Lincoln, Lyon, Murray, Pipestone, Redwood, Rock Counties

# ANNUAL REPORT 2018

## Southwest Health and Human Services

SOUTHWEST HEALTH & HUMAN SERVICES

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# MESSAGE FROM THE DIRECTOR

Once again, I begin this annual letter with a sense of pride about Southwest Health and Human Services (SWHHS), its many dedicated employees throughout the six counties, and the noble work provided to members residing within our communities.

I am pleased to present SWHHS's 2018 Annual Report. The purpose of this report is to provide communities with an overview of the work being completed by staff and highlight the good things we see and the trends within the profession. We continue to focus on our mission to serve our communities and to respond to challenges in a caring, professional, and fiscally responsible manner. The format of this year's report is significantly different from our 2017 report; we are focusing on case scenarios this year to provide a more personal look into the work staff faces each day. We hope you gain additional information and insight into the services and resources provided to the SWHHS communities each and every day.

I have a deep and abiding faith in SWHHS and its staff; our challenges and opportunities are significant and together, with our community partners, we will do all we can to strengthen our partnerships and collaborations.

I would like to express my abiding gratitude and appreciation for the staff of SWHHS. From this annual report, I hope readers gain an appreciation for the tremendous character and capabilities of these staff and how they help to strengthen the lives of residents in the communities of Lincoln, Lyon, Murray, Pipestone, Redwood and Rock Counties. The dedicated work of the staff continues to help improve the wellbeing and safety of individuals and families within the six counties served by SWHHS.

I am proud to present this annual report and share the work of SWHHS. If you would like more information about services and resources, please visit our website at www.swmhhs.com, or call us directly at 507-537-6713. We always welcome opportunities for partnerships and improvement.

Sincerely,

Beth M. Wilms

Director

# MISSION AND GUIDING PRINCIPLES

Mission

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

## Guiding Principles

### Respect

We treat people with dignity and consideration, and we listen openly to integrate a variety of perspectives and create environments that foster trust.

### Honesty

We are truthful and responsible in our interactions with the public and each other. We demonstrate compassion, acceptance, and will safeguard dignity and confidentiality.

### Trust

We are people of character and integrity who keep our word and honor our commitments, resulting in a safe environment for staff and clients.

### Communication

We engage in timely, responsive, effective, and open information sharing to improve our work and maintain our reputation as a trusted source for program and service delivery.

### Teamwork

We are committed to common goals based on open and honest communication while showing concern and support for each other.

### Flexibility

We are an organization willing to learn, create innovative ideas, and adapt to the ever-changing environment while striving for a healthy work-life balance.

# STRUCTURE AND GOVERNANCE

Southwest Health and Human Services is a joint-powers human services and public health agency covering Lincoln, Lyon, Murray, Pipestone, Redwood, and Rock Counties in southwest Minnesota. The agency has six offices and employs 247 staff. The offices are located in Ivanhoe, Marshall, Slayton, Pipestone, Redwood Falls, and Luverne.

SWHHS-Lincoln County
319 N Rebecca St.
PO Box 44
Ivanhoe, MN 56142
1-800-657-3781

SWHHS-Lyon County
607 West Main St
Marshall, MN 56258
1-800-657-3760

SWHHS-Murray County
3001 Maple Road Suite 100
Slayton, MN 56172
1-800-657-3811

SWHHS-Pipestone County
1091 N Hiawatha Avenue
Pipestone, MN 56164
1-888-632-4325

SWHHS-Redwood County
266 E Bridge St
Redwood Falls, MN 56283
1-888-234-1292

SWHHS-Rock County
2 Roundwind Rd
Luverne, MN 56156
1-855-877-3762

SWHHS provides essential services designed to protect and enhance the health and well-being of our six-county residents, especially our most vulnerable populations. The agency is made up of three key departments: Business Services, Social Services, and Public Health. Each of these departments play an important role in providing effective health and human services.

The Governing Board consists of two appointed County Commissioners from each of the member counties and by Minnesota statute, has responsibility for the development of an affordable system of care for all residents, especially, uninsured or underinsured children, families, and adults. The Human Services Governing Board has one layperson from each county who serves on the board.

# DEMOGRAPHICS

**73,999** *Population*

**42.7** *Median Age*

### *Income*

- **11.3%** - Residents living below 100% of the Federal Poverty Level ($12,140 for 1st person + $4,320 for each additional person)
- **$52,838** - Median Household Income
- **30.9%** - Population below 200% of Federal Poverty Level ($24,280 for 1st person + $8,640 for each additional person) (1), (2)

### *Education among Residents Ages 25+*

- **9.5%** - No high school diploma
- **35.5%** - High school diploma (include GED)
- **33.1%** - Some college or Associate's degree
- **16.4%** - Bachelor's degree
- **5.5%** - Advanced degree (2)

### *Language*

- **5.1 % -** Language other than English spoken at home (2)

### *Race*

- **1.3%** - Non-Hispanic American Indian and Alaska Native Alone
- **2.3%** - Non-Hispanic Asian Alone
- **1.7%** - Non-Hispanic Black or African American Alone
- **1.0%** - Non-Hispanic Two or More Races
- **89.3%**- Non-Hispanic White Alone (2)

### *Ethnicity*

- **3.6%** - Hispanic Origin of any Race (2)

### *National Origin*

- **4.1%** - Foreign Born (2)

### *Gender*

- **49.8%** - Male
- **50.2%** - Female (2)

*Other genders not available in US Census Data

## 2018 Actual Annual Budget (Audited)

| | Human Services | Public Health | TOTAL |
|---|---|---|---|
| Intergovernmental Revenues | 24,030,708 | 3,001,968 | 27,032,676 |
| Charges for Services | 2,209,226 | 629,149 | 2,838,375 |
| Investment Earnings | 35,153 | 6,695 | 41,848 |
| Other Revenue | 484,246 | 14,721 | 498,967 |
| Total Revenue | 26,759,333 | 3,652,533 | 30,411,866 |
| Expenditures | 26,214,459 | 3,668,905 | 29,883,364 |
| Property Tax | 10,127,820 | 928,795 | 11,056,615 |

# 2018 MAJOR PROJECTS/HIGHLIGHTS

- Quality of life survey was conducted in all six counties as part of SWHHS community health assessment work. There were 1,855 people that responded. Findings from this survey will help to inform the top ten health needs in SWHHS service area.

