SERVICES FUND					
REVENUES					
CONTRIBUTIONS FROM COUNTIES	0.00	221,307.35-	10,127,818.00-	2	33
INTERGOVERNMENTAL REVENUES	15,000.00-	20,000.00-	109,907.00-	18	33
STATE REVENUES	133,528.60-	1,057,484.04-	5,343,608.00-	20	33
FEDERAL REVENUES	314,348.55-	2,136,659.80-	7,756,313.00-	28	33
FEES	170,449.59-	753,397.20-	2,191,354.00-	34	33
EARNINGS ON INVESTMENTS	1,482.31-	7,720.22-	8,400.00-	92	33
MISCELLANEOUS REVENUES	188,438.90-	614,252.29-	993,200.00-	62	33
TOTAL REVENUES	823,247.95-	4,810,820.90-	26,530,600.00-	18	33
EXPENDITURES					
PROGRAM EXPENDITURES	745,654.39	3,326,863.44	10,064,471.00	33	33
PAYROLL AND BENEFITS	1,024,958.94	4,637,745.33	13,733,885.00	34	33
OTHER EXPENDITURES	225,651.35	862,826.41	2,732,244.00	32	33
TOTAL EXPENDITURES	1,996,264.68	8,827,435.18	26,530,600.00	33	33

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Southwest Health and Human Services

Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
1 FUND	Health Services Fund							
410 DEPT	General Administration							
0 PROGRAM	...		Revenue					33
			Expend.	2,404.44	14,164.57	160.00	8,853	33
			Net	2,404.44	14,164.57	160.00	8,853	33
930 PROGRAM	Administration		Revenue	254,742.92-	496,670.18-	939,995.00-	53	33
			Expend.	46,963.22	209,279.55	614,515.00	34	33
			Net	207,779.70-	287,390.63-	325,480.00-	88	33
410 DEPT	General Administration	Totals:	Revenue	254,742.92-	496,670.18-	939,995.00-	53	33
			Expend.	49,367.66	223,444.12	614,675.00	36	33
			Net	205,375.26-	273,226.06-	325,320.00-	84	33
481 DEPT	Nursing							
100 PROGRAM	Family Health		Revenue	6,161.33-	10,039.50-	18,160.00-	55	33
			Expend.	1,467.74	8,332.24	14,764.00	56	33
			Net	4,693.59-	1,707.26-	3,396.00-	50	33
103 PROGRAM	Follow Along Program		Revenue	9,320.41-	12,287.47-	26,966.00-	46	33
			Expend.	2,409.56	11,797.53	35,676.00	33	33
			Net	6,910.85-	489.94-	8,710.00	6-	33
110 PROGRAM	TANF		Revenue	0.00	36,675.41-	127,876.00-	29	33
			Expend.	36,675.41	73,350.82	127,876.00	57	33
			Net	36,675.41	36,675.41	0.00	0	33
130 PROGRAM	WIC		Revenue	93,348.00-	235,048.00-	435,696.00-	54	33
			Expend.	99,470.62	233,165.36	467,435.00	50	33
			Net	6,122.62	1,882.64-	31,739.00	6-	33
140 PROGRAM	Peer Breastfeeding Support Program		Revenue	0.00	14,162.00-	78,244.00-	18	33
			Expend.	4,128.51	20,372.15	78,244.00	26	33
			Net	4,128.51	6,210.15	0.00	0	33
210 PROGRAM	CTC Outreach		Revenue	45,729.21-	106,466.34-	271,412.00-	39	33
			Expend.	19,293.51	81,969.66	271,412.00	30	33
			Net	26,435.70-	24,496.68-	0.00	0	33
270 PROGRAM	Maternal Child Health		Revenue	30,346.31-	60,799.12-	334,648.00-	18	33
			Expend.	18,408.77	88,946.88	315,553.00	28	33
			Net	11,937.54-	28,147.76	19,095.00-	147-	33

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Southwest Health and Human Services

Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
280 PROGRAM	MCH Dental Health		Revenue	232.82-	21,551.86-	70,300.00-	31	33
			Expend.	1,799.04	9,206.48	48,549.00	19	33
			Net	1,566.22	12,345.38-	21,751.00-	57	33
285 PROGRAM	MCH Blood Lead		Revenue	0.00	0.00	1,000.00-	0	33
			Expend.	27.63	662.66	0.00	0	33
			Net	27.63	662.66	1,000.00-	66-	33
295 PROGRAM	MCH Car Seat Program		Revenue	1,124.80-	4,818.39-	33,200.00-	15	33
			Expend.	2,150.73	10,157.32	41,745.00	24	33
			Net	1,025.93	5,338.93	8,545.00	62	33
300 PROGRAM	Case Management		Revenue	43,970.96-	145,000.38-	368,800.00-	39	33
			Expend.	30,912.49	145,295.29	361,007.00	40	33
			Net	13,058.47-	294.91	7,793.00-	4-	33
330 PROGRAM	MNChoices		Revenue	19,637.50-	73,025.87-	171,500.00-	43	33
			Expend.	20,719.76	93,745.63	293,918.00	32	33
			Net	1,082.26	20,719.76	122,418.00	17	33
603 PROGRAM	Disease Prevention And Control		Revenue	37,351.72-	55,663.90-	157,292.00-	35	33
			Expend.	16,921.72	72,303.22	240,454.00	30	33
			Net	20,430.00-	16,639.32	83,162.00	20	33
660 PROGRAM	MIIC		Revenue	0.00	0.00	1,500.00-	0	33
			Expend.	7.09	347.40	0.00	0	33
			Net	7.09	347.40	1,500.00-	23-	33
481 DEPT	Nursing	Totals:	Revenue	287,223.06-	775,538.24-	2,096,594.00-	37	33
			Expend.	254,392.58	849,652.64	2,296,633.00	37	33
			Net	32,830.48-	74,114.40	200,039.00	37	33
483 DEPT	Health Education							
500 PROGRAM	Direct Client Services		Revenue	1,925.75-	3,708.74-	2,770.00-	134	33
			Expend.	705.17	4,372.25	61,613.00	7	33
			Net	1,220.58-	663.51	58,843.00	1	33
510 PROGRAM	SHIP		Revenue	29,649.95-	122,303.49-	224,631.00-	54	33
			Expend.	15,921.78	68,368.77	220,396.00	31	33
			Net	13,728.17-	53,934.72-	4,235.00-	1,274	33
550 PROGRAM	P&I Grant		Revenue	30,294.00-	63,478.00-	188,679.00-	34	33
			Expend.	15,598.08	45,643.74	186,869.00	24	33
			Net	14,695.92-	17,834.26-	1,810.00-	985	33

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Southwest Health and Human Services

Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
900 PROGRAM	Emergency Preparedness		Revenue	0.00	20,695.47-	98,295.00-	21	33
			Expend.	6,658.89	37,324.57	124,290.00	30	33
			Net	6,658.89	16,629.10	25,995.00	64	33
901 PROGRAM	Med Reserve Corps		Revenue					33
			Expend.	0.00	1,039.58	0.00	0	33
			Net	0.00	1,039.58	0.00	0	33
483 DEPT	Health Education	Totals:	Revenue	61,869.70-	210,185.70-	514,375.00-	41	33
			Expend.	38,883.92	156,748.91	593,168.00	26	33
			Net	22,985.78-	53,436.79-	78,793.00	68-	33
485 DEPT	Environmental Health							
800 PROGRAM	Environmental		Revenue	3,967.24-	156,174.42-	229,000.00-	68	33
			Expend.	22,466.18	97,919.10	275,682.00	36	33
			Net	18,498.94	58,255.32-	46,682.00	125-	33
820 PROGRAM	Healthy Homes Grant		Revenue	0.00	0.00	20,000.00-	0	33
			Expend.	0.00	0.00	19,806.00	0	33
			Net	0.00	0.00	194.00-	0	33
830 PROGRAM	FDA Standardization Grant		Revenue	0.00	2,978.60-	0.00	0	33
			Expend.	0.00	11.88	0.00	0	33
			Net	0.00	2,966.72-	0.00	0	33
485 DEPT	Environmental Health	Totals:	Revenue	3,967.24-	159,153.02-	249,000.00-	64	33
			Expend.	22,466.18	97,930.98	295,488.00	33	33
			Net	18,498.94	61,222.04-	46,488.00	132-	33
1 FUND	Health Services Fund	Totals:	Revenue	607,802.92-	1,641,547.14-	3,799,964.00-	43	33
			Expend.	365,110.34	1,327,776.65	3,799,964.00	35	33
			Net	242,692.58-	313,770.49-	0.00	0	33

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Southwest Health and Human Services

Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
5 FUND	Human Services Fund							
410 DEPT	General Administration							
0 PROGRAM	...		Revenue					33
			Expend.	5,350.24	53,485.67	83,935.00	64	33
			Net	5,350.24	53,485.67	83,935.00	64	33
410 DEPT	General Administration	Totals:	Revenue					33
			Expend.	5,350.24	53,485.67	83,935.00	64	33
			Net	5,350.24	53,485.67	83,935.00	64	33
420 DEPT	Income Maintenance							
600 PROGRAM	Income Maint Administrative/Overhea		Revenue	2,824.09-	105,458.83-	3,246,752.00-	3	33
			Expend.	131,633.24	559,265.70	1,666,654.00	34	33
			Net	128,809.15	453,806.87	1,580,098.00-	29-	33
601 PROGRAM	Income Maint/Random Moment Payro		Revenue					33
			Expend.	194,765.06	863,306.56	2,562,216.00	34	33
			Net	194,765.06	863,306.56	2,562,216.00	34	33
602 PROGRAM	Income Maint FPI Investigator		Revenue	0.00	11,610.00-	50,000.00-	23	33
			Expend.	4,618.62	20,807.15	61,111.00	34	33
			Net	4,618.62	9,197.15	11,111.00	83	33
605 PROGRAM	MN Supplemental Aid (MSA)/GRH		Revenue	940.20-	13,044.57-	28,000.00-	47	33
			Expend.	0.00	11,118.97	18,750.00	59	33
			Net	940.20-	1,925.60-	9,250.00-	21	33
610 PROGRAM	TANF(AFDC/MFIP/DWP)		Revenue	1,484.00-	7,561.39-	25,000.00-	30	33
			Expend.	0.00	341.08	19,550.00	2	33
			Net	1,484.00-	7,220.31-	5,450.00-	132	33
620 PROGRAM	General Asst (GA)/General Relief/Buri		Revenue	5,461.94-	12,420.24-	25,000.00-	50	33
			Expend.	17,885.00	97,601.99	251,250.00	39	33
			Net	12,423.06	85,181.75	226,250.00	38	33
630 PROGRAM	Food Support (FS)		Revenue	11,934.00-	142,524.00-	516,000.00-	28	33
			Expend.	8,468.20	10,128.52	7,500.00	135	33
			Net	3,465.80-	132,395.48-	508,500.00-	26	33
640 PROGRAM	Child Support (IVD)		Revenue	574.05-	274,840.65-	1,653,893.00-	17	33
			Expend.	97,077.79	398,483.87	1,153,303.00	35	33
			Net	96,503.74	123,643.22	500,590.00-	25-	33

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Southwest Health and Human Services

Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
650 PROGRAM	Medical Assistance (MA)		Revenue	312,679.14-	1,005,592.58-	3,350,000.00-	30	33
			Expend.	137,965.09	649,469.40	2,476,000.00	26	33
			Net	174,714.05-	356,123.18-	874,000.00-	41	33
680 PROGRAM	Refugee Cash Assistance (RCA)		Revenue	0.00	0.00	1,000.00-	0	33
			Expend.					33
			Net	0.00	0.00	1,000.00-	0	33
420 DEPT	Income Maintenance	Totals:	Revenue	335,897.42-	1,573,052.26-	8,895,645.00-	18	33
			Expend.	592,413.00	2,610,523.24	8,216,334.00	32	33
			Net	256,515.58	1,037,470.98	679,311.00-	153-	33
431 DEPT	Social Services							
700 PROGRAM	Social Service Administrative/Overhea		Revenue	47,875.51-	761,549.05-	9,991,780.00-	8	33
			Expend.	210,700.40	891,926.58	2,754,328.00	32	33
			Net	162,824.89	130,377.53	7,237,452.00-	2-	33
701 PROGRAM	Social Services/SSTS		Revenue					33
			Expend.	542,708.94	2,461,949.31	7,149,115.00	34	33
			Net	542,708.94	2,461,949.31	7,149,115.00	34	33
710 PROGRAM	Children's Social Services Programs		Revenue	66,544.22-	458,606.91-	1,934,098.00-	24	33
			Expend.	339,330.74	1,243,484.65	3,619,941.00	34	33
			Net	272,786.52	784,877.74	1,685,843.00	47	33
712 PROGRAM	CIRCLE Program		Revenue	6,000.00-	11,000.00-	5,000.00-	220	33
			Expend.	592.55	1,702.25	8,000.00	21	33
			Net	5,407.45-	9,297.75-	3,000.00	310-	33
713 PROGRAM	"SELF Program" Grant		Revenue	13,208.00-	13,208.00-	54,100.00-	24	33
			Expend.	3,640.12	7,809.36	54,100.00	14	33
			Net	9,567.88-	5,398.64-	0.00	0	33
715 PROGRAM	Childrens Waivers		Revenue	5,456.81-	29,598.47-	105,000.00-	28	33
			Expend.	0.00	0.00	10,000.00	0	33
			Net	5,456.81-	29,598.47-	95,000.00-	31	33
716 PROGRAM	FGDM/Family Group Decision Making		Revenue	0.00	30,799.71-	56,914.00-	54	33
			Expend.	91.91	6,255.81	56,914.00	11	33
			Net	91.91	24,543.90-	0.00	0	33
717 PROGRAM	AR/Alternative Response Discretion F		Revenue	0.00	13,385.00-	55,175.00-	24	33
			Expend.	770.15	4,991.41	55,175.00	9	33
			Net	770.15	8,393.59-	0.00	0	33

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Southwest Health and Human Services

INTEGRATED FINANCIAL SYSTEMS

Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
718 PROGRAM	PSOP/Parent Support Outreach Progra		Revenue	0.00	11,572.00-	52,446.00-	22	33
			Expend.	83.36	2,681.92	40,446.00	7	33
			Net	83.36	8,890.08-	12,000.00-	74	33
720 PROGRAM	Ch Care/Ch Prot		Revenue	2,782.84-	10,032.84-	30,000.00-	33	33
			Expend.	475.94	475.94	4,500.00	11	33
			Net	2,306.90-	9,556.90-	25,500.00-	37	33
721 PROGRAM	CC-Basic Slide Fee/Cty Match to DHS		Revenue	1,960.00-	9,616.45-	40,035.00-	24	33
			Expend.	4,749.58	16,087.83	40,035.00	40	33
			Net	2,789.58	6,471.38	0.00	0	33
722 PROGRAM	Child Care/MFIP		Revenue	0.00	225.00-	1,500.00-	15	33
			Expend.					33
			Net	0.00	225.00-	1,500.00-	15	33
726 PROGRAM	MFIP/SW MN PIC		Revenue	1,101.00-	4,385.00-	13,000.00-	34	33
			Expend.					33
			Net	1,101.00-	4,385.00-	13,000.00-	34	33
730 PROGRAM	Chemical Dependency		Revenue	12,608.90-	94,063.81-	293,000.00-	32	33
			Expend.	21,687.78	161,282.83	434,000.00	37	33
			Net	9,078.88	67,219.02	141,000.00	48	33
740 PROGRAM	Mental Health (Both Adults/Children)		Revenue	18.60-	143.30-	0.00	0	33
			Expend.					33
			Net	18.60-	143.30-	0.00	0	33
741 PROGRAM	Mental Health/Adults Only		Revenue	65,611.77-	518,365.55-	1,210,635.00-	43	33
			Expend.	115,706.76	586,907.05	1,598,082.00	37	33
			Net	50,094.99	68,541.50	387,447.00	18	33
742 PROGRAM	Mental Health/Children Only		Revenue	54,284.21-	269,602.20-	864,383.00-	31	33
			Expend.	82,561.45	423,066.63	1,405,984.00	30	33
			Net	28,277.24	153,464.43	541,601.00	28	33
750 PROGRAM	Developmental Disabilities		Revenue	56,610.45-	258,299.27-	856,835.00-	30	33
			Expend.	34,894.24	122,369.56	428,185.00	29	33
			Net	21,716.21-	135,929.71-	428,650.00-	32	33
760 PROGRAM	Adult Services		Revenue	97,925.86-	422,920.29-	1,355,500.00-	31	33
			Expend.	2,848.92	8,941.92	88,800.00	10	33
			Net	95,076.94-	413,978.37-	1,266,700.00-	33	33

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Southwest Health and Human Services

Revenues & Expend by Prog,Dept,Fund

Report Basis: Cash

Element	Description	Account Number		Current Month	Year-To-Date	Budget	% of Bdgt	% of Year
765 PROGRAM	Adults Waivers		Revenue	52,010.86-	235,083.86-	680,000.00-	35	33
			Expend.	11,494.43	30,404.34	81,250.00	37	33
			Net	40,516.43-	204,679.52-	598,750.00-	34	33
431 DEPT	Social Services	Totals:	Revenue	483,999.03-	3,152,456.71-	17,599,401.00-	18	33
			Expend.	1,372,337.27	5,970,337.39	17,828,855.00	33	33
			Net	888,338.24	2,817,880.68	229,454.00	1,228	33
461 DEPT	Information Systems							
0 PROGRAM	...		Revenue	3,351.50-	15,980.93-	35,554.00-	45	33
			Expend.	26,164.17	123,757.88	401,476.00	31	33
			Net	22,812.67	107,776.95	365,922.00	29	33
461 DEPT	Information Systems	Totals:	Revenue	3,351.50-	15,980.93-	35,554.00-	45	33
			Expend.	26,164.17	123,757.88	401,476.00	31	33
			Net	22,812.67	107,776.95	365,922.00	29	33
471 DEPT	LCTS Collaborative Agency							
702 PROGRAM	LCTS		Revenue	0.00	69,331.00-	0.00	0	33
			Expend.	0.00	69,331.00	0.00	0	33
			Net	0.00	0.00	0.00	0	33
471 DEPT	LCTS Collaborative Agency	Totals:	Revenue	0.00	69,331.00-	0.00	0	33
			Expend.	0.00	69,331.00	0.00	0	33
			Net	0.00	0.00	0.00	0	33
5 FUND	Human Services Fund	Totals:	Revenue	823,247.95-	4,810,820.90-	26,530,600.00-	18	33
			Expend.	1,996,264.68	8,827,435.18	26,530,600.00	33	33
			Net	1,173,016.73	4,016,614.28	0.00	0	33
FINAL TOTALS	983 Accounts		Revenue	1,431,050.87-	6,452,368.04-	30,330,564.00-	21	33
			Expend.	2,361,375.02	10,155,211.83	30,330,564.00	33	33
			Net	930,324.15	3,702,843.79	0.00	0	33

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Social Services Caseload:

Yearly Averages	Adult Services	Children's Services	Total Programs
2015	2648	481	3129
2016	2669	518	3187
2017	2705	604	3308
2018			

2018	Adult Services	Children's Services	Total Programs
January	2647	604	3251
February	2650	627	3277
March	2662	632	3294
April	2699	660	3359
May			
June			
July			
August			
September			
October			
November			
December			
	10658	**2523**	**3295**

Adult - Social Services Caseload

Average	Adult Brain Injury (BI)	Adult Community Alternative Care (CAC)	Adult Community Access for Disability Inclusion (CADI)	Adult Essential Community Supports	Adult Mental Health (AMH)	Adult Protective Services (APS)	Adult Services (AS)	Alternative Care (AC)	Chemical Dependency (CD)	Developmental Disabilities (DD)	Elderly Waiver (EW)	Total Programs
2015	12	227	13		306	34	817	23	403	460	352	2652
2016	13	240	12	0	298	50	829	18	396	452	362	2669
2017	12	266	12	0	315	45	828	16	422	444	343	2705
2018												

*Note: CADI name change and there is a new category (Adult Essential Community Supports)

2018	Adult Brain Injury (BI)	Adult Community Access for Disability Inclusion (CADI)	Adult Community Alternative Care (CAC)	Adult Essential Community Supports	Adult Mental Health (AMH)	Adult Protective Services (APS)	Adult Services (AS)	Alternative Care (AC)	Chemical Dependency (CD)	Developmental Disabilities (DD)	Elderly Waiver (EW)	Total Programs
January	12	270	13	0	293	59	862	17	338	453	330	2647
February	12	268	13	0	293	49	856	17	366	453	323	2650
March	11	289	14	0	292	47	859	18	357	450	325	2662
April	11	293	14	0	302	45	866	19	375	453	321	2699
May												
June												
July												
August												
September												
October												
November												
December												
	12	**280**	**14**	**0**	**295**	**50**	**861**	**18**	**359**	**452**	**325**	**2665**

