SOUTHWEST
HEALTH & HUMAN
SERVICES

Southwest Health and Human Services
Board Agenda
Wednesday, February 21, 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 01/17/18 board minutes

D. Introduce New Staff: None

E. Employee Recognition: None

F. Financial

G. Caseload

	01/18	12/17	11/17
Social Service	3,708	3,685	3,865
Licensing	457	457	457
Out-of-Home Placements	188	185	177
Income Maintenance	12,101	11,946	12,039
Child Support Cases	3,255	3,266	3,267
Child Support Collections	$842,451	$729,511	$762,945
Non IV-D Collections	$112,797	$85,959	$74,475

H. Discussion/Information
1. Children's Mental Health- Karla Arends & Christine Versaevel
2.

I. Decision Items
1.

COMMUNITY HEALTH

J. Call to order

K. Consent Agenda
1. Amend/Approval of Agenda
2. Identification of Conflict of Interest
3. Approval of 01/17/18 board minutes

L. Financial

COMMUNITY HEALTH (cont.)

M. Caseload

	01/18	12/17	11/17
WIC	N/A	2187	2202
Family Home Visiting	44	52	44
PCA Assessments	21	16	16
Managed Care	347	283	315
Dental Varnishing	46	24	47
Refugee Health	5	7	5
Latent TB Medication Distribution	17	18	18
Water Tests	106	n/a	n/a
FPL Inspections	45	n/a	n/a
Immunizations	56	n/a	n/a
Car Seats	22	n/a	n/a

N. Discussion/Information
1. Community Health Assessment- Focus Groups- Ann Orren
2.

O. Decision Items
1.

GOVERNING BOARD

P. Call to order

Q. Consent Agenda
1. Amend/Approval of Agenda
2. Identification of Conflict of Interest
3. Approval of 01/17/18 board minutes

R. Financial

GOVERNING BOARD (cont.)

S. Discussion/Information
1. HR Update- Jodi Robinson & Nancy Walker
2. Credit Card Update- Sarah Kirchner
3. Quality Improvement- Carol Biren & Krista Kopperud

T. Decision Items
1. Engagement Letter for the Office of the State Auditor- 2017 Audit
2. Server Replacement- Karri Harvey
3. Appointment to the Insurance Committee
4. Appointments to the SMAMHC Board
5. Quality Council Charter/QI Plan 2018
6. Donations: Pipestone received a $46.00 donation for diapers from St. John's Lutheran Church, Ladies Aid of Trosky
7. Contracts
8. Closed Session- Director Performance Review

U. Adjournment

Next Meeting Dates:

- **Wednesday, March 21, 2018 – Marshall**
- **Wednesday, April 18, 2018 – Marshall**
- **Wednesday, May 16, 2018 – Marshall**

SOUTHWEST HEALTH & HUMAN SERVICES

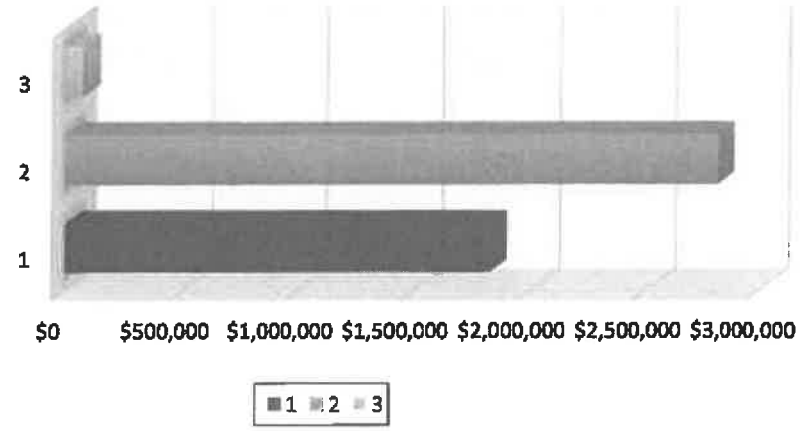
Ivanhoe, Marshall, Slayton, Pipestone, Redwood and Luverne Offices