**86%** are happy with the quality of life in their community

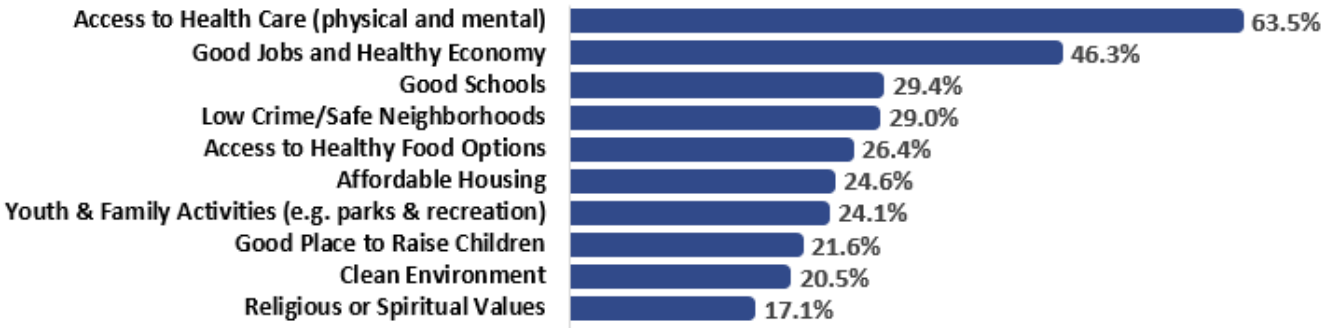
**56%** feel there are jobs available where the pay meets monthly bills

**69%** are happy with the healthcare system

**89%** feel this is a safe place to live

## How healthy would you say your community is?


## 10 Most important factors for a "healthy community"




- Public health was awarded a Toward Zero Deaths Grant in October 2018 for Lyon and Redwood Counties to reduce traffic deaths related to speeding, distracted driving, or substance use.

- SWHHS was awarded $21,557 for an annual Family Support Grant from DHS. Additional funding was requested and approved in the amount of $13,000 to further support families in our area who have children with certified disabilities prevent or delay out-of-home placement for the child's care.
- SWHHS was awarded a respite grant for children struggling with mental health. This grant allows children struggling with mental health to attend camps and other outings that interest the child while giving caregivers a respite.
- The Pipestone Area Coalition, which was developed out of a SWHHS grant to reduce underage alcohol use, assisted Pipestone County with the development of the Social Host Ordinance, which passed in 2018.
- The HUD smoke-free public housing rule requiring all public housing to implement or update their smoke-free policies was passed and all HUD housing needed to implement by July 1, 2018. SWHHS Statewide Health Improvement Program (SHIP) staff assisted housing managers in revising their policies and educating residents to help with a smooth transition.
- SWHHS staff worked with Redwood/Renville Red Cross, law enforcement, fire department, Redwood County Emergency Management, Redwood Area Community Center, Salvation Army, United Community Action Partnership, Thrift Store, Ruby's Pantry, Meals On Wheels, Redwood Lodge, Lions Club, Jackpot Junction Casino Hotel, and the apartment manager to help 24 low-income people displaced by the River Ridge Apartment fire in Redwood Falls find shelter, replace medication, organize meals, find clothing and help with resettlement.

# STORIES OF POVERTY

## A New Approach

Normally annual reports are rather academic. Southwest Health and Human Services (SWHHS) wanted to take a different approach with the 2018 annual report. Showing how services impact the lives of people SWHHS serves in a positive way is important to change the narrative of how the community talks about people in poverty. Many times, people find themselves in poverty by no fault of their own.

## Story of Poverty: Mary, John, and Robert

Mary is a 25-year-old single woman who has a son, John, 30 months and is pregnant with her second child. Her boyfriend Robert is a 27-year-old, who is a veteran that struggles with Post Traumatic Stress Disorder (PTSD) from active duty experiences and substance use. Robert is John's and the new baby's father and lives with Mary. Mary recently laid off from her cashier job at the local gas station and with a high school education is struggling to find employment that pays above $11.00 an hour. Robert also has recently lost his job due to chronically being late which was caused by his substance use as a coping skill for Post-Traumatic Stress Disorder. She comes to SWHHS for food assistance and is also concerned about her son, John's behavior.

**Did you know…**
In 2013, Minnesota adults with a felony drug conviction made up 1.2 percent of the population and 0.4 percent of families participating in Minnesota Family Investment Program (MFIP) had a felony drug conviction. (11)

Mary, who lives in one of our larger communities with transit, takes the bus to SWHHS along with her son John. Her car has broken down and is unable to afford the repairs needed. Mary fills out a Combined Application Form (CAF) and has an interview with an eligibility worker the same day.

Mary qualifies for the Minnesota Family Investment Program (MFIP) which allows her to get assistance for up to 60 months and also requires her to work with her local employment services agency within 10 days. The SWHHS eligibility worker will refer her case to the appropriate agency. During her interview, she also qualified for cash and food assistance

based on her income and shelter expenses. In order to receive benefits, she will need to provide verification for the following: Identification, assets, relationship to children in the home, shelter cost, utility cost, and income proof or stop of work document.

Mary has health insurance through her parents that extends until she is 26 years old. Even with her parent's high deductible coverage, Mary is expecting a large bill when she has her second child and is worried about how she will pay for it. An application is filled out for Minnesota Health Care program where health insurance coverage will also be given to John and the new baby.

After the assistance application has been submitted, Mary asks about the Women, Infants, and Children (WIC) brochure in her eligibility packet. The eligibility worker tells Mary she should go talk to public health staff to get signed up for WIC. WIC is an income-based breastfeeding and nutrition education program that provides supplemental nutritious foods, and referrals to health and other social service programs for infants, children up to the age of five, and pregnant and breastfeeding women. (3)

Once Mary is done talking with the eligibility worker, she talks with a WIC nurse. In Mary's interview, she explains she is pregnant besides having John, who is at the appointment with her, and that the eligibility worker told her she may qualify for WIC. She explains that she has filled out applications for health insurance and food assistance. The nurse has Mary fill out the application for WIC and she presumptively qualifies based on her income.

**Did you know…**

The maximum an average family of four enrolled in the Minnesota Family Investment Program could receive is:

- Cash Assistance of $621 a month
- Food Assistance of $583 a month
- Shelter Expenses of $569 a month allowed for SNAP unless disabled or elderly
- Child Care Expenses are dependent on number of hours needed, the age of the child or type of child care arrangement.

Individuals are only able to be enrolled up to 60 months and are required to work with their local employment services agency within 10 days.

While Mary is filling out the WIC application, the nurse observes John's behavior and interactions with his mother. The nurse has some concerns and asks if the child is enrolled in

the Follow Along Program (FAP). Mary says no. The nurse explains that the program is a screening program available to any child up through the age of 36 months that helps parents figure out if their child is playing, talking, growing, moving, and behaving like other children the same age. (4) Mary explains her concerns about John's behavior and agrees to the screening program. The nurse has Mary sign a consent to refer to other public health services and then gives her a screening tool for growth and development and another for social-emotional development.

The nurse goes on to explain other services that public health offers. Mary is asked if she has a car seat for John and the new baby. She has one for John but not the new baby. The nurse tells her she can get a car seat through public health if she meets income eligibility. Mary sets up a car seat appointment with a car seat technician for two months later since she isn't due for several months yet and doesn't know what health plan she will be assigned.

The nurse also explains that family home visits would also be an option for her because she is income eligible. The nurse talks about how the program could give Mary information about how to have a healthy pregnancy, enrich the baby and John's growth and development, help strengthen their family support network, increase parenting skills, help Mary and Robert connect with their children through age-appropriate activities and provide links to community resources. Mary was glad to hear a program like this could help her with some of her challenges with finding resources, feeling like she was overwhelmed with being a parent, and her family situation. She agreed to have a nurse come out to go through an assessment customized to her family.