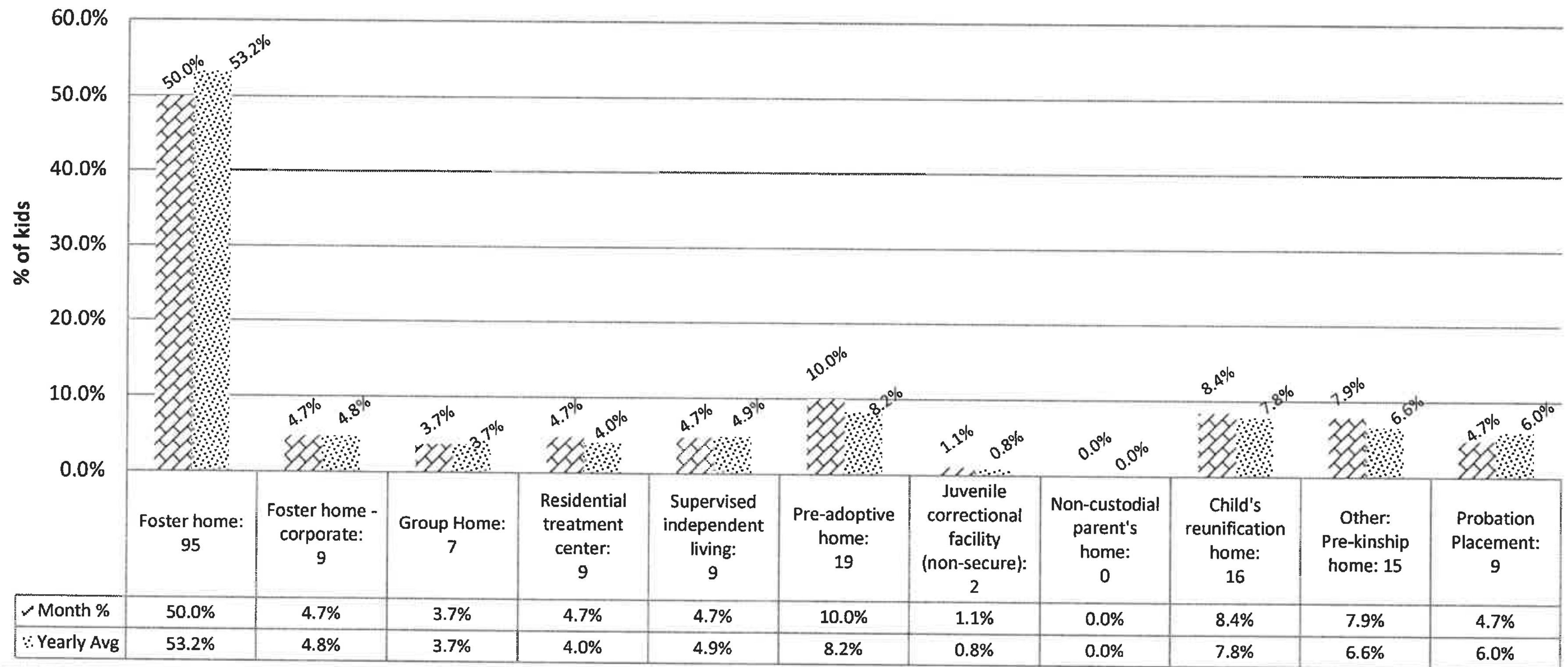
Children's - Social Services Caseload

Average	Adolescent Independent Living (ALS)	Adoption	Child Brain Injury (BI)	Child Community Alternative Care (CAC)	Child Community Alternatives for Disabled Individuals (CADI)	Child Protection (CP)	Child Welfare (CW)	Children's Mental Health (CMH)	Early Inter vention: Infants & Toddlers with Disabilities	Minor Parents (MP)	Parent Support Outreach Program (PSOP)	Total Programs
2015	38	15	1	3	30	153	127	96	0	1	18	482
2016	41	17	2	5	35	175	145	86	0	0	13	518
2017	49	21	0	10	35	195	174	103	0	0	17	604
2018												

2018	Adolescent Independent Living (ALS)	Adoption	Child Brain Injury (BI)	Child Community Alternative Care (CAC)	Child Community Alternatives for Disabled Individuals (CADI)	Child Protection (CP)	Child Welfare (CW)	Children's Mental Health (CMH)	Early Inter vention: Infants & Toddlers with Disabilities	Minor Parents (MP)	Parent Support Outreach Program (PSOP)	Total Programs
January	46	20	0	10	34	188	184	104	0	0	18	604
February	46	20	0	10	36	194	196	109	0	0	16	627
March	47	21	0	10	39	194	190	113	0	0	18	632
April	46	23	0	10	39	218	204	107	0	0	13	660
May												
June												
July												
August												
September												
October												
November												
December												
	46	21	0	10	37	199	194	108	0	0	16	631

2018 KIDS IN OUT OF HOME PLACEMENT - BY COUNTY

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	YTD Average	2017 Average
Lincoln	6	7	9	9									8	7
Lyon	46	44	44	49									46	38
Murray	11	14	16	15									14	10
Pipestone	15	15	16	15									15	19
Redwood	96	92	88	85									90	95
Rock	14	16	16	17									16	16
Monthly Totals	188	188	189	190	0	0	0	0	0	0	0	0		


April 2018 - Placement by Category
190 Kids in Placement
% of kids
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Foster home: 95
Foster home - corporate: 9
Group Home: 7
Residential treatment center: 9
Supervised independent living: 9
Pre-adoptive home: 19
Juvenile correctional facility (non-secure): 2
Non-custodial parent's home: 0
Child's reunification home: 16
Other: Pre-kinship home: 15
Probation Placement: 9
Month % 50.0% 4.7% 3.7% 4.7% 4.7% 10.0% 1.1% 0.0% 8.4% 7.9% 4.7%
Yearly Avg 53.2% 4.8% 3.7% 4.0% 4.9% 8.2% 0.8% 0.0% 7.8% 6.6% 6.0%

April 2018: Total kids in placement = 190

Total of 11 Children entered placement

4	Lyon	Foster Home
2	Lyon	Residential Treatment Center
1	Pipestone	Residential Treatment Center
3	Redwood	Foster Home
1	Rock	Foster Home

Total of 10 Children were discharged from placement (discharges from previous month)

1	Lyon	Child's Reunification Home
1	Murray	Group Home
1	Pipestone	Residential Treatment Center
1	Pipestone	Probation
3	Redwood	Child's Reunification Home
2	Redwood	Probation
1	Redwood	Pre-kinship Home

SOUTHWEST
HEALTH & HUMAN
SERVICES

2018 Public Health Statistics

	WIC	Family Home Visiting	PCA Assessments	Managed Care	Dental Varnish	Refugee Health	Latent TB/DOT Medication Distribution
'12 Avg	1857	48	15	187	81		
'13 Avg	2302	37	21	211	90		
'14 Avg	2228	60	25	225	112	6	30
'15 Avg	2259	86	23	238	112	12	36
'16 Avg	2313	52	22	265	97	12	27
'17 Avg	2217	47	22	290	56	9	25

	WIC	Family Home Visiting	MnChoices PCA Assessments	Managed Care	Dental Varnish	Refugee Health	LTBI Medication Distribution	Water Tests	FPL Inspections	Immunizations	Car Seats
12/17	2187	52	16	283	24	7	18	n/a	n/a	n/a	n/a
1/18	2207	44	21	347	46	5	17	106	45	56	22
2/18	2166	42	20	308	6	7	15	96	46	70	13
3/18	2177	49	23	378	35	8	14	93	43	60	18
4/18		69	21	357	30	1	10	96	42	48	21
5/18											
6/18											
7/18											
8/18											
9/18											
10/18											
11/18											
12/18											

NON IVD COLLECTIONS

APRIL 2018

PROGRAM		ACCOUNT	TOTAL
MSA/GRH		05-420-605.5802	940
TANF (MFIP/DWP/AFDC)		05-420-610.5803	1,484
GA		05-420-620.5803	5,462
FS		05-420-630.5803	634
CS	(PI Fee, App Fee, etc)	05-420-640.5501	350
MA	Recoveries & Estate Collections (25% retained by agency)	05-420-650.5803	149,344
REFUGEE		05-420-680.5803	0
CHILDRENS			
	Court Visitor Fee	05-431-700.5514	24
	Parental Fees, Holds	05-431-710.5501	3,206
	OOH/FC Recovery	05-431-710.5803	14,343
CHILDCARE			
	Licensing	05-431-720.5502	1,900
	Corp FC Licensing	05-431-710.5505	883
	Over Payments	05-431-721&722.5803	0
CHEMICAL DEPENDENCY			
	CD Assessments	05-431-730.5519	6,589
	Detox Fees	05-431-730.5520	5,920
	Over Payments	05-431-730.5803	0
MENTAL HEALTH			
	Insurance Copay	05-431-740.5803	19
	Over Payments	05-431-741 or 742.5803	2,925
DEVELOPMENTAL DISABILITIES			
	Insurance Copay/Overpayments	05-431-750.5803	6
ADULT			
	Court Visitor Fee	05-431-760.5803	0
	Insurance Copay/Overpayments	05-431-760.5803	9

TOTAL NON-IVD COLLECTIONS **194,038**

SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 1

EFFECTIVE DATE: 01/01/11
REVISION DATE: 12/17/14, 08/17/16; 05/16/18
AUTHORITY: Southwest Health and Human Services Joint Governing Board
MN Statutes, Chapter 13
MN Rules Governing Data Privacy, Chapter 1205

--- DATA PRIVACY POLICY AND PROCEDURES ---

Section 1 - Introduction

a. The purpose of this policy is to assist the staff of Southwest Health and Human Services in complying with the data privacy statutes to: 1) safeguard information about individuals that the agency collects, stores, and creates; and 2) to facilitate access to information that the agency has collected or created according to existing state and federal statutes and rules.

b. Data privacy is a form of an implied contract between an individual supplying information and the agency needing information to provide services. Implied in this agreement is the intention of supplying information for a specific program purpose. If the information is to be used for another purpose by another program, other individuals or agencies different from public health or human services, the individual must consent to such use. Individuals have the right to know why the information is requested, how it will be used, who will have access to the information. They also have the right to contest accuracy.

c. The public also has the right to certain information of the agency in order to monitor and evaluate governmental activities. None of these rights are absolute. A privacy policy attempts to maintain a balance between the rights of the individual and the public.

Section 2 – General Principles

a. Individual Ownership of Data

The MN Government Data Practices Act maintains individual ownership of the individual data collected. Southwest Health and Human Services will own the paper, forms, and files, whereas the individual owns the data that is on these forms. The agency is the caretaker of the individual's data. The individual in a very real sense controls the use of the data. When questions arise, the individual's consent is the most legal and ethical approach to be used in the release of information.

b. Program Information

The MN Government Data Practices Act requires that agencies collect only data which is necessary for the administration of authorized programs. Data which is collected from an individual under the authority of federal or state law must only be used by the program for which it was collected. An exchange of data with personnel outside of the program area must have the individual's signed permission, unless there is a statute that authorizes such release. At the time of collection an individual must be made aware that the data they are providing will be shared with other health and human service employees directly involved in providing program services. Staff has a responsibility to maintain data necessary for program purposes and have records and files that are accurate, current, and complete.

c. ~~Release of Information~~Notice of Privacy

The government must give individuals notice when collecting private or confidential information from them. The Notice of Privacy will be given to individuals as per program and their respective requirements. The Notice of Privacy is also posted on SWHHS's website.

~~If the client has been made aware that sharing of data will take place this data may be transferred without release. If the individual has not been made aware, dissemination of data cannot take place without a signed release from the client, or a law that authorizes access or special permission to release this information after the original Notice of Privacy, sometimes referred to as the Tennessen Warning, was given.~~

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d. Release of Information

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The MN Government Data Practices Act does not distinguish between an individual's benefit to release information and a detriment to the individual's release of information. Whatever category the data falls into, it is categorized for all purposes. Example: The individual's address can no more be disclosed without the individual's consent for purposes of settling estate than it can be for the purpose of locating an accused criminal. Any letters from attorneys, subpoenas, dispositions, interrogatories, court orders, and request of clients to see their file should be channeled through their supervisor. In addition, one of the privacy officers or designee shall also be notified.

Section 3 - The MN Government Data Practices Act and the Department of Administration Rules Establish the Rules Under Which Data and Information is Compiled, Classified, Maintained, and Distributed

a. Classification of Data: Data is classified into two main categories and each category is divided into three defined groups.

- **Data on Individuals**: Data on individuals is defined as all data in which an individual can be identified as the subject of that data.
- **Public Data on Individuals**: Data on individuals is public if the statute or

rule does not classify the data as private or confidential and is accessible by the public.

- **Private Data on Individuals:** Private data on individuals is data which is not accessible to the public, but is accessible only to the individual subject of that data and can be released only by the subject of the data's consent.
- **Confidential Data on Individuals:** Confidential data is data on individuals that is classified as confidential by state or federal law, is not accessible by the public, and is not accessible to the individual subject of that data. Client cannot sign to release this information. At a minimum, confidential data includes:
  - medical or psychological information stamped confidential
  - names of reporters
  - adoption records
  - chemical dependency records (per MN Statute Chapter 254A; section 09.)
  - all information related to IRS – IEVS (Income Eligibility Verification Systems), e.g., UNVI or BEER matches.
- **Data Not on Individuals:** Data not on individuals is all data which is not on individuals and does not allow identification of individuals.
  - Public data is data which is accessible by the public.
  - Non-public data is not accessible by the public.
  - Protected non-public data is data not accessible by the public or the subject of that data.

b. Summary data means statistical records and reports derived from data on individuals, but in which the individuals are not in any way identifiable. Data or summary data has all data elements that could link the data to a specified individual have been removed and lists of numbers or other data which would uniquely identify an individual is separated from the summary data; it is not available to persons who gain access to or possess summary data. Unless classified elsewhere, summary data is public and may be requested by and made available to any individual or person. Summary data may be requested by a governmental unit if needed for administration and management.

Section 4 - Access to Data

a. Responsible Authority

Each agency, according to the MN Government Data Practices Act is required to appoint a responsible authority. The responsible authority designates the person in charge of the records and policies concerning data privacy.

The Southwest Health and Human Services Joint Governing Board Bylaws list ~~has appointed~~ the Director of the agency as the responsible authority and is authorized to

assure that the agency acts in accordance with MN Statutes and administrative rules governing data practices.

The responsible authority will designate those individuals who are in charge of individual files and systems containing governmental data.

b. Privacy and Security Officers

~~Dale Hiland, Social Services Supervisor~~ Beth Wilms, Director, and Carol Biren, Public Health Director, are the designated HIPAA/Data Privacy Officers. They are responsible for the development and implementation of the data privacy policies and procedures. Karri Harvey, Management Information Supervisor is the designated Security Officer for SWHHS.

c. Request for Government Data

1. Individual Data
   When a request is made to view a client's file, this request will be referred to the supervisor in charge of the unit providing service. The supervisor will ensure proper release of information and Request for Disclosure of Information (AG#115) have been obtained. In addition, one of the HIPAA/Data P~~p~~rivacy O~~o~~fficers or designee shall also be notified.

~~5.~~2. Summary Data
Summary data is public data which does not identify individuals. Preparation of summary data may be requested by any person or individual. The request will be made in writing to the Director or designee. The Agency will inform the requester of any necessary costs involved in summarizing the data. ~~Funds necessary to reimburse the cost shall be collected prior to releasing the information.~~

~~6.~~3. Public access to records is limited to normal office hours, excluding holidays. Normal office hours of Southwest Health and Human Services are from 8:00 a.m. to 4:30 p.m. Requests for access shall be submitted in writing on form AG#115 and will receive a response immediately or ~~immediately or~~ within 10 working days. The public
has the right to look at (inspect), free of charge, all public data that the Agency keeps. The public also has the right to get copies of public data. The MN Government
Data Practices Act allows us to charge for copies and SWHHS will charge no more than allowed according to statute~~. The public has the right to look at data, free of charge, before deciding to request copies.~~

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~~If copies of data are requested, one free copy will be provided to the client only on an annual basis. If a person/entity, other than the client requests copies or electronic transmittal of data of 100 pages or more, SWHHS will require the requesting person to pay the actual costs of searching for and retrieving government data, including the cost of employee time (at lowest office support services specialist rate of pay), for making, certifying, and electronically transmitting the copies of the data, and a copy cost of 25 cents per page but will not charge for separating public from not public data. However, if 100 or fewer pages of black and white, letter or legal size paper copies are requested, actual costs shall not be used, and instead, SWHHS will charge 25 cents for each page copied. If the information cannot be picked up at the local office, the cost of postage will also be charged. No documents will be released until payment has been made.~~

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d. Access to private data is limited to:

- the subject of the data,
- entities or individuals given access by expressed written direction of the subject of the data,
- staff members with the Agency whose work assignments require access, and
- persons designated by the courts.

The intended purpose for which the subject provided the data shall be used as the guiding factor in determining which staff has access to the records. All requests shall be made in writing~~person by the person requesting the data~~.

If access to records is denied, the person requesting access must be informed in writing of the reason why access is being denied.

Release of information of private data to a third party can only be done when written consent of the subject of the data has been obtained. The consent form must identify the individual to whom the information can be released and must contain the following information:

- Identify the individual to whom the information can be released.
- The consent form ~~should~~ states the general purpose for which the requested information would be used.
- The consent form ~~should~~ designates the specific data, appropriate dates, and type of information which is authorized to be released.
- The consent form ~~should~~ will be dated and signed.
- The consent form ~~should~~ will only be honored if received within 1 year after the date of the signature and can only release information obtained prior to and including the date of the signature.

- The consent form ~~should~~ states that such consent may be revoked by the individual at any time.

Parents have the right to look at and get copies of public and private data about their minor children (under the age of 18). Legally appointed guardians have the right to look at and get copies of public and private data about an individual for whom they are appointed guardian.

Minors have the right to ask the Agency not to give data about them to their parent or guardian. The Agency informs the minor that they have this right. We may ask the minor to put their request in writing and to include the reasons why we should deny their parents access to the data. We will make the final decision about the request based on the minor's best interests. The decision will be made with the staff person's supervisor. Information will be documented in the case notes.

e. Verifying Identity

The following constitute proof of identity:

- An adult individual must provide a valid photo ID, such as;
  - a state driver's license
  - a military ID
  - a passport
  - a Minnesota ID
  - a Minnesota tribal ID
- A minor individual must provide a valid photo ID, such as;
  - a state driver's license
  - a military ID
  - a passport
  - a Minnesota ID
  - a Minnesota Tribal ID
  - a Minnesota school ID
- The parent or guardian of a minor must provide a valid photo ID and either;
  - a certified copy of the minor's birth certificate or
  - a certified copy of documents that establish the parent or guardian's relationship to the child, such as;
    - a court order relating to divorce, separation, custody, foster care
    - a foster care contract
    - an affidavit of parentage
- The legal guardian for an individual must provide a valid photo ID and a certified copy of appropriate documentation of formal or informal appointment as guardian, such as;
  - court order(s)

- valid power of attorney

~~Note: Individuals who do not exercise their data practices rights in person must provide either notarized or certified copies of the documents that are required or an affidavit of ID.~~

f. Appropriate Administrative, Technical and Physical Safeguards

The Agency will reasonably safeguard private data from any intentional or unintentional use or disclosure that is in violation of the MN Governmental Data Practices Act. Records stored in the Agency will be kept secure at all times. Employees who are handling private data during the course of the day will protect the privacy of the material. In the unfortunate event that we determine a security breach has occurred and an unauthorized person has gained access to your data, we will notify the individual(s) ~~you~~ as required by law.

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Section 5 – Security of Individual Files

a. ~~a.~~ Staff members must also recognize that any information that is gained through work concerning clients is not to be talked about with any other person who does not have the need to know this information. It is also the policy of the agency that cases shall not be discussed in the break room, halls, texting, social media, other communication methods or any place where other people may gain access to that information ~~within physical limitation of the agency~~.

b. Employee Sanctions: If there is a report of non-compliance or if employees fail to comply with the Agency's privacy and security policies or procedures, the Agency will apply appropriate disciplinary sanctions.

Section 6 – Individual's Right to Contest Data and/or Request to Amend ~~IIHI~~ Private Data

a. An individual, parent of a minor or legal guardian has a right to contest the public or private data collected by the Agency.

b. The individual, parent of a minor or legal guardian shall notify the agency in writing describing the nature of his contention, disagreement with any specific data contained in the file. A staff person will assist the individual wishing to contest such data. The written notice shall become part of the individual file. If corrections in data need to be

made, these will be done by the appropriate staff person. An individual, parent of a minor or legal guardian will be notified in writing about the corrections. If no corrections are necessary, the client, parent of the minor or legal guardian shall be notified of that decision. If files of other individuals have the same inaccuracy, the staff will be instructed to make necessary corrections and send letters of notification to the individuals. If there is any disagreement between the agency and the client, parent of a minor or legal guardian that a satisfactory conclusion has not been reached, the client, parent of the minor or legal guardian has the right to appeal this to the Department of Administration.

Section 7 - Simplified Classification Lists

a. Data collected during a criminal investigation is classified as confidential by Minnesota Statutes 13.39, Subdivision 2.

b. Adoption records are classified as confidential by Minnesota Statutes 259.27, Subdivision 3.

c. Child protection records are classified as private and/or confidential by Minnesota Statutes 626.556, Subdivision 11.

d. Chemical dependency records are classified as private by 42 CRF 2.1 1976.

e. Licensing records are classified as public, except personal and personal financial information about family day care and foster care records. All information on the actual license for family day care or foster care is public except social security number and reference. (Licensing information being used in an investigation is protected non-public.)

f. Data pertaining to medical providers who provide medical services to individuals under the State MA program, including their names and information pertaining to their financial reimbursement for providing such services, is public.

g. Vendors of services are not classified as individuals under the data privacy law.

h. Personnel records of all public agencies, including the Merit System, are classified as public except for that information classified as private under Minnesota Statutes. The following data about public employees is public information: name, actual gross salary, salary range, contract fees, pension, value and nature of employee's fringe benefits, and the basis for and the amount of any added remuneration including expense reimbursement. In addition to salary; job title, job description, education, training and background, previous work experience, date of first and last employment, the status of any complaints or charges against the employee (whether or not the complainer charged resulted in disciplinary action), the final disposition of any

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disciplinary action, work location, work telephone number, payroll time sheets that are used to account for employees' work time (except to the extent that the release of time data would reveal the employee's reason for the use of sick or other medical leave or other non-public data), the city and county of residence. This is all contained in Minnesota Statutes Section 13.43, Subdivision 2.

i. WIC data is considered private.

Section 8 – Breach Investigation and Notification

The HIPAA/Data Privacy and/or Security Officer(s) shall serve as the investigators of the breach process. The investigators shall be responsible for the management of the breach investigation process and coordinating with others in the Agency as appropriate (e.g., administration, human resources, HIPAA, Data Privacy and Security Team, legal counsel, etc.). The investigators or designee shall be the key facilitators for all breach notification processes to the appropriate individuals and/or entities as required by law.

~~Agency Forms Regarding This Policy:~~
~~AG#009 – Notice of Privacy Rights~~
~~AG#115 – Request for Disclosure of Information~~

SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 8

EFFECTIVE DATE: 01/01/11
REVISION DATE: 12/18/13, 06/15/16; 05/16/18
AUTHORITY: Southwest Health and Human Services Joint Governing Board

----DISASTER RECOVERY PLAN----

Section 1 - Purpose

a. The purpose of this policy is to detail the disaster recovery procedures for Southwest Health and Human Services. This policy identifies the following:
  - Current physical equipment that requires a "plan" for disaster recovery
  - Current backup systems for data
  - Hot sites and contracted or other agreements for alternate sites and replacement equipment.
  - I.T., management, and user personnel involved in plan and recovery
  - Recovery procedures after an actual disaster
  - Testing of Disaster Recovery Plan(DRP)

Section 2 - Current Servers

a. Critical Servers:
  - ~~LLMHS01~~ SWMSHL01 Human Services Data Server containing day to day documents, etc.
  - ~~SWMAIL01~~ MAIL & EXCHANGE Human Services and Lyon County Exchange/Email Server
  - ~~SWHHS14Human Services Terminal Server (used by telecommuters for access to SWHHS data and e-mail services)~~
  - IBM I Series Server, contains LLMHS and Lyon County accounting software and associated data
  - SWHHS06 Pipestone (on their premises)
  - ~~PHFILE server Redwood~~ Red-dc1 (on their premises)
  - ~~SWHHS06~~ LuverneRock (on their premises)
  - ~~SWMSHLDC~~ Mar-dc1Entire Active Directory
  - SWHHS15 – Appxtender Server

b. Non-Critical Servers:
  - ~~LLMHS10~~ and LLMHS12 (~~these are antivirus and~~ Windows software updates servers).
  - State Firewall Routers are installed in all county government centers, and provide wide data/internet access to other county and state government systems.