SUMMARY OF FINANCIAL ACCOUNTS REPORT For the Month Ending **January, 31 2018**

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

Description	Month	Running Balance
BEGINNING BALANCE		**$1,797,574**
RECEIPTS		
Monthly Receipts	2,400,549	
County Contribution	453,506	
Interest on Savings	2,749	
TOTAL MONTHLY RECEIPTS		2,856,805
DISBURSEMENTS		
Monthly Disbursements	2,823,256	
TOTAL MONTHLY DISBURSEMENTS		2,823,256
ENDING BALANCE		**$1,831,123**
REVENUE		
Checking/Money Market	***$1,831,123***	
Bremer Savings	***$2,814,592***	
Great Western Bank Savings	***$75,329.70***	
ENDING BALANCE		**$4,721,045**
DESIGNATED/RESTRICTED FUNDS		
Agency Health Insurance		**$547,461**
LCTS Lyon Murray Collaborative		**$93,354**
LCTS Rock Pipestone Collaborative		**$42,091**
LCTS Redwood Collaborative		**$46,722**
Local Advisory Council		**$1,389**
AVAILABLE CASH BALANCE		**$3,990,028**

REVENUE DESIGNATION



SOUTHWEST HEALTH AND HUMAN SERVICES CHECK REGISTER
JANUARY 2018

DATE	RECEIPT or CHECK #	DESCRIPTION	+ DEPOSITS	-DISBURSEMENTS	BALANCE
	BALANCE FORWARD				1,797,573.93
1/2/18	27194-27437	Dep	224,946.49		2,022,520.42
1/2/18	9650	Disb		65,138.04	1,957,382.38
1/5/18	3649-3651 ACH	Disb		527.76	1,956,854.62
1/5/18	85431-85479	Disb		10,265.74	1,946,588.88
1/5/18	3652-3697 ACH	Disb		47,748.52	1,898,840.36
1/5/18	85480-85532	Disb		224,090.07	1,674,750.29
1/5/18	85533	Disb		1,460.16	1,673,290.13
1/5/18	8140-8163	Payroll		143,330.09	1,529,960.04
1/5/18	48403-48663 ACH	Payroll		505,914.03	1,024,046.01
1/5/18	27438-27543	Dep	327,763.73		1,351,809.74
1/8/18	9651	Disb		98,927.24	1,252,882.50
1/8/18	9652	Disb		3,060.21	1,249,822.29
1/9/18	27544-27598	Dep	131,675.80		1,381,498.09
1/10/18	9653	Disb		10,444.18	1,371,053.91
1/11/18	9654	Disb		54,233.05	1,316,820.86
1/12/18	85534-85557	Disb		15,671.41	1,301,149.45
1/12/18	3698	Disb		129.38	1,301,020.07
1/12/18	85558-85649	Disb		238,285.15	1,062,734.92
1/12/18	3699-3728	Disb		19,094.71	1,043,640.21
1/12/18	27599-27628,630-645,649,27651-27681	Dep	239,728.89		1,283,369.10
1/12/18	9655	Disb		577.00	1,282,792.10
1/12/18	9656	Disb		15.00	1,282,777.10
1/16/18	9657	Disb		35,175.81	1,247,601.29
1/16/18	27629,27646-48,50,27682-27698	Dep	70,927.15		1,318,528.44
1/18/18	Savings Transfer Bremer	Dep	1,000,000.00		2,318,528.44
1/19/18	85650-85749	Disb		14,215.80	2,304,312.64
1/19/18	85750-85903	Disb		66,916.78	2,237,395.86
1/19/18	3729-3730 ACH	Disb		980.47	2,236,415.39
1/19/18	8164-8181	Payroll		142,190.83	2,094,224.56
1/19/18	48664-48914 ACH	Payroll		504,667.07	1,589,557.49
1/19/18	85904-85936	Disb		2,989.08	1,586,568.41
1/19/18	3731 ACH	Disb		42.24	1,586,526.17
1/19/18	85937-85992	Disb		91,493.37	1,495,032.80
1/19/18	3732-3739 ACH	Disb		2,694.43	1,492,338.37
1/19/18	27699-27764	Dep	170,548.03		1,662,886.40
1/22/18	9658	Disb		9,568.45	1,653,317.95
1/22/18	9659	Disb		150,002.83	1,503,315.12
1/23/18	27765-27795	Dep	194,442.74		1,697,757.86
1/24/18	9660	Disb		10,418.98	1,687,338.88
1/25/18	48915-48918 ACH	Payroll		2,900.98	1,684,437.90
1/26/18	85993-86048	Disb		5,497.72	1,678,940.18
1/26/18	86049-86121	Disb		309,248.55	1,369,691.63
1/26/18	3740 - 3751	Disb		2,407.03	1,367,284.60
1/26/18	27796-27866	Dep	321,372.51		1,688,657.11
1/29/18	9661	Disb		33,373.44	1,655,283.67
1/30/18	85968 VOID	Disb		-259.49	1,655,543.16
1/31/18	85634 VOID	Disb		-180.00	1,655,723.16
1/31/18	27867-27912,27914-27926	Dep	175,449.58		1,831,172.74
1/31/18	9662 adjust R 27762	Dep	-50.00		1,831,122.74
					1,831,122.74
					1,831,122.74
					1,831,122.74
					1,831,122.74
					1,831,122.74
	Balanced 2/1/18 jvp	TOTALS	2,856,804.92	2,823,256.11	