A few days later the public health family home visiting nurse goes to Mary's home for her appointment. The nurse goes through a parent survey assessment to get to know Mary and

**Did you know…**

Once Mary has found a job and worked toward a raise, she may end up having less income to work with had she stayed on benefits alone. In the industry this is called the benefits cliff. At certain points the reduction in benefits for food assistance, housing assistance, health care subsidies, child care assistance and other aid can be larger than the raise, putting the family back in financial trouble. This serves as a disincentive to continue the progress that Mary has worked so hard for. (13)

Robert's needs better. The nurse takes the information and provides Mary and Robert with a customized resource list that includes phone numbers, websites, and a description of services at the next visit.

Mary also gives the nurse both of the FAP screening tools back. The nurse scores both screening tools and lets Mary know that her concerns are valid. Based on John's score on the ASQ-SE the nurse recommends Mary follow up with her school district and tells her that the nurse could, with Mary's consent, send a referral and results of the screening to the school district. Mary signs consent for public health to share information with the school district.

Mary qualifies for family home visiting based on the parent survey and because there is an opening, she is enrolled in the program. Mary tells the nurse how excited she is to have a nurse come into her home and provide her with education about parenting and other goals she has for her children. She also tells the nurse that she has been feeling overwhelmed with how to take care of John with his challenges and with no money coming in until she or Robert finds a job. She is also worried about Robert's substance use and how that is impacting John.

## Fleeing a War-Torn Land: Mohamed

Fleeing a war-torn country for a strange new land is not easy when you don't speak the language and don't know the culture you are expected to assimilate too. Mohamed was fortunate that upon his arrival he was able to work with a resettlement agency through United Community Action Partnership (UCAP) to help him understand his new environment.  There he was taught about American culture, banking system and United States currency, using a clock and calendar, his rights as a refugee, how to use modern appliances, maintain a toilet and bathtub/shower, what electrical outlets are and dangers, landlord/tenant responsibilities, home safety, transportation, utilities, phone, laundry, how to find and maintain employment, employee rights and employer expectations, education system, legal system, social service

system, nutrition, and health care system among other things. SWHHS public health division along with the local resettlement agency helped Mohamed navigate a complex system. Public health provided referrals to health care clinics to assess the refugee's health status. Public health's goal was to assist Mohamed in establishing a primary care clinic. It is important to establish a medical home as some countries have very limited health services available. A public health nurse reviewed Mohamed's immunization and health history to determine if he was protected against infectious diseases. Tuberculosis and intestinal parasites are also screened for either by public health or the health care clinic to ensure Mohamed started his new life in the United States healthy. The public health nurse worked with Mohamed's clinic to make sure all the needed screenings were conducted. The public health nurse also reviewed and submitted the required paperwork to Minnesota Department of Health within 90 days of his arrival.

SWHHS eligibility worker reviews Mohamed's case. Mohamed applies for medical assistance and Refugee Cash Assistance Program (RCA), a program that assists refugees in the first eight months of living in the U.S. In order for eligibility to be acquired, Mohamed must present verification he is working with UCAP, any assets, possible income, immigration card, and address. After he has provided all the documents the eligibility worker will review and determine if he is eligible for RCA which is $360 a month. The SWHHS eligibility worker will then refer Mohamed's case to his local employment services agency as that is another requirement of the RCA program.

**Did you know…**

If Mohamed came into this country as an undocumented immigrant, he would be denied all social services benefits which includes housing support, food assistance, and health insurance.

The MNSure application for Medical Assistance is given to the SWHHS METS (Minnesota Eligibility Technology System) unit for screening and assignment. Electronic sources such as Social Security, SAVE (Systematic Alien Verification for Entitlements Program), and the Federal Hub are used to verify his refugee status and any sources of income. If verifications are still required, a letter requesting the information is sent. If no further verifications are requested by the METS system an approval letter is issued. Mohamed is eligible for Medical Assistance for an adult with no children due to his refugee status and income within the income limit for a household of one.

After having lived in the United States for one year, Mohamed returned to public health to help him initiate his change of status/green card health screenings. This enabled him to seek employment and become self-supporting. Public health played a key role in supporting Mohamed's health needs as he settled into our community.

## Story of Mental Health: Hannah

Hannah is a 17-year-old teen that had struggled with anxiety and depression her whole childhood. Her mom Amy requested Children's Mental Health case management services from SWHHS when Hannah was diagnosed at the age of 12. Amy was referred to the program by Hannah's mental health provider to help Amy manage her care needs and provide support.

A diagnostic assessment was needed for Hannah to determine the extent of her mental health needs and to see if Hannah qualified under Minnesota Rule 79 as being a child with a serious emotional disturbance. Hannah met with a local therapist over two sessions to complete the assessment. SWHHS covered the cost of the assessment but not the time off from Amy's work or the transportation to the clinic. This diagnostic assessment is required every three years to remain in the children's mental health program under Minnesota Rule 79. However, the diagnostic assessment is usually done on an annual basis. The diagnostic assessment is a written evaluation of the child's current life situation and sources of stress, current functioning and symptoms, history of mental health problems, diagnosis and statement of Severe Emotional Disturbance (SED) and a need for mental health services.

Once the diagnostic assessment was done and Hannah began receiving Children's Mental Health case management services the case manager worked with Hannah and her family to complete a functional assessment; identifying the strengths and needs of Hannah and her family. The information found through the functional assessment was then used to develop an

Individual Family Community Support Plan (IFCSP). The IFCSP contains the goals that Hannah and her family hope to achieve and serves as a guide for the services and changes needed to achieve them. The IFCSP is reviewed with Hannah and her family during monthly case manager visits. Through these visits, the case manager monitors Hannah's progress towards her goals and coordinates services. The case manager also monitors service impact to see that they are meeting Hannah and her family's needs. Most insurance companies cover the cost of case management services; Hannah's family is not charged by SWHHS for the cost of this service.

**Did you know…**
Children's Mental Health unit provided 110 children, along with their families, case management services in 2018.

One of the services utilized through Children's Mental Health was in-home family-based therapy. This service provides therapy to Hannah's families in their home to assist the family to grow stronger with appropriate boundaries, discipline, and consequences for behavior. This service is covered by most insurance policies and in some situations, the cost of the service may be covered by SWHHS.

Hannah's case manager also attended Hannah's school Individual Education Plan (IEP) meetings to support Amy and to help with the plan development to meet Hannah's needs. The case manager communicates with the school as needed to assess any changes or needs.