Section 3 - Current Backup Systems

a. I series full system tape backups, which includes all software and user Id's. The operating system is completed on a quarterly basis. Copies of this are kept off site.

b. I series daily tape backups of all accounting and associated changing data are completed daily, with weekly off site copies.

c. Email/Exchange Server tape backups are completed daily, ~~with weekly off site copies.~~

d. Staff data/documents ~~tape backups are completed daily with weekly off site copies.~~Buffalo &Synology Disc Storage

e. SSIS server tape backups are completed daily, with weekly off site copies.

Section 4 - Hot Sites and Contracted or Other Agreements for Alternate Sites, and Replacement Equipment

a. State router replacement would be the complete responsibility of the State of MN. These are in place and usable at any county location in the State of MN. b. Current "Hot" servers at the Lincoln (Ivanhoe),Murray (Slayton), Redwood (Redwood Falls), Pipestone (Pipestone) and Rock (Luverne) sites are already in place and functional on the same domain as the central site in Lyon (Marshall). Copies of current off-site backups would be restored to one of these selected sites to make all data available to system users.

c. I series equipment replacement will be available through an Emergency Hardware Replacement Contract with our IBM solutions vendor CPS Technology Solutions, Inc.(signed 04/27/09). All off site backups can be restored to this replacement system which could be delivered to our site or alternate site within the time period specified in the contract (2 working days).

d. Other systems such as Maxis, MMIS, and Prism are all through the Internet and are maintained at the State of MN site by them. These are available to end users from any county location in the State of MN. Nightingale Notes is maintained by Champ.

e. The SSIS server would be replaced by the State of MN.

f. Other servers would have to be secured through a vendor.

SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 8

Section 5 - I.T., Management, and User Personnel Involved in Plan and Recovery

a. Personnel involved in a DRP (Disaster Recovery Plan) recovery situation would include but may not be limited to the following:
- Director
- Management Information Supervisor
- Deputy Director
- Financial Assistance Supervisor
- SS and PH Division Directors
- Lyon County Administrator
- Lyon County Facilities Manager

b. Based on the level of disaster, the members present, and availability of resources job responsibilities will be assigned accordingly.

c. Duties

IT Personnel
- Provide technical support for hardware removal
- Cleanup wiring
- Replace physical equipment
- Test repairs

Director and County Administrator
- Declare level of disaster
- Initial notification of disaster team
- Assist with assessment of the extent of damage
- Authorize purchases and required disbursements
- Oversee recovery status

DRP team
- Determine relocation site and required equipment
- Assign personnel to alternate if needed
- Provide support in the cleanup of the data center or alternate site
- Test repairs

I.T. Supervisor
- Determine which equipment is destroyed
- Review with DRP team
- Contact contracted vendors for replacements
- Provide support in the cleanup of the date center or alternate site
- Test repairs

Materials List

- Telephone sets
- Personal computers
- Network cables
- Server hardware
- Blank computer tapes
- Desks
- Chairs
- Non-computer equipment

Vendor List

- Frontier Phone Company (Slayton and Ivanhoe) 507-372-2266
- Trimin Government Solutions (IFS accounting software) 320-259-5007
- Computer Professional Unlimited (CPU) (Payroll and Lyon County phone system) 320-589-2110
- Fran's Communication (General telephone wiring and Lyon County phone system) 507-532-6467
- CPS Technology Solutions (IBM I-series hardware maintenance contract holder) 800-438-7761
- Office of the Enterprise Technology (OET) (State of MN DHS systems, phone lines, data lines, Maxis, MMIS, and Prism)
- The Computer Man, Inc. (Computer hardware supplier and software maintenance engineer on CISCO equipment) 507-532-7562
- IBM (I-series hardware maintenance) 800-426-7378
- Morris Electronics 320-287-0922

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Section 6 - Recovery procedures after disaster

a. Assemble technical and management team

b. Determine level of disaster

c. Assemble clean up or technical team and repair existing site or prepare alternate site

d. Establish communications links-phone and data

e. Environment; heat, a/c, power, furniture

f. Begin hardware replacement or salvage current equipment

g. Reassemble and review requirements and prepare additional needs list for

vendors

h. Acquire backup copies of necessary data and backup tapes

i. Inform all personnel of the public of recovery place with short and long term expectations

j. Acquire backup copies of necessary data and backup tapes

k. Contact State of MN to reroute email etc. to alternate site

Section 7 - Testing of DRP

a. The State of MN does tests of SSIS restores and other State systems on a regular basis. Monthly system soft tests are performed during regular updates and the rebooting of each of the servers.

b. Making of alternate sites into a primary site in case of physical disaster may mean adding some hard drive space for long term (over 30 days) to restore non-essential data from offsite backup tapes. Tape drives or other form of backup media would need to be acquired from a vendor to restore tapes, and to perform on-going backups, as these servers do not currently have a tape drive.

Section 8 – Contract with other Entities

a. Each county is responsible for their own DRP. SWHHS is responsible to maintain systems and get them back up and online in accordance to their policy. All critical servers will be back online and restored dependent on the type of disaster and equipment needed.

SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 9

EFFECTIVE DATE: 01/01/11
REVISION DATE: 06/15/16; 05/16/18
AUTHORITY: Southwest Health and Human Services Joint Governing Board

----PHYSICAL AND TECHNICAL SAFEGUARDS----

Section 1 - Purpose

a. The purpose of this policy is to detail the Physical and Technical Safeguards for Southwest Health and Human Services. This policy identifies the following:
   - Tape Backups
   - Workstation Security
   - Security of Data Center
   - Firewalls, Virus Software, and Spam/Internet Filters
   - Battery power and generators
   - Access to computer systems
   - Assessment of Controls
   - Contingency Plan
   - Device and Media Accountability, Backup and storage, Disposal and Reuse
   - Technical Safeguards

Section 2 - Tape Backups

a. All servers are backed up to synology data stor and Buffalo storage. The Friday tape is stored off site in a fireproof safe. Month end tapes are saved for 12 months. Year end tapes are saved permanently. This function is performed by Information Technology Specialist.

Section 3 – Workstation Security

a. Workstations are secured in the following ways:
   - Hard drive encryption
   - Unique usernames
   - Passwords that adhere to the password policy, 15 character alpha number.
   - Locking of computer when not in use or stepping away from workstation
   - Limited access, shutting office doors, making sure monitors are not easily seen and if they are in the direction of a walkway have the appropriate privacy screen filters installed and used.

Section 4 - Security of Data Center

a. The doors to the Data Center are locked at all times. Only authorized personnel have access to the Data Center and work area. Internal video surveillance is installed and monitored. Recorded data can be reviewed if necessary.

Section 5 - Firewalls, Virus Software, and Spam/Internet Filters

a. There is a Cisco firewall in place to restrict outside intrusion of the network. Anti-Virus software is in place and updated daily on all personal computers and servers. There is a spam filter in place to monitor and filter all incoming mail. There is an anti-malware and anti-exploit software installed and updated daily.

Section 6 - Battery Power and Generators

a. All servers are powered by uninterruptable power supply batteries, which in turn are backed up by a fuel powered generator.

Section 7 - Access to computer systems

a. Access to the various computer systems functions are restricted to specific employees depending on their job requirements. Supervisors determine the access needed by their staff.

Section 8 - Assessment of Controls

a. Each location has unique security dependent on building controls. All servers and switches are behind locked doors with limited access.

- **Marshall:** Building security is controlled by Lyon County, there are security devices that allow for after-hours access to the building via employee badges. Doors to both Human Services and Public health offices have ~~key pad~~ID Badge Fob Secure entries ~~and the code is changed when there is a change in staffing.~~ IT has a separate area that houses the data center and IT staff, there is a separate keypad entry with code as well as key locks only available to IT staff and janitorial staff. The front desk staff is protected by safety glass.
- **Redwood:** Building security is maintained by Redwood County. Physical access to the building is controlled by key lock and monitored by surveillance cameras. There is a key fob door control to employee office area both for Human Services, Public Health and Eligibility worker area. IT equipment is in the janitorial room with a locked cage securely housing the switches. The service is located in the courthouse with Redwood County's IT secure data center that is controlled with limited access by

their IT staff with key. The front desk staff is protected by safety glass. Child support in the court house has keyed lock.

- **Slayton:** Building security is maintained by Murray County, physical access is granted by key. Employee office area for both Human Services and Public health is accessed by keypad entry. IT equipment is in the janitorial room with limited access by key. The front desk staff is protected by safety glass.
- **Luverne:** Physical security is maintained by Rock County. Physical access to the building is by key lock. There is a keypad that grants access to the human services and public health area. The front desk staff is protected by safety glass. Switches are located in a wiring closet with limited key access. The server is located in the Rock County Courthouse that is in their data center controlled by limited locked access. The front desk staff is protected by safety glass.
- **Ivanhoe:** Building security is maintained by Lincoln County. Physical access is granted by key. All areas have a keypad entrances. Human Services and Public Health have separate keyed entrances. Human Services is in multiple areas within the lower level of the courthouse. IT equipment is located in a secure locked

  cage with limited access.
- **Pipestone:** Has keyed external lock and keyed internal lock. Switches are located in locked wiring closet, server is located in locked are in Courthouse with Pipestone County Servers. Front desk staff is protected by glass.

b. Supervisors are expected to report any concerns with physical or technical security to the Director immediately.

c. Defining access control and validation. Southwest Health and Human Services maintains access to physical locations determined by job specificity. IT staff that have proper BCA clearance are allowed in the data center or secure areas. Janitorial staff also have a proper BCA background check and clearance. Staff are given access to working areas using the keypad or key fob systems in each location. Areas controlled by keys are determined by supervisors and job descriptions.

d. Maintenance records. A signature log is created at the front desk area of all vendors including maintenance repair that would access secure areas. The only exception is in Marshall where the data center is located in a different area of the building. IT maintains a written log of outside professionals who have access for maintenance to buildings or structure.

Section 9 – Contingency Plan

a. This policy defines how the physical spaces are protected when emergency mode operations are put into effect. Logging of authorized personnel will ~~bemaintained~~be maintained of all law enforcement, IT, Directors, Vendors, or designated staff that will need access to the area. Those that don't have security clearance will be accompanied by a member of the staff at all times. If the security of the physical area is compromised during an emergency, we will restore systems at one of our other 5 locations to maintain the integrity of our data. Any hardware that is in a compromised area will be removed and stored securely.

Section 10 - Device and Media Accountability, Backup and Storage, Disposal and Reuse

a. Laptops, Desktops, Servers and mobile devices are used by staff according to their job description. A working inventory is used and updated routinely by IT staff. All items contain a barcode that has data linked including the serial number, ~~purchase date~~, warranty and employee that it was distributed to.

b. Once an employee leaves, equipment is returned to IT staff and securely stored until re-issuance. Prior to re-issuing equipment laptops, desktops, and/or mobile devices are wiped and reloaded so previously stored data is not compromised. Any equipment or storage media that contains confidential, critical, internal use only, and/or private information will be erased by appropriate means or destroyed by the Security Officer or his/her appointed designee before the equipment/media is reused.

c. Disposal: All electronic protected health information (ePHI) on decommissioned devices and storage media must be irretrievably destroyed, in order to protect the confidentiality of the data contained. If the device or media contains ePHI that is not required or needed, and is not a unique copy, a data destruction tool must be used to destroy the data on the device or media prior to disposal. A typical reformat is not sufficient as it does not overwrite the data. If the device or media contains the only copy of ePHI that is required or needed, a retrievable copy of the ePHI must be made prior to disposal.

d. Removable magnetic "disks" (floppies, ZIP disks, and the like) and magnetic tapes (reels, cartridges) can be "degaussed" by an appropriately-sized and -powered degasser or physically destroyed.

e. Fixed internal magnetic storage (such as computer hard drives), as well as removable storage, can be cleansed by a re-writing process. Software is used to over-write all the usable storage locations of a medium. The simplest method is a single over-write; additional security is provided by multiple over-writes with

variations of all 0s, all 1s, complements (opposite of recorded character), and/or random characters.

f. A few kinds of "write-many" optical media (such as CD-RWs) can be processed via an over-write method. This is not the case for the vast majority of "write-once" optical media in use (notably the CD-R). Because such media are optical rather than magnetic, they cannot be degaussed. For the write-once variety, only physical destruction will do.

g. Removable "solid state" storage devices are also now available. These "flash memory" devices are solid state and are non-volatile (the memory maintains data even after all power sources have been disconnected). Examples include CompactFlash, Memory Stick, Secure Digital, Smart Media and other types of plug-ins, and a range of "mini-" and "micro-drive" flash devices that use USB or FireWire ports. Secure overwrites (following manufacturer specifications) are possible for these media as well. Neither degaussing nor over-writing offers absolute guarantees. Unless, of course, one is willing to disintegrate, incinerate, pulverize, shred, or smelt. As with paper, the method of disposal depends on the perceived risks of discovery, and estimates of the type of threat.

h. Paper containing sensitive information should be shredded. Strip cut shredders (also called straight cut or spaghetti cut) render paper into thin, long strips.

i. End of life for equipment: Once equipment reaches its usable expectancy, hardware is properly disposed of. Hard drives are erased using Kill disk with DDOS level (U.S. Department of Defense level) features. After hard drives have been Killdisked, they are stored in the data center until they can be taken to DHS MN.IT Services, 444 Lafayette Road N, St. Paul, MN 55101, where they are shredded. (This includes all tapes, disks, storage devices) PC's, laptops, servers, printers are all recycled through local resources in a manner that is environmentally friendly.

Section 11 - Technical Safeguards

a. Unique User Identification:
- Southwest Health and Human Services IT staff will assign a unique name and/or number for identifying and tracking user identity.

b. Emergency Access Procedures:
- Emergency Access will be established by the Security Officer and as directed in Admin Policy #8 - Disaster Recovery Plan.
- When leaving workstation area, staff must log off their workstation.

c. Encryption and Decryption of PHI:

- All hard drives are encrypted using HP Protect tools or Bitlocker Drive Encryption. Decryption is performed only during times of repair or if data becomes corrupt. The Decryption key is located in the Data Center which has limited access. Email is encrypted by ZIX mail, it is automatic and works with minimal effort from the sender, "Securemail" is to be used as part of the subject line.

d. Audit Controls:

- Audit Controls in place such as user account controls which lock an end-user out of their account after 3 attempted log in failures. ~~Log reports are gathered through Kiwi syslogger for VPN access.~~ Log files are gathered through Appxtender to be reviewed as necessary.

- Southwest users seeking access to any network, system, or application must not misrepresent themselves by using another person's User ID and Password, smart card, or other authentication information.
- Southwest users are not permitted to allow other persons or entities to use their unique User ID and password, smart card, or other authentication information.
- A reasonable effort must be made to verify the identity of the receiving person or entity prior to transmitting EPHI.

SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 14

EFFECTIVE DATE: 02/15/12
REVISION DATE: 12/17/14, 06/15/16, 05/16/18
AUTHORITY: Southwest Health and Human Services
(SWHHS) Joint Governing Board

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---HEALTH CARE INSURANCE PORTABILITY & ACCOUNTABILTY ACT (HIPAA)---

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SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 14

Section 1 – Definitions

Access: Means the ability or the means necessary to read, write, modify, or communicate data/information or otherwise use any system resource.

Agent: An agent of the Agency is determined in accordance with federal common law of agency. The Agency is liable for the acts of its agents. An agency relationship exists if the Agency has the right or authority of the Agency to control the agent's conduct in the course of performing a service on behalf of the Agency (i.e. give interim instructions, direct the performance of the service).

Agency: For the purposes of this policy, the term "Agency" shall mean SWHHS to which the policy and breach notification apply.

Audit: Internal process of reviewing information system access and activity (e.g., log-ins, file accesses, and security incidents). An audit may be done as a periodic event, as a result of a patient complaint, or suspicion of employee wrongdoing. Audit activities shall also take into consideration SWHHS' information system Risk Assessment results.

Audit Controls: Technical mechanisms that track and record computer/system activities.

Audit Logs: Records of activity maintained by the system which provide: 1) date and time of significant activity; 2) origin of significant activity; 3) identification of user performing significant activity; and 4) description of attempted or completed significant activity.

Audit Trail: Means to monitor information operations to determine if a security violation occurred by providing a chronological series of logged computer events (audit logs) that relate to an operating system, an application, or user activities. Audit trails provide:

- Individual accountability for activities such as an unauthorized access of ePHI;
- Reconstruction of an unusual occurrence of events such as an intrusion into the system to alter information; and
- Problem analysis such as an investigation into a slowdown in a system's performance.

An audit trail identifies who (login) did what (create, read, modify, delete, add, etc.) to what (data) and when (date, time).

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Breach: Means the acquisition, access, use, or disclosure of protected health information (PHI) in a manner not permitted under the Privacy Rule which compromises the security or privacy of the PHI and is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors:

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the PHI or to the disclosure was made;
- Whether the PHI was actually acquired or viewed; and
- The extent to which the risk to the PHI has been mitigated.

Breach excludes:

- Any unintentional acquisition, access or use of PHI by an employee or person acting under the authority of a Covered Entity (CE) or Business Associate (BA) if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the Privacy Rule.
- Any inadvertent disclosure by a person who is authorized to access PHI at a CE or BA to another person authorized to access PHI at the same CE or BA, or organized health care arrangement in which the CE participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the Privacy Rule.
- A disclosure of PHI where a CE or BA has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

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Business Associate (BA): Under the HIPAA Privacy and Security Rules, a person (or entity) who is not a member of the covered entity's workforce and who performs any function or activity involving the use or disclosure of individually identifiable health information or who provides services to a covered entity that involves the disclosure of individually identifiable health information, such as legal, accounting, consulting, data aggregation, management, accreditation, etc.

Business Associate Agreement (BAA): Under the HIPAA Privacy and Security Rules, a legally binding agreement entered into by a covered entity and business associate that establishes permitted and required uses and disclosures of protected health information (PHI), provides obligations for the business associate to safeguard the information and to report any uses or disclosures not provided for in the agreement, and requires the termination of the agreement if there is a material violation.

Covered Entity (CE): A health plan, health care clearinghouse, or a healthcare provider who transmits any health information in electronic form.

Designated Record Set (DRS): For the Agency's purposes, the following is defined as a designated record set. A group of records maintained by the Agency that is;

- The medical records and billing records about individuals,

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- The enrollment, payment, claims adjudication, and case management record systems maintained by the agency,
- Used, in whole or in part, by or for the Agency to make decisions about individuals.

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Disclosure: Disclosure means the release, transfer, provision of, access to, or divulging in any manner of information outside the entity holding the information.

Electronic Protected Health Information (ePHI): Any individually identifiable health information protected by HIPAA that is transmitted by or stored in electronic media.

Health Care Operations: Health care operations mean the legitimate business activities of our practice. These activities may include quality assessment and improvement activities; fraud & abuse compliance; business planning & development; and business management & general administrative activities. These can also include agency telephoning an individual to remind an individual of appointments, or using a translation service if there is a need to communicate with an individual in person, or on the telephone, in a language other than English.

Health Information: Health information is any information created or received by a health care provider or health plan that relates to: the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or payment for the provision of health care to an individual. Healht Inforamiton includes inforamiton pertaining to examinations, medical history, diagnosis, findings or treatment, including such information as: laboratory examinations, X-rays, microscopic slides, photographs, and prescriptions.

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HIPAA, Data Privacy and Security ~~Risk Management~~ Team: Individuals who are knowledgeable about the ~~Organization~~Agency's HIPAA Privacy and Security policies, procedures, training, computer system set up, and technical security controls, and who are responsible for the Risk Management process and procedures outlined in this policy. This team is comprised of the Security Officer, HIPAA/Data Privacy Officers, Director, Deputy Director, Social Services Division Director, Public Health Director and other team members as needed.

Individually Identifiable Health Information: That information that is a subset of health information, including demographic information collected from an individual, and is created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Law Enforcement Official: Any officer or employee of an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who

is empowered by law to investigate or conduct an official inquiry into a potential violation of law; or prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

Need to Know: Employees will only be given information that the employee needs to have in order to accomplish a given function and only for proper administration of an appropriate health-related program and HIPAA.

Payment: Payment means our activities to obtain reimbursement for the medical services provided to an individual, including billing, claims management, and collection activities. Payment also may include an individual's insurance carrier's efforts in determining eligibility, claims processing, assessing medical necessity, and utilization review. Payment may also include activities carried out on our behalf by one or more of our collection agencies or agents in order to secure payment on delinquent bills.

Protected Health Information (PHI): Individually identifiable health information that is created by or received by the Agency, including demographic information that identifies an individual, or provides a reasonable basis to believe the information can be used to identify an individual, and relates to:

- Past, present or future physical or mental health or condition of an individual.
- The provision of health care to an individual.
- The past, present, or future payment for the provision of health care to an individual.

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Privacy Regulation: Policies and procedures required by HIPAA Standards for Privacy of PHI.

Record: Means any item, collection, or grouping of information that includes PHI data and is maintained, collected, used or disseminated by the Agency.

Risk: The likelihood that a threat will exploit a vulnerability, and the impact of that event on the confidentiality, availability, and integrity of ePHI, other confidential or proprietary electronic information, and other system assets.

Risk Assessment: (Referred to as *Risk Analysis* in the HIPAA Security Rule); the process:

- Identifies the risks to information system security and determines the probability of occurrence and the resulting impact for each threat/vulnerability pair identified given the security controls in place. The Risk Assessment includes administrative, physical, technical and organizational safeguards that enable and govern ePHI that is received, created, maintained or transmitted;
- Prioritizes risks; and
- Results in recommended possible actions/controls that could reduce or offset the determined risk.

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Risk Management: Within this policy, it refers to two major process components: Risk Assessment and Risk Mitigation. This differs from the HIPAA Security Rule, which defines it as a risk mitigation process only.

Risk Mitigation: Referred to as *Risk Management* in the HIPAA Security Rule, and is a process that prioritizes, evaluates, and implements security controls that will reduce or offset the risks

determined in the Risk Assessment process to satisfactory levels within the Agency given its mission and available resources.

Tennessen Warning: The government must give individuals notice when collecting private or confidential information from them. This is referred to as a "Tennessen warning notice." Government may also call it a "privacy notice," a "notice of collection of private/confidential data," or something similar. The purpose of the notice is to enable people to make informed decisions about whether to give information about themselves to the government.