Savings - Bremer	2,814,592.44
Savings - Great Western	75,329.70
TOTAL CASH BALANCE	**4,721,044.88**

SOUTHWEST HEALTH AND HUMAN SERVICES BREMER BANK SAVINGS REGISTER
JANUARY 2018

DATE	RECEIPT or CHECK #	DESCRIPTION	+ DEPOSITS	-DISBURSEMENTS	BALANCE
	BALANCE FORWARD				3,811,895.63
1/3/2018	33393	Interest	2,696.81		3,814,592.44
1/19/2018	Savings Transfer Bremer	Transfer		1,000,000.00	2,814,592.44
					2,814,592.44
					2,814,592.44
					2,814,592.44
					2,814,592.44
					2,814,592.44
					2,814,592.44
					2,814,592.44
					2,814,592.44
					2,814,592.44
					2,814,592.44
					2,814,592.44

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

DATE	RECEIPT or CHECK #	DESCRIPTION	+ DEPOSITS	-DISBURSEMENTS	BALANCE
	BALANCE FORWARD				75,277.07
1/3/2018	33394	Interest	52.63		75,329.70
					75,329.70
					75,329.70
					75,329.70
					75,329.70
					75,329.70
					75,329.70
					75,329.70
					75,329.70
					75,329.70
					75,329.70
					75,329.70
					75,329.70

Southwest Health and Human Services

Treasurer's Cash Trial Balance

As of 01/2018

Fund			Beginning Balance	This Month	YTD	Current Balance
1	Health Services Fund					
			1,709,545.07			
	Receipts			588,522.86	588,522.86	
	Disbursements			111,169.91-	111,169.91-	
	Payroll			224,683.30-	224,683.30-	
	Fund Total			252,669.65	252,669.65	1,962,214.72
5	Human Services Fund	410		General Administration		
			189,947.30			
	Receipts			52,525.65	52,525.65	
	Disbursements			33,999.05-	33,999.05-	
	Payroll			16,696.19-	16,696.19-	
	Dept Total			1,830.41	1,830.41	191,777.71
5	Human Services Fund	420		Income Maintenance		
			2,690,151.05-			
	Receipts			329,508.85	329,508.85	
	Disbursements			244,739.71-	244,739.71-	
	Payroll			354,481.86-	354,481.86-	
	Dept Total			269,712.72-	269,712.72-	2,959,863.77-
5	Human Services Fund	431		Social Services		
			8,275,091.90			
	Receipts			655,440.87	655,440.87	
	Disbursements			136,681.32-	136,681.32-	
	SSIS			558,133.72-	558,133.72-	
	Payroll			669,158.27-	669,158.27-	
	Dept Total			708,532.44-	708,532.44-	7,566,559.46
5	Human Services Fund	461		Information Systems		
			2,739,744.12-			
	Receipts			3,102.00	3,102.00	
	Disbursements			35.01-	35.01-	
	Payroll			33,983.38-	33,983.38-	
	Dept Total			30,916.39-	30,916.39-	2,770,660.51-