When Hannah was 16, she was admitted to an inpatient facility and placed on a 72-hour hold because she had attempted suicide. Unknown to Amy, Hannah had stopped taking her anxiety and depression medications because she hated how foggy they made her feel. She had also started sneaking different prescription medications to numb her pain. School was difficult as she was being bullied by several classmates. She struggled with her academics' even though she had an IEP in place at school to support her educational needs. She didn't have many friends that she could really talk to about her struggles because her anxiety always got her so worried about what other people would think. The one friend she did have, had started dating the boy she had a crush on even though the friend knew Hannah liked him. That was really hard on their friendship. All these hardships, along with her anxiety, lead her to feel helpless, like she wasn't good enough, unlovable, and like she didn't belong. She couldn't see how her life would get any better and just wanted the pain to stop so Hannah

overdosed on several bottles of medication. Her mom found her in time and got her to the hospital.

Unfortunately, the closest inpatient hospital the local ER could find to admit Hannah was in Grand Forks, North Dakota. Being in an inpatient facility in Grand Forks, North Dakota was extremely hard on Hannah's family. Therapy required an assessment that her mom needed to help with and participation in the therapy session. This was really difficult to do when the facility is a five-hour drive one way. It was at this point that Amy, with the help of Hannah's case worker's encouragement, decided to apply for Social Security Income for Hannah's disability.

As Hannah and her mother met for family therapy, it was discovered that Hannah had been using prescription pills that were not prescribed to her. Upon discharge from the hospital, Hannah agreed to have a Chemical use assessment. Voluntary Chemical Use assessments are at the request of the person with the need. Although in many cases a person may be reluctant to call in to set up an assessment. At her mother's request, Hannah did call on Tuesday to make an appointment. She was scheduled for an assessment on Thursday with a County Chemical Dependency Assessor.

Hannah arrived for her Rule 25 assessment with her mother. Generally, the up-front cost of the assessment is $150.00. Hannah's mom provided her health insurance card to bill for Rule 25. If health insurance does not cover any or all of the cost of Rule 25, Hannah will not be billed due to the voluntary status of the assessment.

**Did you know…**

Inpatient Mental Health Treatment facilities that accept children in mental health crisis include:

- Hutchinson Health, Hutchinson, MN
- St Cloud Hospital, St Cloud, MN
- Lake Region Healthcare, Fergus Falls, MN
- PrairieCare, Brooklyn Park, MN
- Abbott Northwestern Hospital, Minneapolis, MN
- University of Minnesota Medical Center Fairview, Minneapolis, MN
- United Hospital, St Paul, MN
- Mayo Psychiatry & Psychology Treatment Center, Rochester, MN
- Essentia Health, Duluth, MN
- Sanford Behavioral Health Center, Thief River Falls, MN
- Prairie St Johns, Fargo, ND
- Red River Behavioral Health System, Grand Forks, ND
- Avera Behavioral Health Hospital, Sioux Falls, SD

During the initial stages of the assessment, Hannah's mother came back to sign the paperwork necessary to open a case. Due to Hannah's age, her mother did not have to sign the paperwork, although it is always preferred. Hannah was also given a privacy notice indicating that all of her chemical health records would be private unless she signed a release and she was also notified that the actual assessment tool could not be released to anyone without her consent. Hannah's mom left the room for the remainder of the assessment. The assessment took approximately an hour and a half, covering topics ranging from her history with substance use, any medical conditions, mental health or behavioral conditions, and her day to day life. The assessor also communicated with contacts provided by Hannah, including her mother, her therapist and her CMH worker. From the information provided by these contacts as well as Hannah, the assessor determined that although Hannah may have been abusing drugs and was diagnosed with a substance use disorder, Hannah did not meet the criteria for residential substance abuse treatment at this time. The assessor felt that Hannah would benefit from outpatient substance abuse treatment which is a three-hour group, three days a week, however, there are no local adolescent outpatient groups and Hannah would be required to travel to Willmar, an hour one way, to get to the nearest adolescent group. It was determined Hannah would continue with all services she currently had and if any additional concerns regarding substance use came up, Hannah would return for an updated assessment at that time.

As Hannah reaches 18, it is important that the children's mental health social worker and the adult mental health targeted case manager (AMH-TCM) collaborate for a smooth transition of care. Hannah has a strong relationship with her children's mental health case manager and this transition time helps Hannah to feel comfortable and start to build a relationship with the new AMH-TCM. AMH-TCM services remain voluntary. By the final transition to these services, efforts will be made to develop a new relationship and offer service and support options that will assist in Hannah's continued recovery efforts and meeting her goals.

**Did you know…**
The Adult Mental Health unit provided 282 adults, along with their families, case management services in 2018.

As Hannah moves to be a legal adult, her care will no longer be directed by her mother. The AMH-TCM will continue to work with Hannah and her mother as Hannah allows. This is a new

reality for Hannah. As a legal adult, Hannah can decide if she wants to take medication, continue to have an AMH-TCM involved, whether to follow through on treatment that keeps her disease from spiraling out of control, decide how much she wants her family to know about her treatment or even if she wants to continue a relationship with her family. No law requires an adult with serious and persistent mental illness to receive treatment unless she becomes a threat to herself or others. At that point, the civil commitment proceeding could begin.

Once Hannah leaves her mother's home, she will need to find food, housing, and a source of income through a job. These are all areas that an AMH-TCM could assist in providing options to and guidance on the next steps on securing these basic needs. If she is too ill to hold down a job, and Hannah allowed, AMH-TCM may refer her to providers that can assist her with applying for adult SSI. Social Security Income (SSI) helps provide income for those who are unable to work and do not have a work history. Certification from social security can take several months to a year. To help speed up the process, the eligibility worker suggests they refer Hannah to the State Medical Review Team to get a disability certification for the public assistance program while she waits for SSI. SSI also helps a client become automatically eligible for Medical Assistance with a disability status to help pay for all medical expenses. At age 26, Hannah will no longer be on her mother's commercial insurance policy and will be responsible for her own health insurance.

**Did you know…**
If Hannah had been approved for social security income for her disability at age 17 years 9 months, she would have to reapply on her 18th birthday. She could not send in her application until the day of her 18th birthday. During this application time payments would stop.

Housing support is a cash assistance program that could help pay for Hannah to live in a group residential housing if she chooses to leave her parents' home but is unable to live on her own. Before receiving or becoming eligible for SSI, she could receive Housing Support and/or General Assistance cash depending on her disability. SNAP will be another program she could apply for depending on where she resides once she turns 18.

Services have not been built with a continuum of care in mind at the state and national levels because of funding and laws that structure services. Generally, when laws and services are

built, they have the seven-county metro area in mind which has greater availability and variety of services in a compact geographical area.

## Story of Families Involved with Child Protection: Emma, Nick, and Joe

SWHHS received a report of discipline by a parent the reporter felt was abuse. Emma and Nick are an unmarried couple who have two-year-old Joe that goes back and forth between his parents' care. The reporter indicated Joe came back from a weekend with his mother and had bruises on his abdomen and side that were noticed during bath time. Joe cannot say what happened but does say "owie" when his stomach is touched. Nick reached out to Emma to ask about the marks and said she never noticed anything but did state that Joe was difficult this weekend.