Threat: the potential for a particular threat-source to successfully exercise a particular vulnerability. Threats are commonly categorized as:

- Environmental – external fires, HVAC failure/temperature inadequacy, water pipe burst, power failure/fluctuation, etc.
- Human – hackers, data entry, workforce/ex-employees, impersonation, insertion of malicious code, theft, viruses, SPAM, vandalism, etc.
- Natural – fires, floods, electrical storms, tornados, etc.
- Technological – server failure, software failure, ancillary equipment failure, etc. and environmental threats, such as power outages, hazardous material spills.
- Other – explosions, medical emergencies, misuse or resources, etc.

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Threat Action: The method by which an attack might be carried out (e.g., hacking, system intrusion, etc.).

Threat Source: Any circumstance or event with the potential to cause harm (intentional or unintentional) to an IT system. Common threat sources can be natural, human or environmental which can impact the Agency's ability to protect ePHI.

Treatment: Treatment means the provision, coordination, or management of an individual's health care and related services by health care providers involved in an individual's care. Students may be a member of the health care team. It includes the coordination or management of health care by a provider with a third party insurance carrier, communication with lab or imaging providers for test results, consultation between agency clinical staff and other health care providers relating to an individual's care, or agency referral of an individual

to a specialist physician or facility. Agency treatment includes collaboration with other community agencies to address an individual's health needs, including schools, community action agencies, food shelves, transportation providers who are not typically considered "health care" providers.

Trigger Event: Activities that may be indicative of a security breach that require further investigation.

Unsecured Protected Health Information: Protected health information (PHI) that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Pub. L.111-5 on the HHS website.

- Electronic PHI has been encrypted as specified in the HIPAA Security rule by the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without the use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. To avoid a breach of the confidential process or key, these decryption tools should be stored on a device or at a location separate from the data they are used to encrypt or decrypt. The following encryption processes meet this standard.
    - Valid encryption processes for data at rest (i.e. data that resides in databases, file systems and other structured storage systems) Valid encryption processes for data in motion (i.e. data that is moving through a network, including wireless transmission).
- The media on which the PHI is stored or recorded has been destroyed in the following ways:
    - Paper, film, or other hard copy media have been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed. Redaction is specifically excluded as a means of data destruction.

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Vulnerability: A weakness or flaw in an information system that can be accidentally triggered or intentionally exploited by a threat and lead to a compromise in the integrity of that system, i.e., resulting in a security breach or violation of policy.

Workforce: Workforce means employees, Board members, volunteers, trainees, students and other persons whose conduct, in the performance of work for a covered entity or business associate, is under the direct control of such entity, whether or not they are paid by the covered entity or business associate.

Section 2 – Purpose

SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 14

a. The Federal Health Insurance Portability and Accountability Act (HIPAA) was passed by Congress in 1996. HIPAA responds to concerns from citizens, the health care industry and government agencies for enhanced security and privacy of individual health information. In passing HIPAA, Congress intended to:

- Improve the portability and continuity of health insurance coverage for consumers;
- Combat waste, fraud, and abuse in health insurance and health care delivery;
- Standardize electronic data interchanges between health care organizations;
- Protect the security, privacy, and availability of individual health information.

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Section 3 -- HIPAA/Data Privacy Officers and Security Officer

a. ~~Dale Hiland, Social Services Supervisor~~Beth Wilms, Director and Carol Biren, Public Health Director are the designated HIPAA/Data Privacy Officers and Karri Harvey, Management Information Supervisor is the Security Officer for HIPAA/Data Privacy purposes. These people are responsible for the development and implementation of the policies and procedures required by HIPAA Standards for Privacy of Individuals Identifiable Health Information (IIHI) or Electronic Individuals Identifiable Health Information (eIIHI), hereafter referred to as Protected Health Information (PHI) and the privacy regulation. The HIPAA/Data Privacy Officers also serve as the people to receive complaints and who should provide further information about matters covered by the privacy notice. The HIPAA/Data Privacy Officers need to be familiar with the privacy regulation. Delegation of some of these duties may be given to other employees of the agency. Responsibilities of the HIPAA/Data Privacy Officers and Security Officer will include:

- Building a strategic and comprehensive privacy program that defines, develops, maintains and implements policies and procedures that enable consistent, effective privacy and security practices which minimize risk and ensure the confidentiality of PHI, paper and/or electronic, across all media types. Ensures privacy forms, policies, standards, and procedures are up-to-date.
- Serves in a leadership role for privacy compliance.
- HIPAA/Data Privacy Officers collaborate with the Security Officer to ensure alignment between security and privacy compliance programs including policies, practices, investigations, and acts as a liaison to the IT department.
- HIPAA/Data Privacy Officers establishes, with the Security Officer, an ongoing process to track, investigate and report inappropriate access and disclosure of PHI. Monitor patterns of inappropriate access and/or disclosure of PHI.
- Performs or oversees initial and periodic HIPAA Privacy and Security Risk Assessment and Risk Mitigation Plans.
- Facilitates audits to validate Security compliance efforts throughout the Agency.

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- Takes a lead role, to ensure the Agency has and maintains appropriate privacy and confidentiality consents, authorization forms and information notices and materials reflecting current Agency and legal practices and requirements.
- Oversees, develops and delivers initial and ongoing privacy and security training to the workforce.
- Participates in the development, implementation, and ongoing compliance monitoring of all business associates and business associate agreements, to ensure all privacy concerns, requirements, and responsibilities are addressed.
- Works cooperatively with Public Health and other applicable Agency units in overseeing ~~patient~~ individual rights to inspect, amend, and restrict access to PHI when appropriate.
- Manages all required breach determination and notification processes under HIPAA and applicable State breach rules and requirements.
- Establishes and administers a process for investigating and acting on privacy and security complaints.
- Performs required breach investigations, documentation, and mitigation. Works with Human Resources to ensure consistent application of sanctions for privacy and security violations.
- Initiates, facilitates and promotes activities to foster information privacy and security awareness within the Agency and related entities.
- Maintains current knowledge of applicable federal and state privacy laws and accreditation standards.
- Works with Agency administration, legal counsel, and other related parties to represent the Agency's information privacy interests with external parties (state or local government bodies) who undertake to adopt or amend privacy legislation, regulation, or standard.
- Cooperates with the U.S. Department of Health and Human Service's Office for Civil Rights, State regulators and/or other legal entities in any compliance reviews or investigations.
- Serves as information privacy resource to the Agency regarding release of information and to all departments for all privacy related issues.

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Section 4 - Use and Disclosure

a. **Notice of Privacy** – The Notice of Privacy will be given to individuals as per program and their respective requirements. The Notice of Privacy is also posted on SWHHS's website.

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ba. **Uses and Disclosures** - For appropriate uses, the Agency is permitted to use and disclose PHI as follows:

- To the individual who is the subject of the data.

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- Those persons or entities that are authorized by the client individual to receive their PHI.
- Those entities that are required or allowed by the privacy regulations and state law.
- Those employees on a need to know basis. Employees will only be given information that the employee needs to have in order to accomplish a given function.

cb. **Disclosure of Information**

- Requests for copies of PHI in the DRS shall be managed by the HIPAA/Data Privacy Officers or designee.
- Employees will not release PHI without approval of HIPAA/Data Privacy Officers or designee.
- Please refer to the Request for PHI (section 5) for specific practice.
- All clients individuals will be required asked to sign the Notice of Privacy and the Authorization for Release of Information or the Tennessen Warning at the time of the initial visit and annually thereafter. for Tthe Releaserelease/ or the Tennessen, which will includes the statement for disclosure of PHI for the purposes of treatment, payment, and healthcare operations.

Two attempts will be made to obtain signature on above documents. If unable to obtain required signatures, the notice and release will be provided by mail. This will be documented in the client's file.

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de. **Confirmation of a Valid Authorization**

- A valid authorization consists of a written request that includes:
  - Name of clientindividual
  - Who is disclosing the information
  - Who is receiving the information
  - Description of information being disclosed
  - Purpose of disclosure
  - Signature and date
  - Effective / Expiration date
  - Statement of right to revoke
  - Statement of condition of treatment, payment, and healthcare operations
  - Potential for redisclosure
- If any pieces of the authorization above are missing, the requestor will be contacted and requested to properly complete a disclosure for PHI.
- If the patientindividual is a minor, the parent and/or guardian is responsible for the signature on the authorization. SWHHS will provide verification that the individual is the responsible party for the patientindividual.

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ed. **Routine and Non-Routine Disclosures** will be individually evaluated and processed per request. The Agency will ensure that only the minimum amount of information is disclosed to satisfy the request.

fe. **Limit Use Disclosures to Those Authorized by the ClientIndividual**
PHI will be provided to the individual and to the Office of Civil Rights. Disclosure of PHI will be allowed under the following circumstances:

- If the client individual has authorized a use or disclosure;
- If the disclosure is for health care operations, payment or treatment and the client individual has signed a consent form for the Agency, or a consent form is not required;
- If the client individual has agreed to the disclosure for a facility directory or to an individual necessary for the care of the individual; or
- If the disclosure is one of the social responsibility disclosures and all conditions for such disclosure are met. Social responsibility disclosures include:
  - Uses and disclosures required by law;
  - Use and disclosures for public health activities;
  - Disclosures about victims of abuse, neglect or domestic violence;
  - Uses and disclosures for health oversight activities;
  - Disclosures for judicial and administrative hearings;
  - Disclosures for law enforcement purposes;
  - Uses and disclosures about decedents;
  - ~~Uses and disclosures for cadaveric organ, eye or tissue donation purposes;~~
  - Uses and disclosures to avert a serious threat to health or safety;
  - Uses and disclosures for specialized government functions; and
  - Disclosures for workers' compensation.

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gf. **Limit Request to Minimum Necessary**
The Agency will limit its requests for disclosure of PHI to the amount necessary to accomplish the purpose for which the request is made. Only individuals with a legitimate need to know may use or disclose PHI. Each individual may only use or disclose the minimum information necessary to perform their designated role regardless of the extent of access provided to them.

hg. **Ability to Rely on Request for Minimum Necessary**
The Agency may rely on a reasonable request as the minimum necessary for the stated purpose(s) when:

- The disclosure is to a public official as allowed in the social responsibility reporting.

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- The information is requested by another covered entity.
- The information is requested by an employee or business associate of the agency.

i~~h~~. **Verification Policies**

Before disclosing PHI, the Agency will verify the identity of the person requesting the PHI and the authority of that person to have access. The Agency may rely on written statements, if such reliance is reasonable. For public officials, the Agency may rely on an identification badge or a letter written on government letterhead.
~~For requests by phone, the Agency will obtain a number to return the call, establish the legitimacy of the number provided, call the person back at the verified number, and confirm that the person is who he or she claims to be.~~ The Agency will treat a personal representative as the individual for purposes of the privacy regulations:

- A personal representative is someone who has, under applicable law, the authority to act on behalf of an individual in making decisions related to health care.
- The Agency will abide by special provisions for un-emancipated minors, deceased individuals, and abuse-neglect and endangerment situations.

Verifying Identity

The following constitute proof of identity:

- An adult individual must provide a valid photo ID, such as:
  - a state driver's license
  - a military ID
  - a passport
  - a Minnesota ID
  - a Minnesota tribal ID
- A minor individual must provide a valid photo ID, such as:
  - a state driver's license
  - a military ID
  - a passport
  - a Minnesota ID
  - a Minnesota Tribal ID
  - a Minnesota school ID
- The parent or guardian of a minor must provide a valid photo ID and either:
  - a certified copy of the minor's birth certificate or
  - a certified copy of documents that establish the parent or guardian's relationship to the child, such as:
    - a court order relating to divorce, separation, custody, foster care
    - a foster care contract
    - an affidavit of parentage

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- The legal guardian for an individual must provide a valid photo ID and a certified copy of appropriate documentation of formal or informal appointment as guardian, such as:
    - court order(s)
    - valid power of attorney

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i. **Uses and Disclosures of PHI Permitted or Required by Law**

In some circumstances, SWHHS may be legally bound to use or disclose an individual's PHI without an individual's consent or authorization. State and federal privacy law permits or requires such use or disclosures regardless of an individual's consent or authorization in certain situations, including, but not limited to:

- **Emergencies:** If an individual is incapacitated and requires emergency medical treatment, the Agency will use and disclose PHI to ensure the necessary medical services are received. The Agency will attempt to obtain consent as soon as practical following treatment.
- **Others involved in an individual's Healthcare:** Upon an individual's verbal authorization, the Agency may disclose, to a family member, close friend or other person an individual designates, only that PHI that directly relates to that individual's involvement in an individual's healthcare and treatment. The Agency may also need to use PHI to notify a family member, personal representative or someone else responsible for an individual's care of an individual's location and general condition.
- **Communication barriers:** If the Agency tries but cannot obtain an individual's consent to use or disclose an individual's PHI because of substantial communication barriers and an individual's physician, using his or her professional judgment, infers that an individual consents to the use or disclosure, or the physician determines that a limited disclosure is in the individual's best interests, the Agency may permit the use or disclosure.
- **Required by Law:** The Agency may disclose PHI to the extent that its use or disclosure is required by law. This disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- **Regulatory Activities:** The Agency may disclose PHI to an authorized public health authority to prevent or control disease, injury, or disability or to comply with state child or adult abuse or neglect law. The Agency is obligated to report suspicion of abuse and neglect to the appropriate regulatory agency.
- **Food and Drug Administration:** The Agency may disclose PHI to a person or company as required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations as well as to track product usage, enable product recalls, make repairs or replacements or to conduct post-marketing surveillance.

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- **Health oversight activities:** The Agency may disclose an individual's PHI to a health oversight agency for audits, investigations, inspections, and other activities necessary for the appropriate oversight of the health care system and government benefit programs such as Medicare and Medicaid.
- **Judicial and administrative proceedings:** The Agency may only disclose an individual's PHI in the course of any judicial or administrative proceeding in response to a court order expressly directing disclosure, or in accordance with

  specific statutory obligation compelling us to do so, or with individual's permission.
- **Law enforcement activities:** The Agency may not disclose an individual's PHI to a law enforcement officer for law enforcement purposes without court order, statutory obligation or patient authorization.
- **Coroners, medical examiners, funeral directors and organ donation organizations:** The Agency may disclose an individual's PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other lawful duties. The Agency also may disclose an individual's PHI to enable a funeral director to carry out his or her lawful duties. PHI may also be disclosed to organ banks for cadaveric organ, eye, bone, tissue and other donation purposes.
- **Serious threats to health or safety:** The Agency may disclose an individual's PHI to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Military activity & national security:** The Agency may disclose the PHI of members of the armed forces for activities deemed necessary by appropriate military command authorities to assure proper execution of the military mission. The Agency also may disclose an individual's PHI to certain federal officials for lawful intelligence and other national security activities.
- **Worker's Compensation:** The Agency may disclose an individual's PHI as authorized to comply with worker's compensation law.
- **U.S. Department of Health and Human Services:** The Agency must disclose an individual's PHI to that individual upon request and to the Secretary of the United States Department of Health & Human Services to investigate or determine the Agency's compliance with the privacy laws.
- **Disaster Relief Activities:** The Agency may disclose an individual's PHI to local, state or federal agencies engaged in disaster relief and to private disaster relief assistance organizations (such as the Red Cross if authorized to assist in disaster relief efforts).
- **Student Immunizations to Schools:** The Agency may disclose immunization record(s) to schools when mandated by state law with an oral authorization

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rather than written. The release of immunization records will be documented on the Master Records Request Log.

- **Decedent:** Information may be disclosed regarding a decedent to the family members and others involved in care or payment for care, unless it was an expressed wish prior to death and it is allowed by state law. The release of records released will be documented on the Master Records Request Log.

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Section 5 - HIPAA Patient Rights

a. **Individual Rights**

Individuals have a right to access any PHI that is used to make decisions about the individual subject of the data, including information used to make health care decisions or information used to determine whether a claim will be paid. The individual has a right to access their designated record set. The right of access also applies to health care clearinghouses; health care providers that create or receive PHI other than as a business associate of the Agency.

b. **Request for PHI**

An individual may request that the Agency release PHI. The Aagency will require that the request be in writing and clearly identify the information requested. It will be the responsibility of the HIPAA/Data Privacy Officers or designee to review the request, determine its legitimacy, review and approve the data requested prior to release, advise the requester if the data cannot be released and why, and ensure the request is logged appropriately. All requests for PHI data should be sent to the HIPAA/Data Privacy Officers or designee, SWHHS, 607 West Main Street, ~~Suite 100~~, Marshall, Minnesota 56258.

c. **Request for PHI Approved**

If the Agency approves the request for release of PHI, the Agency will:

- Make copies of the requested PHI;
- Inform the individual of the approval for release and determine a method for delivering the information to the individual;
- Document the release of PHI

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d. **Request for PHI Denied**

The Agency will permit any individual to request access to inspect or copy the designated record set for as long as it is maintained by the Agency with the following exceptions:

- Information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding.

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- Any data determined by Minnesota State Law to be determined to be "confidential," or "private" i.e.,
  - medical or psychological information stamped confidential
  - names of reporters
  - adoption records
  - chemical dependency records (per MN Statute Chapter 254A; section 09.)

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e. **Accounting of Disclosures**

The Agency will obtain from the Master ~~HIPAA Request~~ Records Release Log and provide, upon request, a 6-year accounting of disclosures made of the individual's PHI , except for disclosures:

- To carry out treatment, payment or health care operations.
- To the individual data subject (i.e., requests the individual made about his/her own information).
- To facility directories or to person's involved in the individual's care or other notification purposes.
- For national security or intelligence purposes.
- To corrections officials or law enforcement personnel when the individual is in custody.

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- Which were made before the compliance date.
- To a record locator service, unless the individual has elected to be excluded from the service.

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In certain circumstances involving health oversight agencies or law enforcement agencies, the Agency may temporarily suspend the individual's right to receive an accounting of disclosures.

Information that must be must be maintained (tracked) and included in an accounting:

- Date of disclosure.
- Name of individual or entity who received the information and their address, if known.
- Brief description of the protected health information disclosed.
- Brief statement of the purpose of the disclosure or a copy of the individual's written request for disclosure.

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f. **Amendment Requests**

- The Agency will permit an individual to request that the Agency amend PHI. The Agency will require that the request be in writing, clearly identify the information to be amended, and that a reason be stated for the amendment.

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The Agency will so inform any individual of this expectation. All requests to amend PHI data should be sent to the HIPAA/Data Privacy Officers, SWHHS, 607 West Main Street, Suite 100, Marshall, Minnesota 56258.

- The Agency will have up to 60 days to act on the request. One 30 day extension is allowed. The subject of the data's written request will become a part of any case file maintained on the subject. The document will be retained for 6 years.

g. **Accepting an Amendment**

If the Agency decides to accept an amendment, the Agency will:

- Make the appropriate amendment to the PHI or record that is the subject of the request for amendment by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment. Inform the individual in a timely manner that the amendment has been accepted. The Agency will obtain agreement from the individual to allow the Agency to share the amendment with individuals or entities identified by the individual and the Agency.
- Make reasonable efforts to inform and provide the amendment within a reasonable time to:
    - persons identified by the individual as having received PHI about the individual and needing the amendment; and
    - persons, including business associates, that the Agency knows have the PHI that is the subject of the amendment and that may have relied, or could foreseeable rely, on such information to the detriment of the individual.

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h. **Denying an Amendment**

Requests for amendment may be denied if the information to be amended:

- If the Agency was not the originator of the information, unless the originator is no longer available to amend the request.
- Is not part of the designated record set.
- Is not accessible to the individual because federal or state law does not permit it.
- Is accurate and complete as determined by the Agency upon review.

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If the Agency denies all or a part of the requested amendment, the Agency will:

- Provide the individual with a timely, written denial. The denial will use plain language and contain:
    - the basis for the denial;
    - the individual's right to submit a written statement disagreeing with the denial and how the individual may file such a statement;

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- a statement that, if the individual does not submit a statement of disagreement, the individual may request that the Agency provide the individual's request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment; and
- a description of how the individual may complain to the Agency or make appeal pursuant to Administrative Procedures Act (Minn. Stats. Chapter 14).

- Permit the individual to submit a written statement disagreeing with the denial of all or part of a requested amendment.
- Prepare a written rebuttal to the individual's statement of disagreement.
- Identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link the individual's request for an amendment, the Agency's denial of the request, the individual's statement of disagreement, if any, and the Agency's rebuttal, if any, to the designated record set.
- If the individual has submitted a statement of disagreement, the Agency must include the material appended, or an accurate summary of any such information, with any subsequent disclosure of the PHI to which the disagreement relates.
- If the individual has not submitted a written statement of disagreement, the Agency will include the individual's request for amendment and its denial, or an accurate summary of such information, with any subsequent disclosure of PHI only if the individual has requested such action.

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i. **Actions on Notice of an Amendment**
If the Agency is informed by another covered entity of an amendment to an individual's PHI, the Agency will amend the PHI in designated record sets. Amendments will be made in a reasonable time period, as expeditiously as possible.

j. **Documentation**
All requests to amend PHI data should be sent to the HIPAA/Data Privacy Officers, Southwest Health and Human Services, 607 West Main Street~~, Suite 100~~, Marshall, Minnesota 56258. All requests to amend documentation will be retained for 6 years.

k. **Alternative Means of Communication Request**
The Agency will accommodate all reasonable requests from individuals to receive communication of PHI by alternative means or at an alternative location.
The agency will require that the request be in writing and clearly identify the information requested. It will be the responsibility of the HIPAA/Data Privacy Officers to review the request, determine its legitimacy, review and approve the request prior to release, advise the requester if the data cannot be released or communicated by an

alternate means and why, and ensure the request is logged. The outcome of the request will be communicated to the ~~patient~~individual upon final determination. All requests should be sent to the HIPAA/Data Privacy Officers, SWHHS, 607 West Main Street~~, Suite 100~~, Marshall, Minnesota 56258.
The Agency will have up to 60 days to act on the request. One 30 day extension is allowed. The subject of the data's written request will become a part of any case file maintained on the subject. The document will be retained for 6 years.

l. **Accepting the Request for Alternative Means of Communication**
If the Agency approves the request, the Agency will:

- Provide the PHI via an alternated means of communication;
- Inform the individual of the approval for the alternate means of communication and determine a method for delivering the information to the individual;
- Document the release of PHI.

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m. **Denying the Request for Alternative Means of Communication**
If the Agency denies the request, the Agency will:

- Provide the individual with a timely, written denial. The denial will use plain language and contain the basis for the denial.