Fund		Beginning Balance		This Month	YTD	Current Balance
5	Human Services Fund		471	LCTS Collaborative Agency		
		0.00				
	Dept Total			0.00	0.00	0.00
	Fund Total	3,035,144.03		1,007,331.14-	1,007,331.14-	2,027,812.89
61	Agency Health Insurance					
		753,857.36				
	Receipts			230,454.13	230,454.13	
	Disbursements			436,850.41-	436,850.41-	
	Fund Total			206,396.28-	206,396.28-	547,461.08
71	LCTS Lyon Murray Collaborative Fund		471	LCTS Collaborative Agency		
		93,353.73				
	Dept Total			0.00	0.00	93,353.73
	Fund Total	93,353.73		0.00	0.00	93,353.73
73	LCTS Rock Pipestone Collaborative Fund		471	LCTS Collaborative Agency		
		44,725.46				
	Disbursements			2,634.00-	2,634.00-	
	Dept Total			2,634.00-	2,634.00-	42,091.46
	Fund Total	44,725.46		2,634.00-	2,634.00-	42,091.46
75	Redwood LCTS Collaborative		471	LCTS Collaborative Agency		
		46,722.12				
	Dept Total			0.00	0.00	46,722.12
	Fund Total	46,722.12		0.00	0.00	46,722.12
77	Local Advisory Council		477	Local Advisory Council		
		1,398.86				
	Disbursements			9.98-	9.98-	

Southwest Health and Human Services

Treasurer's Cash Trial Balance

As of 01/2018

Fund		Beginning Balance	This Month	YTD	Current Balance
	Dept Total		9.98-	9.98-	1,388.88
	Fund Total	1,398.86	9.98-	9.98-	1,388.88
All Funds		5,684,746.63			
	Receipts		1,859,554.36	1,859,554.36	
	Disbursements		966,119.39-	966,119.39-	
	SSIS		558,133.72-	558,133.72-	
	Payroll		1,299,003.00-	1,299,003.00-	
	Total		963,701.75-	963,701.75-	4,721,044.88

Southwest Health and Human Services

RM-Stmt of Revenues & Expenditures

As Of 01/2018 Report Basis: Cash

DESCRIPTION	CURRENT MONTH	YEAR TO-DATE	2018 BUDGET	% OF BUDG	% OF YEAR
FUND 1 HEALTH SERVICES FUND					
REVENUES					
CONTRIBUTIONS FROM COUNTIES	232,198.78-	232,198.78-	928,795.00-	25	8
INTERGOVERNMENTAL REVENUES	150,449.80-	150,449.80-	187,300.00-	80	8
STATE REVENUES	86,334.79-	86,334.79-	855,647.00-	10	8
FEDERAL REVENUES	84,677.87-	84,677.87-	1,362,742.00-	6	8
FEES	32,819.46-	32,819.46-	454,980.00-	7	8
EARNINGS ON INVESTMENTS	485.91-	485.91-	1,600.00-	30	8
MISCELLANEOUS REVENUES	1,524.98-	1,524.98-	8,900.00-	17	8
TOTAL REVENUES	588,491.59-	588,491.59-	3,799,964.00-	15	8
EXPENDITURES					
PROGRAM EXPENDITURES	0.00	0.00	0.00	0	8
PAYROLL AND BENEFITS	224,683.30	224,683.30	2,907,719.00	8	8
OTHER EXPENDITURES	111,138.64	111,138.64	892,245.00	12	8
TOTAL EXPENDITURES	335,821.94	335,821.94	3,799,964.00	9	8