Child protection reviews the report at the morning screening call and looks at the details of the report and how they fit with the current Child Protection Screening Guidelines issued by the Department of Human Services. After review, the report is screened in for physical abuse. The report is then cross-reported to law enforcement and the county attorney's office.

The immediate safety of Joe is discussed and a plan is made with law enforcement and the assigned worker for making contact with the family. The assigned worker makes a call to Nick since he has Joe for the next couple of days and a home visit is set up for later in the day to see Joe and discuss the received allegations.

Before the scheduled home visit, the assigned worker will re-arrange the scheduled meetings and appointments to allow enough time to handle the immediate situation. Law enforcement and the assigned worker will also discuss the interviews of both parents and any other adults who were responsible for Joe's care over the last couple of days.

At the home visit, the social worker explains the reason for the involvement and reviews the privacy rights with the family. The worker discusses the current parenting arrangement and any other individual who helps with Joe's care on a regular basis. The social worker also

discusses who lives in the home, Joe's development, medical and dental providers, childcare providers, and any concerns with Joe's well-being. Also discussed is Nick's employment status, housing status, mental health concerns, abuse/neglect history and how the basic food, clothing and shelter needs are being met for the family. All of these things can be indicators of stressors in the home and/or areas the child protection worker can assist the family with. While in the home, the social worker can get a tour and see the living environment to asses for any concerns.

**2018 Average Count of Children in Out of Home Placement**

| | Average Count |
|---|---|
| SWHHS | 177 |
| Lincoln | 9 |
| Lyon | 44 |
| Murray | 12 |
| Pipestone | 16 |
| Redwood | 80 |
| Rock | 16 |

Nick shares that Joe is still showing tenderness in his abdomen and has been "clingy" all day. Due to the continued concerns and limited verbal ability, the social worker asks Nick to take Joe into the clinic today to ensure his physical health is okay. Nick states he has to go into work later today and isn't sure if going to the doctor is necessary. The social worker uses open-ended questions to gather more information from Nick about his hesitancy to take Joe in. The social worker then explains the reasons for the request and why it will help to ensure things are okay since we do not know what is occurring below what is visible. With further discussion, Nick discloses he recently changed jobs and doesn't have insurance for Joe, only for himself. Nick is also concerned about missing too much work so early into the job and if he will be fired. The social worker can problem-solve with Joe and assist in calling the clinic to discuss open appointment times given the concerns. Nick said he is willing to see any provider as long as he can get to work on time. The social worker and Nick also discuss the possibility of having Nick or Emma apply for medical assistance given the family's current limited income.

The social worker has a strong working relationship with a couple of providers at the clinic and calls them with Nick's permission. They are willing to squeeze Joe in today to assess his immediate safety. Nick, Joe and the social worker go to the clinic to have Joe assessed. The social worker has Nick take the lead during the appointment and is there to share information

as needed. All of Joe's testing comes out as okay and that there are no concerns for internal injuries. A safety plan is developed with Nick to ensure Joe's safety and that no physical discipline will be used on Joe. Nick takes Joe to his parents (as usual) for evening care while Nick is at work and agrees to share the plan with them. Their contact information is given to the social worker.

2018 SWHHS Placement by Category

| | 2018 |
|---|---|
| Foster home | 48.0% |
| Other pre-kinship home | 10.0% |
| Pre-adoptive home | 9.9% |
| Child's reunification home | 8.2% |
| Supervised independent living | 5.4% |
| Residential treatment center | 4.8% |
| Foster home: corporate | 4.4% |
| Probation placement | 4.4% |
| Group home | 3.9% |
| Juvenile correctional facility (non-secure) | 1.1% |
| Non-custodial parent's home | 0.0% |

The social worker reaches out to Emma to set up a time to discuss the received allegations as well. The social worker meets with Emma in her home to assess the home environment while discussing the family. The same information that was asked to Nick is asked to Emma. Emma is also asked about the injuries and asked to go through the events of the weekend. Emma shares that Joe was throwing multiple temper tantrums during the weekend when he was told no. Emma described the tantrums as Joe throwing himself on the floor, crying, screaming and kicking. Emma said there were times he would throw himself on toys from off the edge of the bed. Emma is wondering if that is where the bruises came from. A safety plan is created with Emma when Joe is in her care. Emma states she is the only caregiver for Joe so the plan does not need to be shared with anyone else. Emma said she and Nick discussed the social worker's recommendation to apply for medical assistance since they do not have insurance for Joe and Emma agreed. The social worker explained where to go and how the process works. Emma said she feels she can handle this task and she agrees to let the social worker know when it is done.

Joe is observed with both parents and does not display any fear with either parent. Joe is seen seeking out comfort and support from both parents while in their respective homes. Joe's living spaces in both homes are adequate to meet his needs.

The social worker consults with medical providers who are part of the child protection team to discuss Joe's injuries and any additional concerns and/or next steps the provider may have. The provider feels that the injuries could have been caused by falling on toys but cannot say for certain.

Given Emma's concern about Joe's behavior, it is decided that SWHHS will make a Help Me Grow Referral to have Joe's development assessed. The referral is made and the social worker is in close communication with the assessor during the assessment. Joe is determined to be behind in language and a recommendation for speech therapy is made. The social worker follows up with the family to ensure follow through with services.

Emma also expressed concerns during the initial contact about some depression ever since she had Joe. The social worker and Emma meet again to discuss how things are going and the possibility of a mental health referral for Emma's well-being. Emma agrees and the social worker makes a referral to the local mental health center for a diagnostic assessment to be completed.

The social worker meets with both Emma and Nick a couple of more times over the 45 days of the assessment/investigation period. The social worker completed the Structured Decision-Making assessment and it is determined that there is a moderate risk for Joe. Both Emma and Nick say that they feel they have things under control but find the monthly check-ins with the social worker helpful. It is decided that Joe and Emma will have a couple of months of case management and sit down to create a case plan.

**Did you know…**

It is not the goal of SWHHS child protection staff to take away a child(ren) from their family. Staff are however required by Minnesota Statute 626.556 to investigate allegation of child maltreatment that involve:

- Substantial child endangerment
- Sexual abuse
- Neglect
- Physical abuse
- Mental injury
- Threatened injury.

If after investigation the child maltreatment report is ruled in as valid, staff work with the family to address the issues that have created the abusive environment so that the family may be reunited. If a family refuses to make improvements, it is then that termination occurs.

## Story of Restorative Justice: Hunter and Will

Hunter and Will, both 13-year-olds, are out in the community and decide to damage a community bathroom and are caught in the process. Law enforcement investigates and sends their report to the county attorney's office. At that time, the county attorney office reviews the case and determines eligibility for the SWHHS Restorative Justice's Program. Upon reviewing the report, the County Attorney calculates, because of the extensive damage, Hunter and Will could be charged with felony-level Criminal Damage to Property and refers the two juveniles to Circle Sentencing. SWHHS staff meet with the youth and their parents to assess interest and their willingness to participate in the Circle process. Hunter and Will have the option of going through the traditional court process or Circle Sentencing to address their charges. Once the family accepts, the acceptance Circle is scheduled.