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n. **Restricted Use Request**
The Agency will allow an individual to request that the Agency restricts its use and disclosure of PHI for treatment, payment or health care operations. The Agency will require that the request be in writing and clearly identify the information requested. It will be the responsibility of the HIPAA/Data Privacy Officers to review the request, determine its legitimacy, review and approve the request prior to use and disclosure, advise the requester if the data cannot be restricted and why, and ensure the request is logged.

o. **Restriction to a Health Plan Procedure**

- The ~~patient~~individual will complete the Request for Restriction of Health Information, and indicate it is a restriction to a health plan.
- The ~~patient~~individual must provide payment, in full, to SWHHS prior to the services being conducted.
- The PHI for that specific date of service will be deemed self-pay.
- SWHHS will ensure that the information from that specific date of service is not released to the insurance company.
- If approved, SWHHS will document the restriction within the patient's medical record. When releasing records, the staff will always review the list of

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restrictions to ensure they are abiding by the approved ~~patient~~individual request for that specific date of service.

- The restriction to health information to the health plan specified is only for the specific date of service.
- If denied, SWHHS will inform the ~~patient~~individual in writing, including the reason for the denial of the request for restriction of health information.
- All documentation regarding restrictions will be stored in the patient's medical record.

Section 6 – Miscellaneous

a. **Complaints Policy**
The Agency will provide a process for individuals to make complaints to the Agency concerning its HIPAA privacy regulations policies and procedures, its compliance with those policies or procedures or its compliance with the privacy regulations itself. The notice provided to individuals will include a brief description of how individuals may file a complaint, including the title, phone number and address to contact for further information on the policies for filing a complaint. Complaints will be logged appropriately and directed to the HIPAA/Data Privacy Officers. The Agency will document all complaints received and their disposition.

b. **Anti-Retaliation Policy**
The Agency will not retaliate against any person for exercising a right under the HIPAA privacy regulations, or for filing a complaint, participating in an investigation, or opposing any lawful act in relation to the privacy regulations.

Section 7 – Breach Investication and Notification

a. **Purpose**
To provide guidance for breach notification by covered entities when impermissive or unauthorized access, acquisition, use and/or disclosure of the Agency's ~~patient~~individual PHI occurs. Breach notification will be carried out in compliance with the American Recovery and Reinvestment Act (ARRA)/Health Information Technology for Economic and Clinical Health Act (HITECH), Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act (Omnibus Rule), as well as any other federal or state notification law.

b. **Discovery of Breach**

- A breach of PHI shall be treated as discovered as of the first day on which an incident that may have resulted in a breach is known to the Agency, or, by exercising reasonable diligence would have been known to the Agency (includes breaches by the Agency's business associates). The Agency shall be deemed to have knowledge of a breach if such breach is known or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a employee or agent (e.g. a business associate acting as an agent of the Agency) of the Agency.

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c. **Breach Investigation**

- The HIPAA/Data Privacy and/or ~~HIPAA~~ Security Officer(s) shall serve as the investigators of the breach process. The investigators shall be responsible for the management of the breach investigation process~~, completion of a Risk Assessment,~~ and coordinating with others in the Agency as appropriate (e.g., administration, human resources, HIPAA, Data Privacy and Security ~~Risk Management~~ Team, legal counsel, etc.) The investigators shall be the key facilitators for all breach notification processes to the appropriate entities (e.g., HHS, media, law enforcement officials, etc.). All documentation related to the breach investigation~~, including the Risk Assessment and notifications made,~~ shall be retained for a minimum of six years.
- The following information ~~risk assessment~~ will be ~~completed~~documented for each breach investigation:
  - The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
  - The unauthorized person who used the protected health information or to the disclosure was made;
  - Whether the protected health information was actually acquired or viewed; and
  - The extent to which the risk to the protected health information has been mitigated.

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d. **Documentation**

The Agency shall document the information~~Risk Assessment~~ as part of the investigation in the breach investigation ~~incident report~~ form noting the outcome of the ~~Risk Assessment~~ process. The Agency has the burden of proof for demonstrating that all notifications were made as required or that the use or disclosure did not constitute a breach. Based on the outcome of the investigation~~Risk Assessment,~~ the Agency will determine the need to move forward with breach notification. ~~The Agency may make breach notifications without completing a Risk Assessment.~~

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e. **Timeliness of Notification**

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- Upon determination that breach notification is required, the notice shall be made without unreasonable delay and in no case later than 60 days after the discovery of the breach by the Agency involved or the business associate involved that is acting as the Agency's agent. It is the responsibility of the Agency to demonstrate that all notifications were made as required, including evidence demonstrating the necessity of delay.

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f. **Delay of Notification Authorized for Law Enforcement Purposes**

- If a law enforcement official states to the Agency that a notification, notice, or posting would impede a criminal investigation or cause damage to national security, the Agency shall:
  - If the statement is in writing and specifies the time for which a delay is required, delay such notification, notice, or posting of the time period specified by the official; or
  - If the statement is made orally, document the statement, including the identify of the official making the statement, and delay the notification, notice, or posting temporarily and no longer than 30 days from the date of the oral statement, unless a written statement as described above is submitted during that time.

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g. **Content of the Notice**

- The notice shall be written in plain language and must contain the following information:

  - A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.
  - A description of the types of unsecured PHI that were involved in the breach (such as whether full name, Social Security number, date of birth, home address, account number, diagnosis, disability code or other types of information were involved).
  - Any steps the individual should take to protect themselves from potential harm resulting from the breach.
  - A brief description of what the Agency is doing to investigate the breach, to mitigate harm to individuals, and to protect against further breaches.
  - Contact procedures for individuals to ask questions or learn additional information, which includes a toll-free telephone number, an e-mail address, Web site, or postal address.

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h. **Methods of Notification**

- The method of notification will depend on the individuals/entities to be notified. The following methods must be utilized accordingly:

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  - **Notice to Individual(s)**

    Notice shall be provided promptly and in the following form:

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    - Written notification by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification shall be provided in one or more mailings as information is available. If the Agency knows that the individual is deceased and has the address of the next of kin or personal representative of the individual, written notification by first-class mail to the next of kin or personal representative shall be carried out. Limited examples:

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      - —The Agency may send one breach notice addressed to both an individual— ~~plan participant~~ and the individual~~participant~~'s spouse or other dependents ~~under the plan~~ who are affected by a breach, if they all reside at a single address and all individuals to which the notice applies are clearly identified on the notice. When an ~~plan participant~~individual (and/or spouse) is not the personal representative of a dependent ~~under the plan~~, however, address a breach notice to the dependent himself or herself

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        ~~I~~in the limited circumstance that an individual affirmatively chooses not to receive communications from the Agency at any written addresses or email addresses *and* has agreed only to receive communications orally or by

        telephone, the ~~provider~~Agency may telephone the individual to request and have the individual pick up their written breach notice from the Agency directly. In cases in which the individual does not agree or wish to travel to the Agency to pick up the written breach notice, the Agency should provide all of the information in the breach notice over the phone to the individual and document that it has been done.

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      - Substitute Notice: In the case where there is insufficient or out-of-date contact information (including a phone number, email address, etc.) that precludes direct written or electronic notification, a substitute form of notice reasonably calculated to reach the individual shall be

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provided. A substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative.

- In a case in which there is insufficient or out-of-date contact information for fewer than 10 individuals, then the substitute notice may be provided by an alternative form of written notice, telephone, or other means. In the case in which there is insufficient or out-of-date contact information for 10 or more individuals, then the substitute notice shall be in the form of either a conspicuous posting for a period of 90 days on the home page of the Agency's website, or a conspicuous notice in a major print or broadcast media in the Agency's geographic areas where the individuals affected by the breach likely reside. The notice shall include a toll-free number that remains active for at least 90 days where an individual can learn whether his or her PHI may be included in the breach.
- If the Agency determines that notification requires urgency because of possible imminent misuse of unsecured PHI, notification may be provided by telephone or other means, as appropriate in addition to the methods noted above.

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- **Notice to Media**
  - Notice shall be provided to prominent media outlets serving the state and regional area (of the breached ~~patient~~individuals) when the

    breach of unsecured PHI affects 500 or more of the Agency's ~~patient~~individuals of a State or jurisdiction.
  - The Notice shall be provided in the form of a press release.
  - What constitutes a prominent media outlet differs depending upon the State or jurisdiction where the Agency's affected ~~patient~~individuals reside. For a breach affecting more than 500 individuals across a particular state, a prominent media outlet may be a major, general interest newspaper with a daily circulation throughout the entire state. In contrast, a newspaper serving only one town and distributed on a monthly basis, or a daily newspaper of specialized interest (such as sports or politics)

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would not be viewed as a prominent media outlet. Where a breach affects more than 500 individuals in a limited jurisdiction, such as a city, then a prominent media outlet may be a major, general-interest newspaper with daily circulation throughout the city, even though the newspaper does not serve the whole State.

- **Notice to Secretary of HHS**
  - Notice shall be provided to the Secretary of HHS as follows below. The Secretary shall make available to the public on the HHS Internet website a list identifying covered entities involved in all breaches in which the unsecured PHI of more than 500 ~~patient~~individuals is accessed, acquired, used, or disclosed.
  - For breaches involving 500 or more individuals, the Agency shall notify the Secretary of HHS as instructed at www.hhs.gov at the same time notice is made to the individuals.
  - For breaches involving less than 500 individual, the Agency will maintain a log of the breaches. The breaches may be reported during the calendar year or no later than 60 days after the end of that calendar year in which the breaches were discovered (e.g., 2012 breaches must be submitted by 3/1/2013 – 60 days). Instructions for submitting the logged breaches are provided at www.hhs.gov.

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- **Maintenance of Breach Information/Log**
  - As described above and in addition to the reports created for each incident, the Agency shall maintain a process to record or log all breaches of unsecured PHI regardless of the number of ~~patient~~individuals affected. The following information should be collected/logged for each breach:
    - A description of what happened, including the date of the breach, the date of the discovery of the breach, and the number of ~~patient~~individuals affected, if known.
    - A description of the types of unsecured PHI that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, etc.).
    - A description of the action taken with regard to notification of ~~patient~~individuals, the media, and the Secretary regarding the breach.

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- The results of the breach investigation will be logged appropriately.
- Resolution steps taken to mitigate the breach and prevent future occurrences.

- **Business Associate Responsibilities**

  The business associate (BA) of the Agency that accesses, creates, maintains, retains, modifies, records, stores, transmits, destroys, or otherwise holds, uses, or discloses unsecured PHI shall, without unreasonable delay and in no case later than 60 days after discovery of a breach, notify the Agency of such breach (when the business associate is an agent of the Agency, this notification must be provided within a shorter timeframe as specified in the Business Associate Agreement policy). Such notice shall include the identification of each individual whose unsecured PHI has been, or is reasonably believed by the BA to have been, accessed, acquired, or disclosed during such breach. The BA shall provide the Agency with any other available information that the Agency is required to include in notification to the individual at the time of the notification or promptly thereafter as information becomes available. Upon notification by the BA of discovery of a breach, the Agency will be responsible for notifying affected individuals, unless otherwise agreed upon by the BA to notify the affected individuals (note: it is the responsibility of the Covered Entity to document this notification).

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Section 8 – Auditing Information System Activity

a. SWHHS shall audit access and activity of electronic protected health information (ePHI) applications, systems, and networks and address standards.

b. Violation of this policy and its procedures by employees may result in corrective disciplinary action, up to and including termination of employment. Violation of this policy and procedures by others, including providers, providers' offices, business associates and partners may result in termination of the relationship and/or associated privileges. Violation may also result in civil and criminal penalties as determined by federal and state laws and regulations.

c. **Purpose**

It is the policy of SWHHS to safeguard the confidentiality, integrity, and availability of ~~patient~~individual health information applications, systems, and networks. To ensure

that appropriate safeguards are in place and effective. This policy applies to organizational information applications, systems, networks, and any computing devices, regardless of ownership [e.g., owned, leased, contracted, and/or stand-alone).

d. **Scope**

This policy has been developed to address the Agency-wide approach to information system auditing processes. Departments and business units shall work with the Security Officer and/or IT to develop specific procedures based on applications and systems for auditing processes.

e. **Procedures**

- Responsibility for auditing information system access and activity is assigned to SWHHS Security Officer or other designee as determined by SWHHS' administration. The responsible individual shall:
    - Assign the task of generating reports for audit activities to the individual responsible for the application, system, or network.
    - Assign the task of reviewing the audit reports to the individual responsible for the application, system, or network, the HIPAA/Data Privacy Officer, or any other individual determined to be appropriate for the task.

  SWHHS' auditing processes shall address access and activity at the following levels listed below. Auditing processes may address date and time of each log-on attempt, date and time of each log-off attempt, devices used, functions performed, etc.
- SWHHS shall determine the systems or activities that will be tracked or audited by:
    - Focusing efforts on areas of greatest risk and vulnerability as identified in the Risk Assessment and ongoing Risk Mitigation Plan.
    - Maintaining confidentiality, integrity, and availability of ePHI applications and systems.
- SWHHS shall identify trigger events or criteria that raise awareness of questionable conditions of viewing of confidential information. The events may

  be applied to the entire Agency or may be specific to a department, unit, or application. At a minimum, SWHHS shall provide immediate auditing in response to:
    - ~~Patient~~Individual complaint
    - Employee complaint
    - Suspected breach of ~~patient~~individual confidentiality
    - High risk or problem prone event (e.g., VIP admission)
    - Any action that causes suspicion or poses a concern

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- SWHHS shall determine auditing frequency by reviewing past experience, current and projected future needs, and industry trends and events. SWHHS will determine its ability to generate, review, and respond to audit reports using internal resources. SWHHS may determine that external resources are also appropriate.
- SWHHS' IT Department, Security Officer or designee is authorized to select and use auditing tools that are designed to detect network vulnerabilities and intrusions. Audit documentation/reporting tools may address the following data elements:
  - Application Audited
  - Date
- The process for review of audit logs, trails, and reports shall include:
  - Description of the activity as well as rationale for performing audit.
  - Identification of which employees or department/unit will be responsible for review (employees shall not review audit logs which pertain to their own system activity).
  - Frequency of the auditing process.
  - Determination of significant events requiring further review and follow-up.
  - Identification of appropriate reporting channels for audit results and required follow-up.
- Vulnerability testing software may be used to probe the network to identify what is running (e.g., operating system or product versions in place), if publicly-known vulnerabilities have been corrected, and evaluate whether the system can withstand attacks aimed at circumventing security controls.

f. **Evaluation and Reporting of Audit Findings**

- Audit information that is routinely gathered must be reviewed in a timely manner by the individual/department responsible for the activity/process. The reporting process shall allow for meaningful communication of the audit findings to those departments/units sponsoring the activity.
  - Significant findings shall be reported immediately in a written format. SWHHS' breach form may be utilized to report a single event.
- Reports of audit results shall be limited to internal use on a minimum necessary/ need-to-know basis. Audit results shall not be disclosed externally without administrative and/or legal counsel approval.
- Security audits constitute an internal, confidential monitoring practice that may be included in SWHHS' performance improvement activities and reporting. Care shall be taken to ensure that the results of the audits are disclosed to administrative level oversight structures only and that information which may further expose organizational risk is shared with extreme caution. Generic

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security audit information may be included in organizational reports (individually-identifiable patient PHI shall not be included in the reports).

- Whenever indicated through evaluation and reporting, appropriate corrective actions must be undertaken. These actions shall be documented and shared with the responsible and sponsoring departments/units.

g. **Auditing Business Associate and/or Vendor Access and Activity**

- We work directly with BA on audits as deemed necessary.

h. **Audit Log Security Controls and Backup**

- Audit logs shall be protected from unauthorized access or modification, so the information they contain will be available if needed to evaluate a security incident. Generally, system administrators shall not have access to the audit trails or logs created on their systems.
- Audit logs maintained within an application shall be backed-up as part of the application's regular backup procedure.
- SWHHS shall audit internal back-up, storage and data recovery processes to ensure that the information is readily available in the manner required. Auditing of data back-up processes shall be carried out:
    - On a periodic basis for established practices and procedures.
    - More often for newly developed practices and procedures (e.g., weekly, monthly, or until satisfactory assurance of reliability and integrity has been established).

i. **Retention of Audit Information**

- Audit logs and trail report information shall be maintained based on organizational needs. Retention of this information shall be based on:
    - Organizational history and experience.
    - Available storage space.
- Logs summarizing audit activities shall be retained for a period of six years.

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Section 9 – HIPAA Security Oversights

a. SWHHS Human Resources, HIPAA/Data Privacy Officers, Security Officer or designee is responsible for facilitating the training and supervision of all employees, investigation and sanctioning of any employee that is in non-compliance with the HIPAA privacy and security regulations.

b. **Employee Training**

- The Agency will train all members of its workforce in the policies and procedures adopted by the Agency necessary to comply with the HIPAA privacy and security regulations. Agency staff will receive training annually. Training will be provided to each new member of the Agency's workforce at the time of hire ~~and~~ as part of new employee orientation.
- Training can be done in a variety of ways, including, but not limited to: speaker, on-line, department meetings, or other.
- Training is mandatory for all employees.
- Human Resources maintains documentation of the training session materials and attendees for a minimum of six years.
- Employees will be trained on the employee responsibility information listed below.

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c. **Employee Responsibilities**

- SWHHS will monitor access and activities of employees and will address any discrepancies.
- Workstations may only be used to perform assigned job responsibilities.
- Employees may not download software onto SWHHS' workstations and/or systems without prior approval from the Security Officer or designee.
- Employees are required to report malicious software to the Security Officer or designee immediately.
- Employees are required to report unauthorized attempts, uses of, and theft of SWHHS' systems and/or workstations.
- Employees are required to report unauthorized access to facilities.
- No employee may alter ePHI maintained in any system, even if they have the technical ability to do so without specific authorization.
- Employees will understand that they are responsible for the security of any portable devices that they use. The level of encryption and security must correspond to the most sensitive information stored on the device. Loss or theft must be reported immediately.
- Employees are required to understand their role in SWHHS' contingency plan.
- Employees may not share their user names nor passwords with anyone.

- When a request is made for disclosure of information, employee must determine if PHI is in information to be released and notify the HIPAA/Data Privacy Officers and receive approval before authorizing the release of information.

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- The Security Officer facilitates the timely communication of security updates and reminders to all employees to which it pertains. Examples of security updates and reminders include, but are not limited to:
  - Latest malicious software or virus alerts
  - SWHHS' requirement to report unauthorized attempts to access ePHI
  - Changes in creating or changing passwords
  - Changes in regulatory standards
- Additional training is provided to employees in the information services department. Employees will receive training based on the scope of their job.

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d. **Supervisor Responsibilities**

- Although the Security Officer is responsible for implementing and overseeing activities related to compliance to the Security rule, it is the responsibility of all leaders (i.e. Executive Team , Supervisors, Lead Workers) to supervise employees, third party vendors, contractors or other users of SWHHS' systems, applications, servers, workstations, etc. that contain ePHI.
- Leaders monitor workstations and applications for unauthorized use, tampering, and theft and report non-compliance. Leaders assist the Security Officer to ensure appropriate role-based access is provided to all employees.
- Leaders take reasonable steps to hire, retain, and promote employees and provide access to employees who comply with the Security regulation and SWHHS' security policies and procedures.
- Human Resources gets input from Supervisors who identify appropriate systems access for all new staff. HR provides the information to IT for access.
- When an employee is terminated or transfers to another unit/program from SWHHS, the Supervisor completes the appropriate form with last date of employment or transfer date and routes to IT for terminating access.
- Supervisors are required to report a change in an employee's title, role, department, and/or location.
  - Refer to Admin Policy #9 for Physical and Technical Safeguards.

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e. **Non-compliance of SWHHS' policies and procedures**

- All employees and any others with system access report non-compliance of SWHHS' policies and procedures to the Security or HIPAA/Data Privacy Officer(s) or Human Resource. Individuals that report violations in good faith may not be subjected to intimidation, threats, coercion, discrimination against, or any other retaliatory action as a consequence.

- Investigation/Employee Sanctions: If there is a report of non-compliance or if employees fail to comply with the Agency's privacy and security policies or procedures, the Agency will apply appropriate disciplinary sanctions.

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- The HIPAA/Data Privacy or Security Officer(s) or Human Resources promptly facilitates a thorough investigation of all reported violations of SWHHS' privacy and security policies and procedures. The HIPAA/Data Privacy or Security Officer(s) or Human Resources may request the assistance from others such as the employee's supervisor, other employees, and/or other vendor/contractors as needed.
    - The Security Officer completes an audit trail/log to identify and verify the violation and sequence of events.
    - Human Resources interviews any individual that may be aware of or involved in the incident.
        - All individuals are required to cooperate with the investigation process and provide factual information to those conducting the investigation.
        - HR provides individuals suspected of non-compliance of the security rule and/or SWHHS' policies and procedures the opportunity to explain their actions to determine whether it was an unintentional or malicious deviation from established policies and procedures.
    - HR thoroughly documents the investigation in a timely manner.
    - The Security Officer facilitates taking appropriate steps to prevent recurrence of the violation (when possible and feasible).
- Violation of any security policy or procedure by employees may result in corrective disciplinary action, up to and including termination of employment. Violation of this policy and procedures by others, including providers, providers' offices, business associates and partners may result in termination of the relationship and/or associated privileges. Violation may also result in civil and criminal penalties as determined by federal and state laws and regulations.
- HR maintains all documentation of the investigation, sanctions provided, and actions taken to prevent reoccurrence for a minimum of six years after the conclusion of the investigation.

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f. **Dissemination of HIPAA Policies and Procedures**

The Agency will place a copy of its HIPAA Policies and Procedures for the workforce consumption on SharePoint.

SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 14

a. **Purpose**
This policy establishes the scope, objectives, and procedures of SWHHS' HIPAA, Data Privacy and Security Risk Assessment and HIPAA, Data Privacy and Security Risk Mitigation Plan process. The Risk Assessment and Risk Mitigation Plan is intended to support and protect the Agency and its ability to fulfill its mission.

b. **Policy**
It is the policy of SWHHS to conduct HIPAA, Data Privacy and Security Risk Assessments on a regular basis or upon major changes in the technical infrastructure, implementation of a new application with ePHI or upon changes in regulations.

- During the Risk Assessment process, a system identification and characterization will be conducted to determine what systems create, store, maintain, or transmit protected health information.

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- All threats and vulnerabilities to the system will be evaluated through reviews of systems.
- Based on threat and vulnerability evaluation as well as evaluation of current controls, SWHHS will evaluate;
  - The likelihood of a threat and/or vulnerability occurring
  - The impact of a threat and/or vulnerability occurring.

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- Upon understanding the threat and vulnerabilities of a threat or vulnerability being exploited, a level of risk will be assigned.