Southwest Health and Human Services

RM-Stmt of Revenues & Expenditures

As Of 01/2018 Report Basis: Cash

DESCRIPTION	CURRENT MONTH	YEAR TO-DATE	2018 BUDGET	% OF BUDG	% OF YEAR
FUND 5 HUMAN SERVICES FUND					
REVENUES					
CONTRIBUTIONS FROM COUNTIES	221,307.35-	221,307.35-	10,127,818.00-	2	8
INTERGOVERNMENTAL REVENUES	5,000.00-	5,000.00-	109,907.00-	5	8
STATE REVENUES	137,274.92-	137,274.92-	5,343,608.00-	3	8
FEDERAL REVENUES	316,139.37-	316,139.37-	7,756,313.00-	4	8
FEES	149,393.38-	149,393.38-	2,191,354.00-	7	8
EARNINGS ON INVESTMENTS	2,309.53-	2,309.53-	8,400.00-	27	8
MISCELLANEOUS REVENUES	155,030.00-	155,030.00-	993,200.00-	16	8
TOTAL REVENUES	986,454.55-	986,454.55-	26,530,600.00-	4	8
EXPENDITURES					
PROGRAM EXPENDITURES	723,886.31	723,886.31	10,064,471.00	7	8
PAYROLL AND BENEFITS	1,071,985.95	1,071,985.95	13,733,885.00	8	8
OTHER EXPENDITURES	214,106.28	214,106.28	2,732,244.00	8	8
TOTAL EXPENDITURES	2,009,978.54	2,009,978.54	26,530,600.00	8	8

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					8
			Expend.	6,162.50	6,162.50	160.00	3,852	8
			Net	6,162.50	6,162.50	160.00	3,852	8
930 PROGRAM	Administration		Revenue	233,660.15-	233,660.15-	939,995.00-	25	8
			Expend.	49,064.23	49,064.23	614,515.00	8	8
			Net	184,595.92-	184,595.92-	325,480.00-	57	8
410 DEPT	General Administration	Totals:	Revenue	233,660.15-	233,660.15-	939,995.00-	25	8
			Expend.	55,226.73	55,226.73	614,675.00	9	8
			Net	178,433.42-	178,433.42-	325,320.00-	55	8
481 DEPT	Nursing							
100 PROGRAM	Family Health		Revenue	2,060.00-	2,060.00-	18,160.00-	11	8
			Expend.	3,085.67	3,085.67	14,764.00	21	8
			Net	1,025.67	1,025.67	3,396.00-	30-	8
103 PROGRAM	Follow Along Program		Revenue	2,899.50-	2,899.50-	26,966.00-	11	8
			Expend.	2,967.06	2,967.06	35,676.00	8	8
			Net	67.56	67.56	8,710.00	1	8
110 PROGRAM	TANF		Revenue	0.00	0.00	127,876.00-	0	8
			Expend.	36,675.41	36,675.41	127,876.00	29	8
			Net	36,675.41	36,675.41	0.00	0	8
130 PROGRAM	WIC		Revenue	37,973.00-	37,973.00-	435,696.00-	9	8
			Expend.	40,347.34	40,347.34	467,435.00	9	8
			Net	2,374.34	2,374.34	31,739.00	7	8
140 PROGRAM	Peer Breastfeeding Support Program		Revenue	0.00	0.00	78,244.00-	0	8
			Expend.	5,072.02	5,072.02	78,244.00	6	8
			Net	5,072.02	5,072.02	0.00	0	8
210 PROGRAM	CTC Outreach		Revenue	19,474.51-	19,474.51-	271,412.00-	7	8
			Expend.	17,117.45	17,117.45	271,412.00	6	8
			Net	2,357.06-	2,357.06-	0.00	0	8
270 PROGRAM	Maternal Child Health		Revenue	4,424.30-	4,424.30-	334,648.00-	1	8
			Expend.	28,922.51	28,922.51	315,553.00	9	8
			Net	24,498.21	24,498.21	19,095.00-	128-	8