Community members or "Circle Volunteers", a SWHHS facilitator, and the youth and their supports make up the Circle. Through the Circle process, the group meets every other week to decide what the youth need to do to repair the harm that was caused by their actions. In this case, Hunter and Will volunteered with the city maintenance department so they got to experience firsthand how their actions impacted the city. In addition to community service, the youth were responsible for writing apology letters and paying restitution and completed any other goals the Circle deems pertinent. Because Will struggled in school, the Circle assisted him in bringing his grades up to passing and getting him back on track for graduation. Hunter had a tense relationship with his mother, so the Circle made goals surrounding their relationship. These goals are discussed with the youth every two weeks in Circle.

Once the youth completed all of their goals and the Circle felt they were no longer at risk to re-offend, a celebration Circle was scheduled. This is not done until the youth have demonstrated a change in thought and behavior, so youth can remain in Circle for 2 or more years at times. Upon completion of the Circle process, the Circle writes a letter to the County Attorney's office explaining the youth has fulfilled their obligations. In turn, the County

Attorney closes the file and the youth are not charged with the offense they were referred to Circle.

*"Body Shop" written by Circle Youth*

There are many struggles in a lifetime. I like to refer to them as "speed bumps", as we are the cars. Each speed bump is in relation to a life struggle. For instants in my life when the incident happened, I was going over a life speed bump. If you take it too fast you ruin your car, if you take it too slow, you will not make it over it. You have to know how to handle the speed bump. When I went over one of my life's speed bumps, I was not thinking and went over it too fast, ruining my "car" or myself. I tried to rush over the speed bump but broke something major on the car. The major thing on the car was trust and my image to others.

Now I am in the "body shop" rebuilding my car frame and axle, brakes, etc. The frame acting as my public image and interior damage acting as trust. Therefore, in reality, all of you, as members of this program are the mechanics fixing me up and getting me ready to go back on the road. Once I am ready to hit the road, again I will be graduated from the "body shop" or circle. I will be a new and improved car ready for whichever speed bump comes my way. The one thing that will be different from the other speed bumps in life is that I will know how to handle them and how to overcome them. And I can thank all of you for that.

**Did you know…**

2018 Circle Volunteers spent 813.75 hours, which is a donated value of $22,443.23 toward SWHHS Clients.

There were 10 youth in Lincoln & Lyon Counties that completed the requirements of Circle and had their criminal charges dismissed.

Victims received 100% repayment of restitution with a value of $5,985.78.

In 2018, 203 community service hours were completed.

Since Circle started in 2013, 505 community service hours have been completed.

Circle Sentencing participants, who were 14 and older, have obtained or maintained employment 79 percent of the time.

## A Story of Successful Transition to Adulthood for Youth (STAY): Jenna

Jenna has big dreams. At 16-years-old she wants to gain independence so she doesn't have to rely on her foster care social worker. In the STAY program, foster care youth who wish to receive STAY funds will need to develop an education plan that removes barriers from their growth and builds knowledge so they can live independently.

Jenna, along with other foster care youth, attended the STAY meeting about Smart Car Shopping. After the meeting, she wanted to know more about buying a car. The STAY worker met with her on a one-to-one basis a couple more times and taught her about car maintenance, insurance, tabs, and title transfers. Eventually, she came up with a dollar amount she needed to buy her first car. The STAY worker helped her come up with a budget and financial goal. Once she reached that goal amount, the STAY worker helped her better understand and look for insurance and get the paperwork she needed to go to a dealership. She was able to get insurance and buy a car on her own using the things she learned at meetings. Jenna used the STAY program to gain information about a big purchase to make an informed decision that will move her toward being more independent and successful in adulthood. (5)

## A Story of Extended Foster Care (EFC): Dillon

Dillon, a senior in high school, has received notice six months prior to turning 18 explaining options for extending foster care until he is 21 or leaving at 18 and generating a personal transition plan to guide him out of foster care. Dillion wants to be successful in life and feels he needs some additional skills like time management, budgeting, grocery shopping, meal planning, and making and completing cleaning lists to help him do that. He agreed to and signed the Voluntary Placement Agreement allowing him to be placed in Extended Foster Care since he wants to attend community college in the fall.

On Dillion's first visit with his worker, an assessment is done to determine what independent life skills Dillion has and needs help with. Together they work out a plan and decide budgeting will be worked on first. His worker asks Dillon to write down all of his spending and what he earns for a month and bring the information to their next meeting. When meeting with his worker, Dillion is shown how to turn the financial information that he gathered over the last month into a budget by looking at what he spends and what categories he needs in his budget. Dillion was also shown how to use the money he earned from his job to finish his budget and plan how to save his EFC money.

**Did you know…**
The base rate a youth receives in EFC is $910 a month. Additional money may be available depending on the Minnesota Assessment of Parenting for Child and Youth (MAPCY) assessment. The average monthly amount youth in SWHHS receive is $950. (6)

At one of his next meetings, Dillion was asked to come up with five recipes for meals he would like to cook. When he meets with his worker, they go shopping for the meal items and discuss how to build a weekly menu out off of that. While shopping he is taught how to use weekly sales, coupons, and understand unit pricing to make his EFC funds go farther. (6)

## Story of Poverty in the Nursing Home Setting: Shirley

Shirley is an 84-year-old diabetic; she entered the nursing home a year ago and has been paying for her care. However, she now has limited funds to pay for the cost of her care. The family contacts SWHHS for assistance and is given the Application for Medical Assistance (MA) for Long-Term Care (LTC) Services.

Once the application is received back, SWHHS has 45 days to process the application. Depending on the circumstances, it may take up to 60 days or more. The completed application and needed verifications are received. (All assets and income need to be verified). SWHHS eligibility worker requests the Physician Certification form to verify the nursing home admission date and the need for nursing facility level-of-care. The worker reviews

verifications to determine if assets are within limits. If not, the client is notified of the need to properly reduce excess assets. Shirley's income needs to be verified, along with any medical deductions. Long-term care also has other requirements that need to be met (home equity limit, uncompensated transfer rules, and naming DHS the remainder beneficiary of certain annuities). Once all needed verifications are received, Shirley's assets are within limit, and LTC requirements met; Medical Assistance for Payment of Long-Term Care Services can be approved. The worker will also determine if she is eligible for the Medicare Savings Program to help with the cost of her premiums.

Shirley and/or her authorized representative will be notified of the outcome of the application. If approved the notice will include the medical assistance begin date and the amount of her "recipient amount". This is the amount she will be responsible to pay toward the cost of her nursing home care each month. The recipient amount is based on her gross income minus any allowable deductions (personal needs, insurance premiums, etc.).

**Did you know…**

Long-term care is expensive. In Minnesota the average cost of care for a year is:

- $60,000 for an average of 44 hours per week of home care in your home.
- $48,000 in an assisted living facility (this cost does not include services and fees)
- $90,000 for care in a nursing home.