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- A Risk Assessment Report will be generated at the completion of the Risk Assessment that will define the;
  - Scope of the Risk Assessment
  - Systems evaluated during the Risk Assessment
  - Findings and Risks from the Risk Assessment
  - Recommended mitigations to address/mitigate risks.

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- The risks will be evaluated, addressed, and mitigated following the Risk Assessment process using the HIPAA Privacy and Security Risk Mitigation Plan.

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c. Maintain documentation of all Risk Assessments, Risk Assessment Reports and Risk Mitigation Plans for a minimum of six years.

Section 11 – Business Associates

a. To establish guidelines for SWHHS to identify those vendor/business relationships which meet the HIPAA definition of a Business Associate (BA) and provide direction in establishing formalized Business Associate Agreements (BAA). SWHHS shall implement-

the required procedures and ensure documentation to establish satisfactory assurance of compliance.

b. **Procedures**

The Agency shall determine responsible oversight for the management of business associate relationships and agreements.

Responsibility may be delegated to HIPAA/Data Privacy Officer or other designated employee.

- The Agency's department units are responsible for facilitating the assessment of both existing and future vendor/business relationships to determine whether the relationship meets the criteria for a ~~HIPAA~~ BAA. The following criteria define a BA under HIPAA:
  - The vendor/business' staff members are not members of the Agency's workforce.
  - The vendor/business' is doing something on behalf of the Agency;
  - That "something" involves the use and/or disclosure of PHI.
  - Note that there are certain disclosures to vendors/businesses that do not require establishment of a BAA. These disclosures include:
    - ➢ Disclosures to disclosures by a covered entity to a health care provider concerning the treatment of the individual;
    - ➢ Disclosures by a group health plan or a health insurance issuer or HMO with respect to a group health plan to the plan sponsor, to the extent that the requirements of § 164.504(f) apply and are met; or
    - ➢ Uses or disclosures by a health plan that is a government program providing public benefits, if eligibility for, or enrollment in, the health plan is determined by an agency other than the agency administering the health plan, or if the protected health information used to determine enrollment or eligibility in the health plan is collected by an agency other than the agency administering the health plan, and such activity is authorized by law, with respect to the collection and sharing of individually identifiable health information for the performance of such functions by the health plan and the agency other than the agency administering the health plan.
- The Agency may determine the need for BAA's through:
  - Reviewing contract management documents/software and identifying where PHI is disclosed to external entities.
  - Assessing new vendor/business arrangements to determine if PHI will be used and/or disclosed.

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- When it has been determined that a BA arrangement exits, a designee shall contact the responsible individual to initiate a BAA. The designee shall provide the following information to customize the BAA:
    - The name and contact information of the BA.
    - A general description of the type of service being provided by the BA.
    - ~~The name of the Agency's department supervisor who established the BAA.~~
    - Date of establishment of the BA relationship and BAA.
- If a vendor/business relationship requiring a BA agreement/addendum is in the process of contract negotiation and development, the provisions of the BAA may be incorporated into the contract as an option (a separate BAA would not be required).
- Obligations and activities which must be addressed in the BAA document include:
    - **Privacy Rule Provisions:**
        - ➢ Stated Purposes for Which BA May Use or Disclose PHI: BA is permitted to use and disclose PHI it creates or receives for or from the Agency for the purposes as described in the addendum. BA may also use Protected Health Information it creates or receives for or from the Agency as minimally necessary for BA's proper management and administration or to carry out BA's legal responsibilities.

          Limitations on Use and Disclosure of PHI: BA agrees it shall not use or disclose, and shall ensure that its directors, officers, employees, contractors and agents do not use or disclose PHI for any purpose other than as expressly permitted by the BAA, or required by law, or in any manner that would constitute a violation of the Privacy Standards if used by the BA.
            - The BAA may permit the BA to use and disclose PHI for the proper management and administration of the BA; and
            - The BAA may permit the BA to provide data aggregation services relating to the health care operations of the covered entity.
        - ➢ Disclosure by Others: To the extent BA is authorized by the BAA to disclose PHI to a third party, BA must obtain, prior to making any such disclosure, reasonable assurances from the third party that the PHI will be held confidential as provided pursuant to the BAA and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and an agreement from the third party to immediately notify BA of any breaches of

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confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

- Minimum Necessary: BA shall disclose to its subcontractors, agents or other third parties, and request from them, only the minimum PHI necessary to performing or fulfilling a specific required or permitted function.

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- Safeguards Against Misuse of Information: BA will establish and maintain all appropriate safeguards to prevent any use or disclosure of PHI other than pursuant to the terms and conditions of the BAA.
- Reporting of Disclosures of PHI: BA shall, within 60 days of discovery of any use or disclosure of PHI in violation of the BBA, report any such use or disclosure to the Agency.
- Agreements by Third Parties: BA shall enter into an agreement with any agent or subcontractor that will have access to PHI that is received from, or created or received by BA on behalf of, the BA pursuant to which such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to BA pursuant to the BAA with respect to PHI.
- Access to Information: Within 7 days of a request by the Agency for access to PHI about an individual contained in a Designated Record Set, BA shall make available to the Agency the PHI it requests for so long as that information is maintained in the Designated Record Set. If any individual requests access to PHI about the individual directly from BA, BA shall make available and provide a right of access to the PHI to the individual, at the times and in the manner required by the Privacy Standards. After receiving the request, BA shall notify the Agency within 7 days of such request.
- Availability of PHI for Amendment: BA agrees to make PHI available for amendment and to incorporate any such amendments in the PHI, at the times and in the manner required by the Privacy Standards.

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- Accounting of Disclosures: Within 7 days of notice by the Agency to BA that it has received a request for an accounting of disclosures of PHI regarding an individual during the six years prior to the date on which the accounting was requested, BA shall make available to the Agency such information as is in BA's possession and is required for the Agency to make the accounting required by the Privacy Standards. At a minimum, BA shall provide the Agency with the following information: the date of

the disclosure; the name of the entity or person who received the PHI, and, if known, the address of such entity or person; a brief description of the PHI disclosed; and a brief statement of the purpose of the disclosure which includes an explanation of the basis for the disclosure. If the request for an accounting is delivered directly to BA, BA shall within 7 days forward the request to the Agency. The Agency is responsible for preparing and delivering the accounting requested. BA agrees to implement an appropriate record keeping process to enable it to comply with the requirements of this Section.

- Availability of Books and Records: BA agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by BA on behalf of, the Agency available to the Secretary for purposes of determining the Agency's and BA's compliance with the Privacy Standards.

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- **Security Rule Provisions:**
  - Implementation of Safeguards: BA agrees to implementation of administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, and transmits on behalf of the Agency.
  - Agents and Subcontractors: BA agrees that any agent, including a subcontractor, to which the BA provides ePHI, agrees to implement reasonable and appropriate safeguards to protect the ePHI.
  - Security Incidents: BA agrees to report to the Agency any security incident of which it becomes aware.

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- **Other Provisions:**
  - The Agency may want to seek legal counsel guidance prior to entering into a BAA that includes language addressing:
    - Insurance responsibilities
    - Indemnification requirements
  - If the Agency chooses to terminate the arrangement with the BA or the BA chooses to terminate the arrangement with the Agency, the agreement must be terminated as outlined in the provisions of the BA agreement/addendum or contract.
  - Upon termination or expiration of the business arrangement between the BA and the Agency, the BA shall either return or destroy all PHI received from the Agency or created or received by BA on behalf of the Agency that the BA still maintains in any

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form as outlined in the provisions of the BAA/addendum or contract.

c. The Agency does not have a statutory obligation to monitor the activities of its BAs. The Agency, however, must respond to reported privacy breaches and security incident events should they occur. The Agency realizes it will be found to be non-compliant unless the Agency took reasonable steps to ~~cure~~ mitigate the breach or end the violation, as applicable, and, if such steps were unsuccessful:
- Terminated the contract or arrangement, if feasible; or
- If termination is not feasible, reported the problem to the Department of Human Services.

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d. The Agency may serve as a BA to another covered entity and may be asked to review and sign that covered entity's external BA agreement/addendum or contract. As a BA, the Agency should:
- Forward the external information to the HIPAA/Data Privacy Officer or designee to review the submitted BAA to ensure that the provisions outlined are consistent with those set forth in this policy.
- If the BAA is not consistent with this policy or contains additional provisions or provisions that are inconsistent with the privacy regulation, the HIPAA/Data Privacy Officer or designee may recommend the following alternatives.
    - Agree to the additional provisions and sign the agreement.
    - Refer the agreement to legal counsel to determine appropriateness before signing.
    - Refuse to agree to the provisions and notify the covered entity to establish a resolution.

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e. To meet the documentation requirements of the Security Rule, the responsible individual shall maintain a file of BAAs/addendums/contracts.

f. All BAA documentation shall be maintained for a period of six years beyond the date of when the BAA relationship is terminated.

g. The BAA shall be effective for the length of the relationship between the BA and the Agency, unless otherwise terminated under the provisions outlined in the BAA.

SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 14

Section 12 - Sales and Marketing

a. SWHHS's current practices or procedures do not include any of the following: Fundraising and PHI, Sale of PHI, Marketing and PHI, Research and PHI, De-identification and Limited Data Sets.

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Supporting Documents and Resources:

- Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act (Omnibus Rule)
- ARRA Title XIII Section 13402 – Notification in the Case of Breach
- FTC Breach Notification Rules - 16 CFR Part 318
- 45 CFR Parts 160 and 164 – HIPAA Privacy and Security Rules
- 45 CFR 164.510 (b) - notification purposes
- 45 CFR 164.512 (k) (5) - individual in custody
- 45 CFR 164.528(a)(2) - accounting of disclosures
- 45 CFR § 164.308(a)(1)(ii)(D) – Information System Activity Review
- 45 CFR § 164.308(a)(5)(ii)(B) & (C) – Protection from Malicious Software & Log-in Monitoring
- 45 CFR § 164.308(a)(2) – HIPAA Security Rule Periodic Evaluation and Assigned Security Responsibility
- 45 CFR § 164.312(b) –Audit Controls
- 45 CFR § 164.312(c)(2) – Mechanism to Authenticate ePHI
- 45 CFR § 164.312(e)(2)(i) – Integrity Controls
- 45 CFR §164.308(a)(1)(ii)(c) HIPAA Security Rule Sanction Policy
- 45 CFR §164.308(a)(3)(ii)(A) HIPAA Security Rule Authorization and/or Supervision
- 45 CFR §164.308(a)(5)(ii)(A) HIPAA Security Rule Security Reminders
- 45 CFR §164.316(a-b) HIPAA Security Rule Documentation
- 45 CFR 164.308(a)(1)(ii)(A) – HIPAA Security Rule Risk Analysis
- 45 CFR 164.308(a)(1)(ii)(B) – HIPAA Security Rule Risk Management
- 45 CFR 164.308(a)(8) – HIPAA Security Rule Evaluation
- 45 CFR § 164.504(e)(2) - Privacy Rule Provisions
- 45 CFR § 164.314 - Security Rule Provisions/ Organizational Requirements BAs Contracts or Other Arrangements
- 45 CFR 164.512 – social responsibility reporting/Uses and disclosures for Research purposes as contained in the final HIPAA Privacy Rules.
- 45 CFR § 164.308(b)(1) – HIPAA Security Rule Administrative Safeguards BAs Contracts and Other Arrangements
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- 45 CFR § 164.502(e)(1) – HIPAA Privacy Rule Uses and Disclosures of PHI: General Rules – Disclosures to BAs
- 45 CFR §164.504 – HIPAA Privacy Rule Uses and Disclosures: Organizational Requirements

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SOUTHWEST HEALTH AND HUMAN SERVICES
NURSING POLICY NUMBER 1

EFFECTIVE DATE: 08/01/2011
REVISION DATE:

---Jail Nursing Policy---

Section 1 - Purpose
To provide the Lyon County Jail with nursing services to promote the general health and well being of the inmates and staff.

Section 2 – Responsibilities

a. SWHHS Governing Board:
   1. The Governing Board will review and approve the contract with the County Board.

b. Community Health Board (CHB):
   1. The CHB will review and approve the agency policy for Jail Nursing.
   2. The CHB will review and approve the Health Services budget for Jail Nursing.

c. Director of Nursing (DON):
   1. DON will develop the agency policy for Jail Nursing.
   2. DON will coordinate the development of the Jail Nursing Policies and Procedures, consistent with the contract and the Department of Corrections guidelines.
   3. DON will coordinate the documentation system required for Jail Nursing.
   4. DON will develop the billing system and codes and coordinate with the Accounting Department.
   5. DON will develop a budget consistent with the contract, Department of Corrections guidelines, and agency priorities.
   6. DON will ensure that PHN/RNs are adequately trained for Jail Nursing.
   7. DON will coordinate meetings with the Corrections staff as needed.
   8. DON will coordinate with the Medical Director regarding Jail Policies, orders, and other issues related to Jail Nursing

d. Public Health Nurse/Registered Nurse (PHN/RN):
   1. The public health nurse will provide skilled nursing services to ensure the correct inmates get the correct medication at the correct time and by the correct route. The nurse will delegate the duties of passing prescribed medications and over the counter medications to trained correctional staff.
   2. The public health nurse will provide skilled nursing assessment to new inmates who have health issues and to inmates requesting the service.
   3. The public health nurse will document in the jail's electronic record and the

inmate's medical record, as applicable.

4. The public health nurse and the correctional staff will follow the Standing Orders signed by the Medical Director and any new doctor's orders for individual inmates.
5. The public health nurse will provide consultation to the Lyon County Jail correctional staff to ensure the health and well being of the inmates and staff.

d. Jail Policies and Procedures

1. Jail Nurse Visit Policy and Procedure
2. See also Lyon County Jail Policy and Procedure Manual

SOUTHWEST HEALTH AND HUMAN SERVICES
NURSING POLICY NUMBER 2

EFFECTIVE DATE: 08/01/2011
REVISION DATE:

---Family Home Visiting Policy---

Section 1 - Purpose

a. Southwest Health and Human Services will conduct the Family Home Visiting program consistent with Minnesota State Statute 145A.17 and the guidelines of the Minnesota Department of Health.

Section 2 - Responsibilities

a. Community Health Board (CHB):
   1. The CHB will review and approve the agency policy for Family Home Visiting.
   2. The CHB will review and approve the Health Services budget for Family Home Visiting.

b. Director of Nursing (DON):
   1. DON will regularly review the statute and MDH guidelines.
   2. DON will develop the agency policy for Family Home Visiting.
   3. DON will coordinate the development of the Family Home Visiting Policies and Procedures.
   4. DON will coordinate the documentation system required for Family Home Visiting.
   5. DON will develop the billing system and codes and coordinate with the Accounting Department.
   6. DON will develop a budget consistent with grant duties, MDH guidelines, and agency priorities.
   7. DON will ensure that PHN/RNs are adequately trained for the Family Home Visiting Programs.

c. Public Health Nurses/Registered Nurses (PHN/RN):
   1. PHN/RN will make initial contact with pregnant or post partum woman or parent or guardian of a newborn infant or child and set up a visiting plan.
   2. PHN/RN will determine pay source, including but not limited to health plans, MCH grant, TANF grant or county funds.
   3. PHN/RN will make visits as indicated, complete documentation, and complete billing information following the Family Home Visiting Policies and Procedures.

d. Family Home Visiting Policies and Procedures
   1. Prenatal Visits
   2. Postpartum Visits

3. Newborn/Infant Visits
4. Client Chart Closure
5. Provider Letter
6. MCH Initial Prenatal Assessment Form
7. MCH Initial Prenatal Assessment Form (Page 2)
8. MCH Follow-up Prenatal Form
9. Post-partum Assessment
10. Postpartum Assessment (Page 2)
11. Breastfeeding Assessment
12. Initial Newborn Assessment
13. Newborn Follow-up Visit (0-3 wks old)
14. One Month Visit (4-7 wks old)
15. Two Month Visit
16. Three Month Visit
17. Four Month Visit
18. Five Month Visit
19. Six Month Visit
20. Seven Month Visit
21. Eight Month Visit
22. Nine Month Visit
23. Ten Month Visit
24. Eleven Month Visit
25. Twelve Month Visit
26. TANF Guidance Sheet
27. Federal Poverty Guideline Percentages
28. TANF Assessment

SOUTHWEST HEALTH AND HUMAN SERVICES
NURSING POLICY NUMBER 3

EFFECTIVE DATE: 08/01/2011
REVISION DATE:

---Child and Teen Check-up Outreach Policy---

Section 1 - Purpose

a. Southwest Health and Human Services will conduct the Child and Teen Check-up (C&TC) Outreach program consistent with the federal grant duties.
b. Southwest Health and Human Services will provide limited services consistent with a C&TC check-up.

Section 2 - Responsibilities

a. SWHHS Governing Board:
   1. The Governing Board will review and approve the Department of Human Services (DHS) contract for C&TC Outreach

b. Community Health Board (CHB):
   1. The CHB will review and approve the agency policy for C&TC Outreach.
   2. The CHB will review and approve the Health Services budget for C&TC Outreach.

c. Director of Nursing (DON):
   1. DON will develop the agency policy for C&TC Outreach.
   2. DON will coordinate the development of the C&TC Outreach Procedures.
   3. DON will coordinate the documentation system and CATCH computer system required for C&TC Outreach.
   4. DON will submit an annual work plan and budget to the grant managers.
   5. DON will develop a agency budget consistent with grant duties and agency priorities.
   6. DON will ensure that PHN/RNs and support staff are adequately trained for the C&TC Outreach Programs.
   7. DON will submit an Annual Report as specified in the grant.

d. C&TC Coordinator
   1. C&TC Coordinator will recruit and train local providers about the C&TC program.
   2. C&TC Coordinator or designee will attend meetings or training with DHS and/or health plans.
   3. C&TC Coordinator will use opportunities to inform or train other professionals or community residents in schools, day care or Head Start agencies, or

community events such as health fairs, county fairs, etc.

4. All contacts are recorded and reported annually.

e. Public Health Nurses/Registered Nurses (PHN/RN):

1. PHN/RN will inform clients from other public health programs, including WIC, MDH, Day Care Centers, etc. about C&TC and hand out materials.
2. PHN/RN will implement C&TC services such as dental varnishing or blood lead screening with other programs.
3. PHN/RN will complete documentation and billing information following the C&TC Procedures.

f. Office Support Staff

1. Office support staff will download monthly reports of eligible families/children in CATCH computer program as directed.
2. Office Support staff will use mail, phone calls, and office visits to inform families and/or children under 21 who are eligible for the C&TC Check-ups about the program. Contacts and responses are entered into the CATCH computer program.
3. Contacts made from other Public Health staff are entered into CATCH.
4. Lists of medical and dental providers are updated every six months.
5. Materials are ordered and made available to eligible families and/or children.

g. C&TC Procedures

1. C&TC Outreach Procedure
   a. Purpose: Families of eligible children are contacted by letter, phone or community event to enroll in the program and public health staff make outreach visits to area medical clinics to assist in implementation of the CTC program.
2. Blood Lead Screening Procedure
   a. Purpose: Education and blood collection for blood lead screening is done for all eligible children during regular PHN clinics and blood samples are sent to MedTox for analysis and reporting.
3. Dental Varnishing Procedure
   a. Purpose: The fluoride varnishing program is done to reduce the number of children who experience early childhood caries through fluoride varnish application and dental health education to parents and is conducted during regular PHN clinics.

SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 13

EFFECTIVE DATE: 05/18/11
REVISION DATE: 08/20/15; 05/16/18
AUTHORITY: Southwest Health and Human Services Joint Governing Board
~~As noted in each section~~ ~~Bulletin 15-89-01~~
MN DHS Bulletin 18-89-01

--- EQUAL EMPLOYMENT OPPORTUNITY AND AFFIRMATIVE ACTION ---

Equal Employment Opportunity and Affirmative Action

Guidelines for the

MINNESOTA MERIT SYSTEM'S

County Human Services Agencies

~~**2015-2017**~~
2018-2020

I. Introduction

The Minnesota Merit System's (MMS) Affirmative Action and Equal Employment Opportunity Policies are administered by the Minnesota Department of Human Services (DHS) Equal Opportunity and Access division (EOAD).

Purpose

The purpose of these Guidelines is to establish minimum affirmative action and equal employment opportunity standards, and provide consistent framework with regard to equal employment opportunity and affirmative action in MMS county/multi-county human services agencies. The Guidelines continues to request each MMS county/multi-county human services agency to adopt, revise, and/or develop equal opportunity and affirmative action guidelines to ensure equal employment opportunity and affirmative action in MMS county/multi-county human services agency workforces.

1. Policy

It is the policy of the MMS that county/multi-county human services agencies conduct all employment practices without regard to race, color, political affiliation, creed, religion, national origin, disability, age, marital status, status with regard to public assistance, sex, membership or activity in a local commission, or sexual orientation. Equal employment opportunity under this policy includes, but is not limited to the following: recruitment, examination, appointment, tenure, compensation, classifications, promotion, or other activities in accordance with applicable federal, state, and local laws and regulations.

A program of affirmative action will be maintained to eliminate barriers to equal employment opportunity and to encourage the employment and advancement of qualified females, minorities and individuals with disabilities when these groups are underrepresented in a county/multi-county human service agency's workforces in any job category.

2. Responsibilities

MMS county/multi-county human services agency directors have overall responsibility for implementing the MMS equal employment opportunity and affirmative action guidelines throughout that agency, including establishing specific internal procedures that minimally meet the standards provided by the MMS guidelines.

3. Role of DHS

The DHS (EOAD) provides consultation, technical assistance, recruitment, training, and goal-setting review and monitoring of MMS human service agencies to ensure affirmative action and equal employment opportunity in these agencies.

II. Scope of Guidelines

All MMS county/multi-county human services agencies and its employees must comply with equal employment opportunity and affirmative action guidelines. Any Minnesota county/multi-county may choose to create a county/multi-countywide affirmative action plan and have it approved by the Minnesota Department of Human Rights, which will issue a certificate of compliance for approved plans. Alternatively, a county/multi-county may choose to adopt the MMS equal employment opportunity and affirmative action guidelines in this bulletin for its human services agency.

Minnesota Rules, part 9575.0090, subpart 2a, require that each MMS human services agency have an affirmative action plan, which must contain the following:

- A policy defining and prohibiting discriminatory harassment, including sexual harassment;
- An internal discrimination complaint policy and procedure that includes notification of DHS EOAD of complaints that are brought, and their resolution;
- Provision for appointment of a person to serve as liaison between the MMS county/multi-county human services agency and DHS EOAD, and to have responsibility for implementation of the guidelines within the agency;
- Provision of the notification of DHS EOAD of periodic hiring goals established by the county/multi-county human services agency; and
- Provision for compliance with the Americans with Disabilities Act (ADA), Title I, which prohibits discrimination against disabled employees or job applicants.