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	20,456.90-	20,456.90-	70,300.00-	29	8
			Expend.	2,252.69	2,252.69	48,549.00	5	8
			Net	18,204.21-	18,204.21-	21,751.00-	84	8
285 PROGRAM	MCH Blood Lead		Revenue	0.00	0.00	1,000.00-	0	8
			Expend.	184.29	184.29	0.00	0	8
			Net	184.29	184.29	1,000.00-	18-	8
295 PROGRAM	MCH Car Seat Program		Revenue	1,811.60-	1,811.60-	33,200.00-	5	8
			Expend.	2,116.05	2,116.05	41,745.00	5	8
			Net	304.45	304.45	8,545.00	4	8
300 PROGRAM	Case Management		Revenue	23,665.72-	23,665.72-	368,800.00-	6	8
			Expend.	43,085.83	43,085.83	361,007.00	12	8
			Net	19,420.11	19,420.11	7,793.00-	249-	8
330 PROGRAM	MNChoices		Revenue	0.00	0.00	171,500.00-	0	8
			Expend.	23,283.37	23,283.37	293,918.00	8	8
			Net	23,283.37	23,283.37	122,418.00	19	8
603 PROGRAM	Disease Prevention And Control		Revenue	705.82-	705.82-	157,292.00-	0	8
			Expend.	15,587.12	15,587.12	240,454.00	6	8
			Net	14,881.30	14,881.30	83,162.00	18	8
660 PROGRAM	MIIC		Revenue	0.00	0.00	1,500.00-	0	8
			Expend.	48.66	48.66	0.00	0	8
			Net	48.66	48.66	1,500.00-	3-	8
481 DEPT	Nursing	Totals:	Revenue	113,471.35-	113,471.35-	2,096,594.00-	5	8
			Expend.	220,745.47	220,745.47	2,296,633.00	10	8
			Net	107,274.12	107,274.12	200,039.00	54	8
483 DEPT	Health Education							
500 PROGRAM	Direct Client Services		Revenue	45.66-	45.66-	2,770.00-	2	8
			Expend.	1,446.01	1,446.01	61,613.00	2	8
			Net	1,400.35	1,400.35	58,843.00	2	8
510 PROGRAM	SHIP		Revenue	75,242.03-	75,242.03-	224,631.00-	33	8
			Expend.	15,796.44	15,796.44	220,396.00	7	8
			Net	59,445.59-	59,445.59-	4,235.00-	1,404	8
550 PROGRAM	P&I Grant		Revenue	33,184.00-	33,184.00-	188,679.00-	18	8
			Expend.	10,237.71	10,237.71	186,869.00	5	8
			Net	22,946.29-	22,946.29-	1,810.00-	1,268	8