The cost of long-term care depends on where you live, the care level a person needs, and the provider you use. (12)

Following approval, Shirley will then need to select a managed health care plan. If one is not selected, she will be auto-enrolled in the plan that was randomly chosen for her. Individuals applying for MA payment LTC Services can have very unique circumstances. It can range from very simple, with someone only having Retirement Survivor's Disability Insurance (RSDI) benefits and a checking account: to very complex, with multiple income sources, multiple assets, annuities, non-homestead realty property, uncompensated transfers, etc.

Once Shirley is on a managed care plan, she is referred to SWHHS, Public Health Unit, to assign a Care Coordinator to advocate for her needs and assist in assuring services are being met. After receiving the referral, a Public Health Nurse will complete an assessment of Shirley within 30 days. This comprehensive assessment includes a face to face contact with Shirley as well as reviewing her chart. The person-centered assessment allows Shirley to

discuss how she feels her needs are being met in the nursing home and allows her to express any questions or concerns. The review of the chart helps the Public Health Nurse establish that Shirley is getting the appropriate care at the nursing home. As the assessment is being completed, Shirley states she has been having trouble finding a dentist and needs some specific items for her diabetic condition. Once the initial assessment is complete, Shirley's Care Coordinator finds a dentist that will see her. The Care Coordinator works with the Social worker at the nursing home to arrange the appointment and transportation. The Care Coordinator also finds a resource that will come to the nursing home to measure Shirley for diabetic shoes. The Care Coordinator arranges the visit and Shirley can order the diabetic shoes that best meet her needs.

## Story of Physical Disability: Richard

Richard is a 59-year-old male who is certified disabled through the Social Security Administration. He receives $815 is Retirement Survivors Disability Insurance (RSDI) benefits and works part-time at a local business making about $85 bi-weekly. He comes into the office to apply for the Supplemental Nutrition Assistance Program (SNAP), cash, and healthcare. He is over the income limit for cash assistance but is eligible to receive some SNAP benefits. Since he is working making more than $65 per month and is disabled, he is eligible for Medical Assistance for Employed Persons with Disabilities (MA-EPD). This program is available to clients who are over the income limit for Medical Assistance with disability type but are working. He will pay a monthly premium based on his average monthly income (limit of $39). In addition, because he is on Medicare, he is also eligible for Qualified Medicare Beneficiaries (QMB); this program helps pay his Medicare premium costs and any co-pay or deductibles associated with Medicare.

Richard's mom was helping him get ready for work as he needs help bathing and dressing. She used a modified van with a ramp to get him to and from work. His Mom is currently in the hospital due to falling and breaking a hip. She is not going to be able to return home after surgery. Richard's brother is going to stay with him for a short time but is not able to help for a long amount of time. They are both expecting that their Mom is going to need to go to the nursing home for rehabilitation and are not sure, how long she will be out of the

home. They would like to know what help might be available. An intake worker spoke with them and offered a MNChoices assessment and Richard agreed. An assessor came to Richard's home to complete the MNChoices assessment and determined that he would be eligible for a Community Access for Disability Inclusion (CADI) waiver. The assessor made a referral for a CADI waiver and he was assigned a social worker. The social worker met with Richard and they developed a plan for care including Personal Care Assistance (PCA) to help Richard bathe and dress at home, a Personal Emergency Response System so he can call for help in an emergency, meal on wheels, housekeeping, and assisted in setting up community transportation to and from work.

# PRIMARY PREVENTION

Some of the people in the stories on the previous pages may have avoided the situations they are in if more prevention programming was available. For example:

- Evidence-based Family Home Visiting has demonstrated a decrease in child abuse and neglect, decreased tobacco and alcohol use during pregnancy, increased breastfeeding rates, reductions in subsequent pregnancies, increased labor force participation by parents, and increased family income. (7) (8)
- Planning and Implementation (P&I) grant that focuses on positive community norms to help youth understand they don't have to use alcohol and other substances because most of their friends are not using. The 20+ communities that previously received P&I funding have seen a dramatic decrease in 30-day alcohol use among youth in their communities.
- Women, Infants, and Children (WIC) is a nutrition education program that provides supplemental foods to promote good health for pregnant, breastfeeding, postpartum women, infants, and children up to age five who meet income guidelines. This evidence-based program is proven to reduce obesity and improve the nutrition of children that live in poverty.
- Education about and administration of immunizations protects all of us from diseases like measle, mumps, polio, hepatitis A, B, and C, tetanus, diphtheria, whooping cough, among others.

To better understand SWHHS prevention approach in our community you need to understand the three categories of prevention activities:

1. **Primary Prevention**–intervening before health effects or injury occurs
    - through measures such as vaccinations,
    - education about healthy and safe habits (eating healthy, regular exercise, not smoking), and
    - banning substances known to be associated with a disease or health condition through legislation and enforcement that ban or control the use of hazardous products (asbestos) or mandate safe and healthy practices (car seat and seatbelt use) (9) (10)
2. **Secondary Prevention**–identify diseases in the earliest stages
    - through regular exams and screening tests before the onset of signs and symptoms, (mammography and regular blood pressure testing)

- encouraging personal strategies to prevent re-injury or recurrence,
- implementing programs to return people to their original health and function to prevent long-term problems (9) (10)

3. **Tertiary Prevention**–decreasing the impact of injury or ongoing disease that has long-lasting effects.

- cardiac or stroke rehabilitation programs, chronic disease management programs
- support groups that allow a member to share strategies for living well
- vocational rehabilitation programs to retrain workers for new jobs when they have recovered as much as possible. (3) (10)

SWHHS has a wide variety of prevention programs available that meet the three prevention approaches:

- Car Seat Program
- Follow Along Program
- Family Home Visiting
- Peer Breastfeeding Support
- Women, Infants, and Children
- Statewide Health Improvement Partnership
- Planning and Implementation Grant
- Toward Zero Deaths
- Public Health Preparedness
- Infectious Disease
- Immunizations
- Tuberculosis Control
- Refugee Health
- Environmental Health
- Birth Defects Information System
- Early Hearing Detection Intervention
- Child and Teen Checkups Program
- Dental Varnishing

On the following pages, you will see some of the prevention work done in each of the SWHHS counties during 2018.

# Prevention at Work in Lincoln County in 2018

3 clients requested car seats with education.

Worksite wellness physical activity kit.


824 annual WIC clinic participants.


Tobacco Free Property posted at worksites and schools.

**Population 5,707**



Vaping and tobacco education provided area schools.

69 clients received care management visits in the nursing home.

5 clients received personal care assessments so they could get help to stay in their home.

Lincoln County

Health Equity Data Analysis

Partnerships were built in Lincoln County to address findings from the 2017 Health Equity Data Analysis.

9 clients received MNChoices or personal care assessments so they could get help to stay in their home.

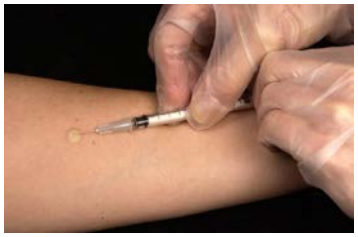

91 Lincoln Elementary School students benefit from Safe Routes to School program.

# Prevention at Work in Lyon County in 2018

139 clients requested car seats with education.