Minnesota state law does not require that Minnesota counties and political subdivisions have an affirmative action plan certified by the Minnesota Department of Human Rights in order to receive any state funds or engage in contracting with the state. Nevertheless, this does not exempt MMS county/multi-county human services agencies from the requirement of the MMS rules, as indicated above.

III. MMS County/Multi-County Human Services Agency Action Required

In order to comply with Minnesota Merit System Rules, part 9575.0090, subpart 2a, your agency should choose one of the two courses of action. Your agency may:

- Adopt the proffered MMS system equal employment opportunity and affirmative action guidelines as your agency's equal opportunity and affirmative action plan and implement the guidelines within your agency, including developing hiring goals where workforce disparities exist and submit a letter indicating the adoption of those guidelines to DHS EOAD;
  or
- Adopt an equal opportunity and affirmative action plan that is certified by the Minnesota Department of Human Rights and submit a copy of the certificate of compliance to EOAD. If your county/multi-county agency already has a certified plan, your agency's adoption of that plan meets requirements under MMS rules.

Send this information to the attention of the Minnesota Merit System Consultant, Minnesota Department of Human Services, Equal Opportunity and Access division, MMS Consultant, Box 64997, St. Paul, MN 55164-0097.

IV. Policies and Requirements

Prohibition of Discriminatory Treatment

Purpose: To establish a means for maintaining a work environment free of discriminatory treatment in MMS county/multi-county human services agencies.

Statement: MMS county/multi-county human services agencies shall provide a work environment free of any form of unlawful discriminatory treatment, including harassment.

Authority:

- United States Civil Rights Act of 1964, Title VII
- United States Equal Pay Act of 1963
- United States Age Discrimination in Employment Act of 1967

- United State Rehabilitation Act of 1973, Section 504
- Americans with Disabilities Act of 1990, Title I
- Americans with Disabilities Act Amendments Act of 2008
- United States Civil Rights Act of 1991
- Genetic Information Nondiscrimination Act of 2008, Title II
- Minnesota Human Rights Act

Discrimination Complaint Handling

Purpose: To provide an internal option to employees who believes they were discriminated against because of race, color, political affiliation, creed, religion, national origin, disability, age, marital status, status with regard to public assistance, sex, membership or activity in a local commission, or sexual orientation.

Statement: While employees of MMS county/multi-county human services agencies have the right to file discrimination complaints with the Minnesota Department of Human Rights or other enforcement agencies at any time, complainants are urged to seek out internal administrative remedies first.

Anyone bringing an employment discrimination complaint shall do so without fear of reprisal, coercion, or intimidation.

Discrimination complaints and relevant investigative data and findings will all be handled in accordance with provisions of the Minnesota Data Practices Act, and the ADA, Title I.

The discrimination complaint handling process will minimally include:

1. A method to resolve both formal and informal complaints,
2. Notification of DHS (EOAD) and
3. A timely response to all complaints.

Authority:

- United States Civil Rights Act of 1964, Title VII
- United States Equal Pay Act of 1963
- United States Age Discrimination in Employment Act of 1967
- United States Rehabilitation Act of 1973, Section 504
- Americans with Disabilities Act of 1990, Title I
- Americans with Disabilities Act Amendments Act of 2008

- United States Civil Rights Act of 1991
- The Minnesota Human Rights Act
- The Minnesota Data Practices Act
- Genetic Information Nondiscrimination Act of 2008, Title II

Prohibition of Discrimination against Individuals with Disabilities

Purpose: To provide work environments free of unlawful discrimination against applicants and employees with disabilities. Together the Americans with Disabilities Act (ADA) and the Americans with Disabilities Act Amendments Act of 2008 (ADAAA) extend federal civil rights protection individuals with disabilities.

Statement: MMS county/multi-county human services agencies shall provide a work environment free of any form of unlawful discrimination. This includes removing barriers to application of employment and ensuring that qualified employees with disabilities are not discriminated against.

The most significant provisions of the ADA with regard to MMS county/multi-county human services agencies are included in Title I, which prohibit employers from discriminating against qualified individuals with disabilities in matters of employment, including the application and hiring process. The provisions in Title I of the ADA are broader in scope than, but similar to, the Minnesota Human Rights Act (Minnesota Statutes, Chapter 363A), and to Section 504 of the federal Rehabilitation Act of 1973 and Volume 29 of the United States Code, section 794.

ADA regulations make clear that employers, including all state and local governments, must comply with the employment provisions of Title I. The ADA prohibits discrimination against an otherwise qualified individual with a disability with regard to the following:

- Job application procedures, including recruitment and advertising;
- Hiring, firing, and advancement; and
- Compensation, training, and other terms, conditions, and privileges of employment such as tenure, layoff, leave, and employee benefits.

Reasonable Accommodations: If a person is qualified to perform the essential functions of a job except for limitations caused by a disability, the employer must consider whether or not that person could perform those functions with a reasonable accommodation.

An employer is required to accommodate a known disability of a qualified applicant or employee unless it would impose an undue hardship. Accommodations are determined by the specifics of the situation and provided on an individual basis.

Interactive Process: The action to accommodate is generally triggered by a request from an applicant or employee with a disability. However, in certain instances, an employer has an obligation to make inquiries about an individual's need for an accommodation. For example, when an employer observes that an applicant or employee has a disability that may prevent him or her from understanding the need to request an accommodation, the employer should initiate discussion about the possible need for accommodation. If the individual with a disability cannot suggest an appropriate accommodation in such circumstances, the employer should work with the individual to identify an effective accommodation.

Undue Hardship: Deciding whether a request for a reasonable accommodation creates an undue hardship is determined on a case by case basis. If it is determined that a specific proposed or requested accommodation would impose an undue hardship on an employer, the employer is still obligated to identify another accommodation that would not impose a hardship. As long as an accommodation provides the person with the disability an equal opportunity to perform the essential function of the job, and enjoy the benefits and privileges of employment that other employees have access to, the accommodation need not be the best accommodation available, nor must it be the accommodation desired by the individual with a disability.

Threat to health and safety of others: If an employer believes that an employee or applicant with a disability would constitute a direct threat to the health or safety of self and others, and that a reasonable accommodation to the person's disability would not eliminate the threat, the employer may determine the individual is not or is no longer qualified to perform the duties of their job. Such a determination must be based on objective facts, and must be specific to the situation and the individual, and cannot be based on speculation or the remote possibility of a threat or risk to the safety of others.

For a more detailed explanation of your obligations and responsibilities under the ADA, contact the United States Equal Employment Opportunity Commission (EEOC), or the United States Department of Justice's Civil Rights Division. Numerous publications explaining the ADA and its requirements are available from these agencies, and are online at their websites. You may also request technical assistance from the Minnesota DHS (EOAD), and from the Minnesota Department of Human Rights. Contact information for all of these agencies is included in Appendix III of these guidelines.

Authority:

- United States Rehabilitation Act of 1973, Section 504
- Americans with Disabilities Act of 1990, Title I
- Americans with Disabilities Act Amendments Act of 2008
- Minnesota Human Rights Act

SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 13

Prohibition of Sexual Harassment

Purpose: To establish a means for maintaining a work environment free of sexual harassment in MMS county/multi-county human services agencies.

Statement: MMS county/multi-county human services agencies shall provide a work environment free of any form of sexual harassment. Sexual harassment is a form of sex discrimination and is covered under the same statutes as any kind of discriminatory treatment.

It is unlawful to harass a person (an applicant or employee) because of that person's sex. Sexual harassment can include unwelcome sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature.

Sexual harassment can also include offensive remarks about a person's sex. For example, it is illegal to harass a woman by making offensive comments about women in general. The harasser can be either a woman or a man, as can the victim. Same-sex sexual harassment is prohibited as is opposite-sex harassment.

Although the law does not prohibit simple teasing, offhand comments, or isolated incidents that are not very serious, harassment is illegal when it is so frequent or severe that it creates a hostile or offensive work environment or when it results in an adverse employment action (such as the victim being fired or demoted, or involving employee's placement on administrative leave, deprivation of ability to take promotional exam, and loss of pay and opportunities for investigative or other job experience).

The harasser can be the victim's supervisor in another area, a co-worker, or someone who is not an employee of the employer, such as a client or contractor.

Authority:

- Civil Rights Act of 1964, Title VII
- Minnesota Human Rights Act

Affirmative Action in Appointment and Selection Decisions

Purpose: To establish that affirmative action hiring goals are created and ensure they are considered when hiring decisions are made within job groups where a workforce disparity exists.

Statement: MMS county/multi-county human services agencies shall act affirmatively to recruit and hire a diverse workforce. When a vacancy occurs in a job group where a disparity exists, agencies shall

utilize affirmative recruitment and hiring strategies to attempt to meet the workforce disparity. When fewer than three protected group candidates are on the eligible list, the MMS will use expanded certification to bring the number of eligible candidates certified to a total of three candidates from the protected group in which a disparity exits. The candidates certified shall be determined by their examination scores in accordance with MMS rules.

Authority:

- Minnesota Statutes, section 256.012, subdivision 1
- Minnesota Rules, part 9575.0620, subpart 7

V. Responsibilities, Duties, and Accountabilities

MMS Affirmative Action Guidelines: Responsibilities, duties, and accountabilities.

Equal Opportunity and Access division at the Minnesota DHS

1. Responsibilities

Equal Opportunity and Access division has oversight responsibility for and authority to monitor the MMS equal employment opportunity and affirmative action efforts in order to ensure compliance with federal and state laws and the MMS rules.

2. Duties

To monitor implementation of MMS county/multi-county human services agencies required affirmative action plans and their compliance with equal opportunity and affirmative action guidelines. To provide technical assistance, as requested, to MMS county/multi-county human services agencies in the implementation of their affirmative action plans.

3. Accountability

To the Commissioner or designee of the Minnesota DHS

MMS Personnel at the Minnesota DHS

1. Responsibilities

The Minnesota DHS MMS personnel have responsibility for ensuring all assessment and selection processes are job-related, and that there are no barriers or hindrances to affirmative action and equal employment opportunity in MMS county/multi-county human services agencies. They will also ensure that MMS county/multi-county human services agencies have the opportunity to act affirmatively in hiring within job categories where there are disparities.

2. Duties

- Publish job announcements for MMS county/multi-county human services agency openings, maintain communication with organizations in targeted communities for recruitment purposes, and conduct recruitment for professional and managerial staff.
- Expand certification, as necessary, to include protected group applicants when a disparity exists in the job class for which the MMS county/multi-county human services agency is hiring.
- Maintain a record of all competitive and promotional examination openings and appointments within agencies by gender and race.
- Review position descriptions and class specifications to ensure that they are accurate and that stated requirements are job-related.
- Ensure that selection processes are free of adverse impact.

3. Accountability

To the Commissioner or designee of the Minnesota DHS.

MMS County/Multi-county Human Services Agency Director

1. Responsibilities

The MMS county/multi-county human services agency director has responsibility for ensuring the overall implementation of the agency's affirmative action and equal employment opportunity polices; and for compliance with fair employment practices; and with federal and state laws, and MMS rules.

2. Duties

- Communicate and demonstrate a commitment to the agency's affirmative action and equal employment opportunity policies and to the MMS affirmative action guidelines.
- Set numerical hiring goals and develop action steps and timetables for recruiting and hiring women and minorities. Ensure that the agency actively recruits applicants with disabilities and provides equal employment opportunities.
- Notify DHS Equal Opportunity and Access division in January of each year of the agency's progress and of activities engaged in to achieve affirmative action hiring goals during the reporting period.
- Resolve internal complaints of discrimination, and notify DHS Equal Opportunity and Access division in January of each year of all discrimination complaints brought by employees of the agency during the reporting period.
- Inform hiring supervisors of equal opportunity and affirmative action guidelines and encourage them to act affirmatively whenever an opportunity exists to hire a qualified protected group applicant into a job category where a disparity exists.
- Ensure that information about equal employment opportunity and affirmative action is disseminated to all MMS employees in the agency.
- Ensure that the workplace is free of discrimination.
- Designate a liaison to DHS Equal Opportunity and Access division and ensure that the liaison has the necessary information and knowledge to carry out the duties required of the liaison. The director will consult at least quarterly with the Affirmative Action and Equal Employment Opportunity (AA EEO) liaison for the purpose of reviewing the status of equal employment opportunities and affirmative action needs in the agency, including any discrimination complaint activity.

3. Accountability

To the county/multi-county agency's director.

SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 13

MMS County/Multi-county Human Services Agency Affirmative Action Liaison and Designee

1. Responsibilities

The MMS county/multi-county human services agency affirmative action liaison or designee has responsibility for ensuring compliance with MMS equal employment opportunity and affirmative action guidelines on a daily basis. The liaison will act in an advisory capacity to the agency director with regard to equal employment opportunities and affirmative action. The liaison will monitor the agency's affirmative action and equal employment opportunity efforts to ensure compliance with federal and state laws and with MMS rules.

2. Duties

- Develop an equal employment opportunity and affirmative action policy statement and an affirmative action plan consistent with those policies.
- Implement the affirmative action plan, including:
    - The internal and external distribution of the agency's EEO and AA policies and the affirmative action plan;
    - The establishment of affirmative action hiring goals, action steps, and timetables;
    - The active recruitment and employment of protected group applicants; and
    - The recruitment and utilization of businesses owned by protected group members.
- Conduct and/or coordinate employee training on and orientation to the agency's EEO/AA policies and plan.
- Ensure that agency managers and superiors understand their responsibilities to take action to prevent the harassment of employees and applicants for employment.
- Ensure that minority, female, and employees with disabilities are provided equal opportunity in attending agency sponsored training and activities, and in benefit plans, pay, and other work related activities and conditions.
- Implement and maintain equal employment opportunity auditing, reporting, and record-keeping systems as a means of gauging the effectiveness of the agency's affirmative action efforts, and of determining whether or not affirmative hiring goals have been attained.
- Actively liaise with DHS EOAD and with other relevant governmental enforcement agencies, and with DHS MMS personnel, as appropriate.

- Coordinate agency and employee support of community programs that may lead to equitable employment of women, minorities, and individuals with disabilities.

3. Accountability

To the county/multi-county agency's director.

MMS Count/Multi-county Human Services Agency Managers and Supervisors

1. Responsibilities

MMS county/multi-county human services agency managers and supervisors have responsibility for ensuring compliance with the MMS equal employment opportunity and affirmative action guidelines and fair treatment of all agency employees.

2. Duties

A. Assist the agency's EEO/AA liaison with identifying and resolving problems related to equal employment opportunity and with eliminating barriers which inhibit or prevent equal employment opportunity and/or affirmative action.
B. Consider qualified protected group members and where possible act affirmatively in hiring and promoting staff.
C. Communicate and demonstrate a personal commitment to the agency's EEO/AA policies and MMS affirmative action guidelines.
D. Make recruitment recommendations to the EEO/AA liaison and assist the liaison with special recruitment projects.
E. Ensure that all employees under your supervision receive and annual orientation to the agency's affirmative action plan and equal employment opportunity policies.
F. Identify, document, and address training needs related to equal employment opportunity and affirmative action.

3. Accountability

To the county/multi-county agency's director.

MMS County/Multi-county Human Services Employees

1. Responsibilities

MMS county/multi-county human services agency employees at all levels shall be responsible for conducting themselves in accordance with the MMS rules and with state and federal laws by refraining from any actions which would interfere with any employee's work performance with respect to that person's race, creed, color, sex, national origin, age, marital status, disability, sexual orientation, reliance on public assistance, membership or activity in a local human rights commission, religion, political opinions or affiliations. Employees who believe they have been subjected to unlawful discrimination are encouraged to utilize the agency's discrimination complaint procedure.

Each employee has the responsibility to become familiar with the MMS equal employment opportunity and affirmative action guidelines and the agencies' policies on non-discrimination and the prevention of sexual and general harassment.

2. Accountability

To the county/multi-county agency's director, management, and supervisors.

MMS Affirmative Action Guidelines

1. Dissemination of information

Internal Dissemination of Information

The ADA requires employers to post a notice stating the provisions of the ADA that apply to job applicants and employees. The notice must be posted in a place accessible to people in wheelchairs, and it must be made available in alternative formats for individuals with a vision loss or reading disabilities. This applies to MMS county/multi-county human services agencies.

In addition, MMS county/multi-county human services agencies must post on their official bulletin boards, accessible to all applicants, employees, and the public, a copy of the MMS EEO and AA guidelines, along with the agency's most recent hiring goals, timetables proposed for meeting those goals, and the action steps to be taken to meet them.

Annually, the MMS county/multi-county human services agency's director will transmit a letter or memo to agency staff affirming the organization's commitment to affirmative action and equal opportunity in employment.

Additionally, the MMS county/multi-county human services agency will hold regular (at least biennial) training sessions for the purpose of ensuring that managers and supervisors understand the MMS EEO and AA guidelines and their responsibilities under the guidelines. Further, a review of these guidelines will be included in new employee orientation.

When appropriate, information about the MMS EEO and AA guidelines and the agency's non-discrimination and harassment-prevention policies will be included in internal publications.

External Dissemination of Information

MMS human services agencies must post on their official bulletin board, accessible to all applicants, employees, and the public, a copy of the MMS EEO and AA guidelines, along with the agency's most recent hiring goals, timetables proposed for meeting those goals, and the action steps to be taken to meet them.

The phrase "An Equal Opportunity and Affirmative Action Employer" or similar will be included in all advertisements for MMS county/multi-county human services agency positions. These positions will be advertised in appropriate protected group publications, whether in print or electronically.

An assurance of non-discrimination will be included in all contracts for programs or other activities which receive any federal assistance.

A written expression of the agency's position on equal employment and affirmative action will be included as appropriate in newspaper, magazine, and web-based advertising and/or brochures and like recruitment materials.

2. Audit and Evaluation

The MMS county/multi-county human services agency director or the appointed EEO/AA designee for that county/multi-county agency will determine annually whether or not minorities or females are underrepresented in the job categories utilized in the agency's workforce. This will be done by comparing the availability of minority and female job-candidates in the geographic recruitment

area with the number of minorities and females who are actually employed in those job categories in the agency. If there is a disparity (under representation) in any job category for either protected group, the agency is obligated to set hiring goals, determine action steps to be taken to achieve those hiring goals, and set timetables for executing the action steps.

A non-discrimination clause will be included in bargaining unit contracts and in purchasing agreements and contracts whenever possible.

In January of each year, the MMS county/multi-county human services agency director or the appointed EEO and AA designee for that county/multi-county will send to the Minnesota DHS Equal Opportunity and Access division a year end summary of the agency's equal employment and affirmative action activities for the previous year. The summary will include an evaluation of the effectiveness of those activities in achieving affirmative action hiring goals and in ensuring a workplace free of unlawful discrimination. The summary will include:

A. Information about employment discrimination complaint activity, specifying the numbers and types of discrimination complaints and the status of their resolution;
B. Information about recruitment activities conducted, specifying the sources of recruitment and the protected group community organizations contacted;
C. The hiring goals set for the year and the action steps towards achieving those goals; and
D. Information about all staff training and/or information sessions conducted related to affirmative action and equal employment opportunity.

Agencies are required to provide equal employment opportunities to, and encouraged to actively recruit individuals with disabilities.

VI. Appendix I

Definitions

Americans with Disabilities Act (ADA)

The Americans with Disabilities Act, passed in 1990, gives civil rights protections to individuals with disabilities that are similar to federal protections provided to individuals on the basis of race, color, sex, national origin, age, and religion. The ADA guarantees equal opportunity for individuals with disabilities in employment, state and local government services, public accommodations, telecommunications, and transportation. Title I of the ADA applies to employers. The ADA does not

protect individuals who are currently using illegal drugs, and employers may seek reasonable assurance from employees that no illegal drug use is occurring.

Americans with Disabilities Act Amendments Act of 2008 (ADAAA)

The ADAAA became effective on January 1, 2009. It is an act to restore the intent and protections of the Americans with Disabilities Act of 1990. Under the ADAAA the definition of disability is construed broadly.

Affirmative Action

A program of proactive efforts to remedy historical discrimination, in employment, against women, minorities, and in Minnesota state government, individuals with disabilities. This remedial program may involve recruitment efforts targeted at these specific groups when disparities in the workforce have been identified. MMS county/multi-county agencies are not required to set hiring goals for people with disabilities, but the federal Rehabilitation Act of 1973 does require MMS county/multi-county human services agencies to track employment data on disabled employees.

(Affirmative) Action Steps

Those steps which an agency plans to take to address workforce disparities. They could include, but are not limited to, identifying and removing barriers to employment for minorities or females; further educating hiring supervisors and managers about their obligations under affirmative action and equal opportunity law; planning events that will increase awareness of, and knowledge about, other cultural groups in your geographic region; targeting recruitment at under-represented groups, even outside the geographic region.

Creed

A system of beliefs, principles, or opinions to which an individual adheres. It might be religious, political or philosophical in nature.

Discrimination

An act or series of acts made toward another group or a perceived member of that group that, when compared with one's behavior towards one's own or other groups, is/are unfair. Such action may be based on prejudice or ignorance.

Discriminatory Harassment

Any form of behavior that is offensive, unwelcome, and/or creates a hostile work environment and which, for purposes of this document, is based on an individual's race, color, political affiliation, creed, religion, national origin, disability, age, sex, marital status, status with regard to public assistance or activity in a local commission, or sexual orientation.

Harassment has occurred when: 1) submission to that conduct or communication is made a term (explicitly or implicitly) of employment; 2) submission to, or rejection of that conduct, or communication, that is used as a factor in decisions affecting an individual's employment; or, 3) the conduct or communication has the purpose or the effect of substantially interfering with an individual's employment or creating an intimidating, hostile, or offensive employment environment.

Disparity

The presence of fewer women, minorities, or individuals with a disability in the workforce than could reasonably be expected based on their availability for work in the geographic area where the underemployment is found.

Ethnic

Designating basic groups or divisions of human beings as distinguished by customs, a common language, a common history, a common religion, or other such characteristics. Ethnicity in general, then, may be regarded as referring to a specific type of culture, and an individuals' ethnicity may be regarded as referring to that person's cultural heritage.

Ethnocentrism

The attitude that one's own ethnic group/nation/culture is superior to all others; this attitude may be expressed in hostile behavior, violence, or discrimination towards members of out-groups.

Equal Employment Opportunity/Equal Opportunity Employment

A system of employment practices wherein individuals are recruited, hired, and promoted on their own merits and, for purposes of this document, without regard to race, color, political affiliation, creed, religion, national origin, disability, age, sex, marital status, status with regard to public assistance, membership or activity in a local commission, or sexual orientation.