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	0.00	98,295.00-	0	8
			Expend.	8,296.67	8,296.67	124,290.00	7	8
			Net	8,296.67	8,296.67	25,995.00	32	8
901 PROGRAM	Med Reserve Corps		Revenue					8
			Expend.	3.01	3.01	0.00	0	8
			Net	3.01	3.01	0.00	0	8
483 DEPT	Health Education	Totals:	Revenue	108,471.69-	108,471.69-	514,375.00-	21	8
			Expend.	35,779.84	35,779.84	593,168.00	6	8
			Net	72,691.85-	72,691.85-	78,793.00	92-	8
485 DEPT	Environmental Health							
800 PROGRAM	Environmental		Revenue	132,909.80-	132,909.80-	229,000.00-	58	8
			Expend.	23,842.25	23,842.25	275,682.00	9	8
			Net	109,067.55-	109,067.55-	46,682.00	234-	8
820 PROGRAM	Healthy Homes Grant		Revenue	0.00	0.00	20,000.00-	0	8
			Expend.	219.75	219.75	19,806.00	1	8
			Net	219.75	219.75	194.00-	113-	8
830 PROGRAM	FDA Standardization Grant		Revenue	21.40	21.40	0.00	0	8
			Expend.	7.90	7.90	0.00	0	8
			Net	29.30	29.30	0.00	0	8
485 DEPT	Environmental Health	Totals:	Revenue	132,888.40-	132,888.40-	249,000.00-	53	8
			Expend.	24,069.90	24,069.90	295,488.00	8	8
			Net	108,818.50-	108,818.50-	46,488.00	234-	8
1 FUND	Health Services Fund	Totals:	Revenue	588,491.59-	588,491.59-	3,799,964.00-	15	8
			Expend.	335,821.94	335,821.94	3,799,964.00	9	8
			Net	252,669.65-	252,669.65-	0.00	0	8

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					8
			Expend.	14,362.44	14,362.44	83,935.00	17	8
			Net	14,362.44	14,362.44	83,935.00	17	8
410 DEPT	General Administration	Totals:	Revenue					8
			Expend.	14,362.44	14,362.44	83,935.00	17	8
			Net	14,362.44	14,362.44	83,935.00	17	8
420 DEPT	Income Maintenance							
600 PROGRAM	Income Maint Administrative/Overhea		Revenue	65,417.72-	65,417.72-	3,246,752.00-	2	8
			Expend.	136,818.48	136,818.48	1,666,654.00	8	8
			Net	71,400.76	71,400.76	1,580,098.00-	5-	8
601 PROGRAM	Income Maint/Random Moment Payro		Revenue					8
			Expend.	194,466.01	194,466.01	2,562,216.00	8	8
			Net	194,466.01	194,466.01	2,562,216.00	8	8
602 PROGRAM	Income Maint FPI Investigator		Revenue	0.00	0.00	50,000.00-	0	8
			Expend.	4,753.32	4,753.32	61,111.00	8	8
			Net	4,753.32	4,753.32	11,111.00	43	8
605 PROGRAM	MN Supplemental Aid (MSA)/GRH		Revenue	4,837.46-	4,837.46-	28,000.00-	17	8
			Expend.	0.00	0.00	18,750.00	0	8
			Net	4,837.46-	4,837.46-	9,250.00-	52	8
610 PROGRAM	TANF(AFDC/MFIP/DWP)		Revenue	396.00-	396.00-	25,000.00-	2	8
			Expend.	0.00	0.00	19,550.00	0	8
			Net	396.00-	396.00-	5,450.00-	7	8
620 PROGRAM	General Asst (GA)/General Relief/Buri		Revenue	806.50-	806.50-	25,000.00-	3	8
			Expend.	22,856.99	22,856.99	251,250.00	9	8
			Net	22,050.49	22,050.49	226,250.00	10	8
630 PROGRAM	Food Support (FS)		Revenue	11,734.00-	11,734.00-	516,000.00-	2	8
			Expend.	0.00	0.00	7,500.00	0	8
			Net	11,734.00-	11,734.00-	508,500.00-	2	8
640 PROGRAM	Child Support (IVD)		Revenue	60,412.33-	60,412.33-	1,653,893.00-	4	8
			Expend.	95,796.00	95,796.00	1,153,303.00	8	8
			Net	35,383.67	35,383.67	500,590.00-	7-	8