13,280 annual WIC clinic participants.


Farmers Market in Lyon County took EBT & credit/debit cards, Marshall Bucks, Power of Produce tokens worth $9,289.



Medications & monitoring provided to 35 Latent & Active TB clients.

**Population 25,839**


117 clients received care management visits in the nursing home.

Minneota Bike Rodeo


$50,000 in Legacy Funds for a new playground in Marshall.


Toward Zero Deaths - Marshall High School Mock

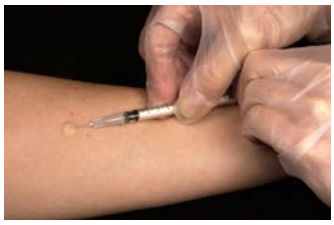
41 clients received personal care assessments so they could get help to stay in their home.

# Prevention at Work in Murray County in 2018


2,008 annual WIC clinic participants.

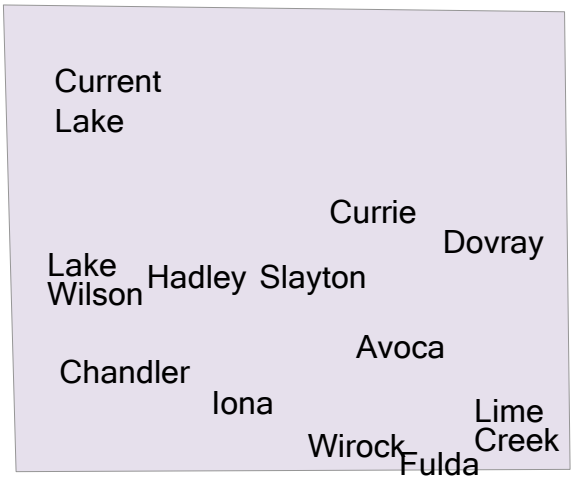

661 Murray County Central students benefit from a Smarter Lunch Room.

Physical activity worksite wellness.



Medications & monitoring provided to Latent TB clients.

**Population 8,353**




36 family home visits were provided.

Healthy snack station worksite wellness.

Vaping and tobacco information provided area schools.

44 clients received care management visits in the nursing home.

7 clients received personal care assessments so they could get help to stay in their home.

Bike Fix It Station in Fulda.

# Prevention at Work in Pipestone County in 2018

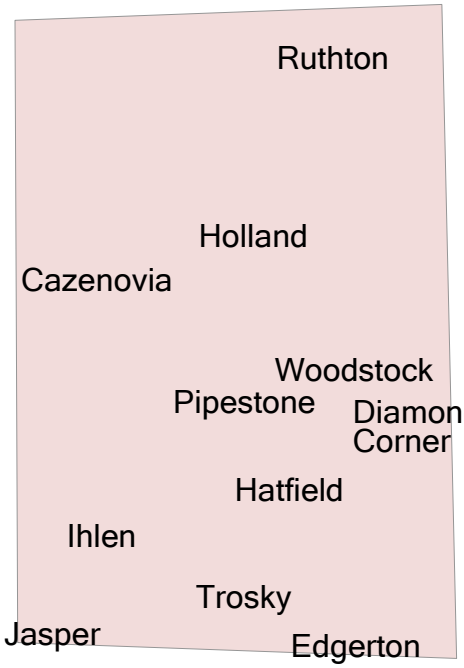

Vaping and tobacco information provided area schools.

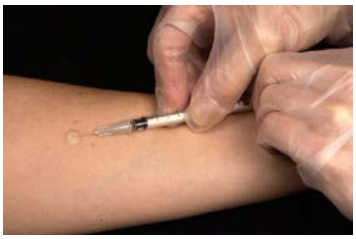
39 clients requested car seats with education.


3,693 annual WIC clinic participants.

172 family home visits were provided.

**Population 9,185**



Medications & monitoring provided to Latent TB clients.


Tobacco Free Property posted at worksites and schools.

32 Prenatal assessment visits were provided.

3 clients received personal care assessments so they could get help to stay in their home.

Hydration stations installed in Pipestone Area Schools.


P & I Grant changes teen behavior when messages focus on the positive!

# Prevention at Work in Redwood County in 2018

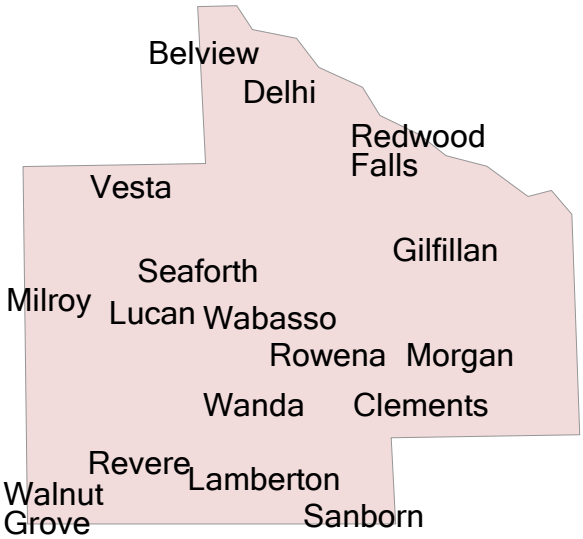
140 family home visits were provided.

Westbrook-Walnut Grove School celebrate locally grown foods through their Farm to School Program.

Redwood Valley High School students stencil buckle-up at high school parking lot exit.

105 clients received care management visits in the nursing home.

**Population 15,331**




Seat Belt Convincer at Farmfest.

Vista Prairie Lactation Room. Also, setup at Farmward.


3,895 annual WIC clinic participants.

19 clients received personal care assessments so they could get help to stay in their home.

LiveWell
Building Healthy Communities

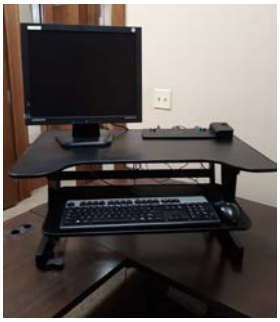
649 community members participated in the Quality of Life Survey.


Vaping and tobacco information provided area schools.

# Prevention at Work in Rock County in 2018


Tobacco Free Property posted at worksites and school.


2,107 annual WIC clinic participants.



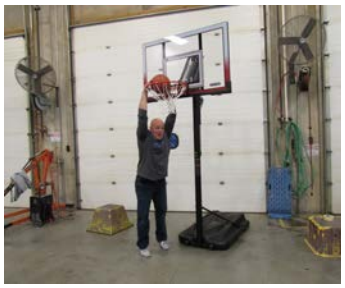
Sit stand work station worksite wellness.

Vaping and tobacco information provided area schools.

**Population 9,413**


23 clients requested car seats with education.

Ribbon cutting for Roll On Luverne bike share program.



Work site wellness at Midwest Fire

11 clients received MNChoices or personal care assessments so they could get help to stay in their home.

9 family home visits were provided.

Power of Produce at the Luverne Farmer's market.

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