Gender

One's physical sex, male or female, usually evident at birth.

General Harassment

Any behavior or combination of behaviors that is repeated by one or more employees and that is directed towards another employee or group of employees that is considered annoying, insulting, or intimidating, or which causes discomfort and/or which has a detrimental effect on the employee's/employees' work performance(s).

SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 13

Genetic Information Nondiscrimination Act of 2008 (GINA)

This law makes it illegal to discriminate against employees or applicants on the basis of genetic information. Genetic information includes information about an individual's genetic tests or information about the genetic tests of an individual's family member(s), as well as information about any disease, disorder or condition of an individual's family member(s) –i.e., and individual's family medical history. The law also makes it illegal to retaliate against a person because the person complained about discrimination, filed a charge of discrimination, or participated in an employment discrimination investigation or lawsuit.

Hiring Goal

A numerical objective designed to remedy a workforce disparity; an employment level to strive for through the use of affirmative recruitment, hiring timetables, and other such action steps; to be achieved within a set period of time, such as a year.

Individuals with a Disability

An individual with a disability is a person who has a physical or mental impairment that substantially limits one or more major life activities; or has a record of such impairment; or is regarded as having such an impairment.

Major Life Activities

These include, but are not limited to, activities such as walking, talking, standing, sitting, hearing, seeing, performing manual tasks, caring for oneself, thinking, concentrating, other cognitive functions, relating to others, working, etc.

Minorities

This terms refers to persons in the workforce, or potential applicants, who are African American/Black, Asian, Native Hawaiian or Pacific Islander, American Indian or Native Alaskan, or of Hispanic heritage.

Parity

A condition in which protected groups are represented in the workforce in proportion to their availability in a geographic labor market.

Protected Group/Class

For purposed of affirmative action and equal employment opportunity, this term refers to individuals who are disabled, members of a minority group, or are female.

Qualified Individual with a Disability

This is a person who has a physical or mental impairment that substantially limits one or more major life activities, or who has a record of such an impairment, or who is regarded by others as having such

an impairment, and who also has the requisite skill, experience, education, or other employment requirements of the position being sought and who can perform the essential functions of that job with or without a reasonable accommodation.

Race

Any of the different varieties of human beings as distinguished by physical characteristics such as form of hair, color of skin, bodily proportions, etc. one of the groups of populations constituting humanity, where differences are biological in nature – and cannot be linked with other traits such as intelligence, personality, or character – and are transmitted genetically; *this term is inappropriate when applied to national, religious, geographic, linguistic or cultural groups.*

Racism

The notion, lacking scientific support, that one race is superior (or inferior) to another; any program or practices of discrimination based on racial differences; the attribution of cultural or psychological values to race, with the aim of furthering the superiority of one's own race or the inferiority of another.

Reasonable Accommodation

Any changes to the application process, work environment, or manner under which the position is customarily performed that enables a qualified individual with a disability to be considered for, to perform the essential functions of, or to enjoy equal benefits from job as similarly situated employees without disabilities.

Sex Role

Learned through socialization/enculturation, this refers to one's understanding and embracing of how, based on one's gender/sex, one is to act in a cultural or social group.

Sexism

The economic and or social exploitation and domination of members of one sex by the members of the other.

Sexual Identity

Acquired over time, this refers to one's awareness and conception of oneself as male or female; as masculine or feminine; as oriented toward opposite–sex, same-sex, or both-sexes; as sexually attractive or sexually unattractive; etc.

Sexual Harassment

Any form of behavior that is offensive, unwelcome, and/or creates a hostile work environment and which is based on an individual's sex/gender. This behavioral conduct may include jokes inappropriate

language, sexual innuendos, inappropriate pictures, sexual gestures, and physical touch that is offensive or unwelcome.

Substantially limited

Means a person is restricted in the conditions, manner, or duration of performing a major life activity in comparison to most people in the general population.

Timetable

Refers to the period of time within which affirmative action steps are to be taken and set hiring goals are to be achieved.

Under Representation

The condition in which fewer protected group members are found in the workplace in a particular job category than would be expected from the availability of qualified protected group members in the labor market.

Undue Hardship

An accommodation action that would require significant difficultly or expense to implement when factors such as the nature and costs of the accommodation are considered in relation to the size, nature, structure, and resources (both financial and personnel.

Race/Ethnicity Categories

The United States Equal Employment Opportunity Commission (EEOC) revised race and ethnicity categories for the purposes of reporting employment statistics. Definitions are as follow:

1. **White**: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East;
2. **Black or African American**: A person having origins in any of the black racial groups of Africa;
3. **American Indian or Alaska Native**: A person having origins in any of the original peoples of North Central, and South America, and who maintains tribal affiliation or community attachment;
4. **Asian**: A person having origins in any of the original peoples of the Far East – i.e., Southeast Asia, the Indian Subcontinent, China, Korea, and Japan;
5. **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands;

6. **Hispanic or Latino**: A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, *regardless of race*.

Categories 1 - 4 are regarded as racial categories by the federal government, while categories 5 and 6 are regarded as an ethnic category. (Office of Management and Budget, *Federal Register*, October 30, 1997)

VII. Appendix II

- Sample Discrimination Harassment Complaint Form
- Sample Reasonable Accommodation Form

VIII. Appendix III

- United States Equal Employment Opportunity Commission (EEOC)

  Minneapolis Area Office
  Towle Building
  330 South Second Avenue, Suite 720
  Minneapolis, MN 55401-2224
  P: 800-669-4000
  F: 612-335-4044
  TTY: 800-669-6820
  ASL Video Phone: 844-234-5122
  https://www.eeoc.gov

- United States Department of Justice's Civil Rights Division

  U.S. Department of Justice
  Civil Rights Division
  950 Pennsylvania Avenue, N.W.
  Office of the Assistant Attorney General, Main
  Washington, D.C. 20530
  P: 202-514-4609
  TTY: 202-514-0716
  https://www.justice.gov/crt

- Minnesota Department of Human Rights

  Freeman Building
  625 Robert Street North
  Saint Paul, MN 55155
  P: 651-539-1100 or 800-657-3704
  MN Relay: 711 or 800-627-3529
  F: 651-296-9042
  Email: Info.MDHR@state.mn.us
  https://mn.gov/mdhr/

- DHS Merit System

  Human Resources Merit System
  PO Box 64997
  St. Paul, MN 55164-0997
  P: 651-431-2990
  F: 651-431-7444
  Email: dhs.merit.system@state.mn.us
  https://mn.gov/dhs/

Americans with Disabilities Act (ADA) Advisory

This information is available in accessible formats for people with disabilities by calling 651-431-3040 (voice) or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

Workforce Development Plan

Adopted on 05/16/2018

Signature Page

This plan has been approved and adopted by the following individuals:

______________________________ ______________

Commissioner Gerald Magnus, Governing Board Chair Date

______________________________ ______________

Beth Wilms, Health and Human Services Director Date

______________________________ ______________

Nancy Walker, Deputy Director Date

Revisions:

Date	Revision Number	Description of Change	Pages Affected	Reviewed or Changed by

For questions about this plan, contact:

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Table of Contents

Training and development of the workforce is one part of a comprehensive strategy toward agency quality improvement. Fundamental to this work is identifying gaps in knowledge, skills, and abilities through the assessment of both organizational and individual needs, and addressing those gaps through targeted training and development opportunities.

This plan serves as the foundation of the Southwest Health & Human Services (SWHHS) ongoing commitment to the training and development of its workforce.

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Acknowledgements

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Agency Profile

Mission

Southwest Health and Human Services is a multi-county agency committed to strengthening individuals, families, and communities by providing quality services in a respectful, caring, and cost-effective manner.

Vision Elements

- Employer of Choice
- Focus on Prevention
- Top Notch Staff
- Strong Community Collaboration
- Financially Stable
- Agency of Excellence
- Well Rounded Communication
- Robust/Leading Edge Technology
- Cutting-Edge Service Delivery

Strategic Priorities

1. Enhance Staff Training
2. Advance Organizational Culture
3. Enrich Prevention Services
4. Maximize Agency Revenue
5. Communications
6. Use Data to Drive Decisions
7. Build Community Partnerships
8. Improve Access to Service
9. Increase Staff Capacity
10. Improve Effective Use of Technology

Governance

SWHHS is one agency with a joint-powers entity with three separate Boards: Human Services, Community Health, and overall Governing. Each Board has certain decisions that can be made

independently. The Governing Board has the ultimate say for decisions that affect all Boards, such as budget decisions, contract and personnel policy approvals. The Governing Board is considered to be the Employer of Record.

Location and Population Served

Southwest Health and Human Services (SWHHS) covers Lincoln, Lyon, Murray, Pipestone, Redwood and Rock Counties. This six county area is located in the southwest corner of Minnesota covering 3,782.11 square miles. Population estimates based on United States Census Bureau 2015 Annual Population Estimate has SWHHS population at 74,199, which is a reduction from the 2010 Census figures of 75,820. The population estimated for 65 years and older is 19.4 percent. Children ages 0-19 make up 26.9 percent of the population.

Populations of color according to 2015 estimates continue to increase in numbers with a net increase of 572 people between 2010 and 2015. The largest increase was 276 people in the Asian/Pacific Islander population. Population by race is White 93.2 percent; Asian/Pacific Islander 2.3 percent; American Indian/Alaskan native 1.6 percent; Two or More Races 1.5 percent; and Black/African American 1.4 percent. Population by ethnicity for SWHHS was 4.4 percent Hispanic/Latino. English only is estimated to be spoken in 93.3 percent of household while Spanish 3.1 percent; Hmong 1.1 percent; and African Languages 0.7 percent are the other top four languages spoken.

Educational attainment for the population 25 years and older is below state and national averages for earning Bachelor's or higher degree 20.62 percent and some college or Associates degree 31.97 percent while holding high school diplomas is above state and national averages 37.28 percent. Because of the lower levels of bachelor prepared population, SWHHS may need to expand their search radius to fill positions in Public Health Nursing and Social Work.

The median income in SWHHS is $50,638 in 2016 inflation-adjusted dollars compared to $63,217 for Minnesota. This difference may make recruitment from outside areas difficult.

Unemployment in SWHHS during 2010-2014 5-year estimate is 4.2 percent compared to 6.5 percent in Minnesota. This may help attract staff to SWHHS.

Learning Culture

SWHHS fosters a future-oriented learning environment that facilitates professional growth and development through continuous enhancement of capabilities, which helps the department fulfill its mission. Staff are innovative in adapting to the changing needs of their positions and use lessons learned through continuous quality improvement to achieve better outcomes. Employee development is an ongoing process which includes a variety of planned, purposeful activities and experiences designed to improve and/or increase the skills, knowledge and

abilities of employees. Staff at all levels are encouraged to seek out learning opportunities and to share information with their peers.

SWHHS annually identifies training and education needs and provides opportunities for ongoing education for all staff to build skills in core competencies, including the ten Essential Public Health Services and Six Areas of Responsibility. Additional offerings are selected based on results of training needs assessments, professional licensing requirements and the agency strategic plan. We provide training opportunities both internally and externally through webinars, in-house trainings, MDH or DHS trainings or through traditional conferences. The budget and Training Schedule is developed considering the gaps identified in the assessments.

Workforce Policies

- Staff Development Policy (PP#7) – outlines the process in which to request training, provides opportunity to gain new skills or enhance abilities; addresses comp time accrual.
- Meal Reimbursement & Travel Policies (PP# 6) – addresses paying costs related to training, including use of private and fleet vehicles.
- Policies that support Recruitment & Retention – telecommuting (PP#4), paid time off (PP#3 & PP#24), employee referral program (PP#25), employee recognition programs (PP#16), volunteerism (PP#10), announcement of job opportunities and recruitment (PP#9), wellness programs (PP#14 & PP#19) and medical donation (PP#23).

Links to Other Agency Plans

Strategic Plan
Each of the agency's prioritized strategies and vision elements correlates with the learning culture, workforce policies, and future workforce and training needs outlined in the Workforce Development Plan.

Quality Improvement Plan
The very learning culture of the agency reflects the integration of continuous quality improvement efforts embedded in the Workforce Development Plan.

Community Health Improvement Plan
The curriculum and training plan is developed with the needs of the community as the top priority. Every consideration is given to how the agency needs to develop and improve in order to attain the goals set forth in the Community Health Improvement Plan.

Workforce Profile

Introduction

This section provides a description of our current and anticipated future workforce needs.

Current Workforce Demographics

The table below summarizes the demographics of our current workforce as of January 1, 2018.

Category	HHS	HS	PH
Total # of Employees:	242		
# of FTE:	238		
% Paid by Grants/Contracts:	10%		
Gender: Female: Male:	 218 24		
Race: Hispanic: Non-Hispanic: American Indian / Alaska Native: Asian: African American: Hawaiian: Caucasian: More than One Race: Other:	 0 0 1 1 1 0 239 		
Age: < 20: 20 – 29: 30 – 39: 40 – 49: 50 – 59: >60:	 0 32 63 65 52 30		
Primary Professional Disciplines/Credentials: Leadership/Administration: Public Health Program Specialist: Nurses: Registered Sanitarian/EH Specialist: Health Educator:	 25 1 21 3 3		

Program Health Aides: Dietician: Social Workers: Income Maintenance/Child Support: Accounting: Information Technology: Office Support/Case Aides:	2 1 93 61 10 3 19		
Average Retention Rate per 5 Years	91%		
Employees < 5 Years from Retirement: Management: Non-Management:	 1 29		

Future workforce

Currently the population is more diverse than the workforce and the race and ethnicity of the population is becoming even more diverse with an influx of various cultures. The culture of poverty needs to be considered as well. The University population tends not to stay in the community post-graduation which leaves a lack of Bachelor and Advanced-Degreed professional workforce. However, the agency is partnering in many different ways, such as adjunct teaching, guest speaking, recruiting interns and preceptorships and participating in career fairs. In addition, nursing supervisors participate on the BSN Advisory Council. Newer generations of workforce will have differing methods of operation and expectations of the workplace environment. There are efforts currently underway to diversify the workforce through human resources including looking at talent management and acquisition: exploring on-the-job training, merit system testing accommodations, and mentorship.

Competencies & Education Requirements

Core Competencies for Agency

The Core Competencies for Public Health Professionals (Core Competencies) are a consensus set of skills for the broad practice of public health, as defined by the 10 Essential Public Health Services. Developed by the Council on Linkages Between Academia and Public Health Practice (Council on Linkages), the Core Competencies reflect foundational skills desirable for professionals engaging in the practice, education, and research of public health. The Core Competencies provide a framework for workforce development planning and action.

In Human Services, staff attend many DHS directed trainings dependent on the program or caseload assigned.

Continuing Education Required by Discipline

Licensures held by staff, and their associated CE requirements, are shown in the table below.

Discipline	Minnesota CE Requirements (as of October 1, 2015)
Registered Nurse, Public Health Nurse	24 contact hours every 2 years
Licensed Practical Nurse	12 hours every 2 years
Registered Sanitarian	24 CEUs every two years, 20 hours must be in food safety every 36 months
Licensed Social Worker	40 hours every 2 years, 24 of the 40 hours in clinical content and 2 hours in ethics
HR	60 CEUs every 3 years
Licensing Supervisors	6 of the 40 hours in practice of supervision and 2 hours in ethics
Dietitian (RD, LD)	15 CEs every year

Training Needs

Introduction

This section provides an overview of Public Health's identified training needs as well as a description of the barriers/inhibitors to the achievement of closing these gaps. In 2015-2016, SWHHS Public Health collaborated with the Minnesota Department of Health to administer and analyze a workforce assessment based on the Core Competencies for Public Health Professionals.

As an agency, we also conduct a wellness survey every other year and this has demonstrated the need for continued staff development.

Competency-based Training Needs for Public Health Staff

Through completion of the Core Competency Assessment, Prioritization Review and High Yield Matrix, the following training needs were identified:

<u>Modified Tier 1 – Administrative Support Staff</u>
- Community Dimensions of Practice
- Communications

Tier 1 – Frontline Staff

- Public Health Sciences, particularly in relaying to the community what is public health and reporting to leadership the stories needed to advocate, defend and negotiate public health services

Tier 2 – Management Staff

- Leadership and Systems Thinking related to the PH Sciences for assisting Tier 1
- Analytical Assessment

Tier 3 – Senior Leadership Staff

- Financial Planning and Management
- Community Dimensions of Practice

Discipline-specific Training Needs

Staff will attend discipline specific trainings as required per program area.

Health Equity Training Needs

Trainings will be identified based on the information from the Cultural Competency portion of the Core Competency Assessment results to determine cultural training needs that might be related to health inequities.

Trainings will be also be identified based on the Health Equity Data Assessment Guide developed by MDH and piloted through SHIP to determine what the community needs are and what training and/or education needs the agency has to address any inequities identified.

Barriers and Solutions

Barriers to training:

Money $	Time	Logistics	Availability of Training(s)	Unclear Parameters
$/Money x 5	Time x3	Travel	Not available	Staff wanting to go to training that isn't their area of focus
Resources $$	Time away	Where Offered	Not available	
Over-night cost	Staff coverage	Space	Limited trainings due to travel etc.	
	Capacity	Logistics/Travel		
	Time/Coverage issues	Scheduling Conflict (personal or professional		Buy in
	Staffing, ability to schedule			
	Front Desk Coverage			

	Coverage for OSS to attend mtgs/trainings			

Solutions to barriers:

Barrier Category	Solution concepts
Money $	Budget, Prioritize training in budget, Training plan related to budget, Have a plan-budget for it, Establish consistent budget, Plan spending around priorities, Staff development plan, create budget, Partner w/other orgs/agencies to bring in local speakers/trainings
Time	Bring training in-house or through webinar when possible, Put section in agenda to share about training attended, Share knowledge at meetings, Teamwork, Rotation – taking turns for trainings everyone needs to go to
Logistics	Internal training opportunities, Offer more on-site trainings (or more than once to accommodate coverage), Large meeting room to have own regional meetings, Agency coordinated scheduling, etc, Remote training technology, Good video conferencing
Availability of Training	Partner with other orgs/agencies to bring in local trainings/speakers (i.e Bridges Out of Poverty)
Unclear Parameters	Assessment of training needs, Clear protocol, Supervisor development of staff, Defined parameters for staff, Unclear parameters – define, Create training parameters, Training plans, Create training plan that prioritizes training choices, Planning, Consideration of requests, Create "flexible" learning funds (not program-specific)

Training Schedule

This section describes the 2018 curricula and training schedule.

2018 Training Schedule						
Topic	Description	Competencies Addressed	Audience	Sched.	Time	Resource
New Employee Orientation	Introduction to agency, goals, strategic priorities and directions, organizational policies and procedures,	Financial Planning and Management, Understands SWHHS Business	All new staff	Within 2-3 months of hire date	2.5 hours	New Employee Orientation, HR page on SharePoint

	org chart, new hire paperwork There will also be 30 minutes of HIPAA, Data Privacy and Security training					
Public Health 101	Online self-study course introducing participants to the history, mission, achievemnts, structure, challenges and opportunities for public health.	Cultural Competency, Community Dimensions of Practice, Public Health Sciences	All PH staff	Online	1.5 CEUs	MNTrain Course #1070153-Public Health 101: A Short Course
Cultural Competency	Promote awareness and inclusion of various cultures.	Cultural Competency, Builds Effective Work Relationships, Provides High-Quality Service	All PH staff	PH Staff Mtg	15-30 min.	Activities and education offered during PH Staff meetings
Quality Improvement/ Performance Management	QI/Perf. Management Training	Introduction to QI/Performance Management and Measures	Management Team and Units with performance measures		15-30 min.	Education provided during unit meeting by QC members

Mandatory Training

The following table outlines program-specific and department-wide mandated trainings.

Mandatory Training			
Training	Applies to	Required	Mandated By
Blood Borne Pathogen, AWAIR, ERTK , Field Safety	All staff	Annually	OSHA/SWHHS
Mandated Reporting	All staff	Annually	MN statute 626.556 Reporting of Maltreatment of Minors
Defensive Driving	All staff	Every 3 years	SWHHS, offered by MCIT
CPR	All Public Health Nurses	Every two years	Department
Fraud Waste and Abuse	All Staff	Annually	SWHHS/Health Plans
HIPAA , Data Privacy & Security	All staff	Annually	SWHHS/DHS https://data-securitytraining.dhs.mn.gov/Account/Login

Implementation & Monitoring

Introduction

This section provides information regarding communication, evaluation, tracking and monitoring/review of the plan.

Communication

The SWHHS Governing Board will approve the Workforce Development Plan (WDP) every other year (odd years). The Executive Team, Focus and staff will be informed of the WDP. This will be communicated via Board meetings, agency staff meetings, unit meetings, and SharePoint.

Training Evaluation

External training provider effectiveness will be tracked for every formal education/training/conference event attended as a whole or by an individual staff person.

Internal training will be evaluated for each in-house agency-sponsored training/skill-building opportunity to evaluate each individual activity's effectiveness.

The effectiveness of the WDP will be evaluated by completing the Core Competency Assessment every other year (even years). The results of the assessment and training evaluations will guide any necessary revisions to the WDP and the Training Schedule.

Tracking

We will be tracking trainings and providing the information to supervisors to review during annual employee evaluations.

Roles and Responsibilities

Human Resources (HR) responsibility – HR is responsible for tracking the mandatory trainings and evaluating their effectiveness.

Employee responsibility – it is the employee's responsibility to request appropriate trainings and fill out the required paperwork and evaluation of the trainings.

Supervisor responsibility – it is the supervisor's responsibility to assure staff are following the staff development process and that they are allowed the necessary time to attend trainings if approved.

Review and Maintenance

The Plan will be reviewed on an annual basis and revised as needed.

HP 9470	Asset Tag	Serial number
	5817	CNU302B62K
	5868	CNU3059PMW
	5790	CNU302B5GP
	5824	CNU302B63P
	5818	CNU302B62Y
	5864	CNU3059QZD
	5814	CNU302B5P9
	5755	CNU302B4JM
	5802	CNU302B5GS
	5774	CNU302B5HG
	5754	CNU302B4SQ
	5785	CNU302B4T6
	5773	CNU302B5KB
	5761	CNU302B4RD
	5853	CNU3049NXN7

MAY 2018

GRANTS ~ AGREEMENTS ~ CONTRACTS
for Board review and approval

☐ **MDH Public Health Emergency Preparedness (PHEP)(Marshall, MN)** – 07/01/18 to 06/30/19; Amendment for the next emergency preparedness grant budget period (2nd year); $97,210 (decrease $1,085)(amendment renewal).
Fiscal Note: 2017 - $98,295 grant allocation for BP1