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	185,677.67-	185,677.67-	3,350,000.00-	6	8
			Expend.	144,303.60	144,303.60	2,476,000.00	6	8
			Net	41,374.07-	41,374.07-	874,000.00-	5	8
680 PROGRAM	Refugee Cash Assistance (RCA)		Revenue	0.00	0.00	1,000.00-	0	8
			Expend.					8
			Net	0.00	0.00	1,000.00-	0	8
420 DEPT	Income Maintenance	Totals:	Revenue	329,281.68-	329,281.68-	8,895,645.00-	4	8
			Expend.	598,994.40	598,994.40	8,216,334.00	7	8
			Net	269,712.72	269,712.72	679,311.00-	40-	8
431 DEPT	Social Services							
700 PROGRAM	Social Service Administrative/Overhea		Revenue	156,453.44-	156,453.44-	9,991,780.00-	2	8
			Expend.	233,904.22	233,904.22	2,754,328.00	8	8
			Net	77,450.78	77,450.78	7,237,452.00-	1-	8
701 PROGRAM	Social Services/SSTS		Revenue					8
			Expend.	566,142.75	566,142.75	7,149,115.00	8	8
			Net	566,142.75	566,142.75	7,149,115.00	8	8
710 PROGRAM	Children's Social Services Programs		Revenue	56,818.90-	56,818.90-	1,946,098.00-	3	8
			Expend.	319,947.25	319,947.25	3,619,941.00	9	8
			Net	263,128.35	263,128.35	1,673,843.00	16	8
712 PROGRAM	CIRCLE Program		Revenue	5,000.00-	5,000.00-	5,000.00-	100	8
			Expend.	244.42	244.42	8,000.00	3	8
			Net	4,755.58-	4,755.58-	3,000.00	159-	8
713 PROGRAM	"SELF Program" Grant		Revenue	0.00	0.00	54,100.00-	0	8
			Expend.	369.30	369.30	54,100.00	1	8
			Net	369.30	369.30	0.00	0	8
715 PROGRAM	Childrens Waivers		Revenue	8,627.68-	8,627.68-	105,000.00-	8	8
			Expend.	0.00	0.00	10,000.00	0	8
			Net	8,627.68-	8,627.68-	95,000.00-	9	8
716 PROGRAM	FGDM/Family Group Decision Making		Revenue	15,575.71-	15,575.71-	56,914.00-	27	8
			Expend.	1,297.15	1,297.15	56,914.00	2	8
			Net	14,278.56-	14,278.56-	0.00	0	8
717 PROGRAM	AR/Alternative Response Discretion F		Revenue	0.00	0.00	55,175.00-	0	8
			Expend.	810.20	810.20	55,175.00	1	8
			Net	810.20	810.20	0.00	0	8

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
718 PROGRAM	PSOP/Parent Support Outreach Progra		Revenue	0.00	0.00	40,446.00-	0	8
			Expend.	2,078.33	2,078.33	40,446.00	5	8
			Net	2,078.33	2,078.33	0.00	0	8
720 PROGRAM	Ch Care/Ch Prot		Revenue	2,750.00-	2,750.00-	30,000.00-	9	8
			Expend.	0.00	0.00	4,500.00	0	8
			Net	2,750.00-	2,750.00-	25,500.00-	11	8
721 PROGRAM	CC-Basic Slide Fee/Cty Match to DHS		Revenue	1,551.00-	1,551.00-	40,035.00-	4	8
			Expend.	3,613.75	3,613.75	40,035.00	9	8
			Net	2,062.75	2,062.75	0.00	0	8
722 PROGRAM	Child Care/MFIP		Revenue	0.00	0.00	1,500.00-	0	8
			Expend.					8
			Net	0.00	0.00	1,500.00-	0	8
726 PROGRAM	MFIP/SW MN PIC		Revenue	962.00-	962.00-	13,000.00-	7	8
			Expend.					8
			Net	962.00-	962.00-	13,000.00-	7	8
730 PROGRAM	Chemical Dependency		Revenue	12,029.23-	12,029.23-	293,000.00-	4	8
			Expend.	42,771.28	42,771.28	434,000.00	10	8
			Net	30,742.05	30,742.05	141,000.00	22	8
741 PROGRAM	Mental Health/Adults Only		Revenue	65,744.12-	65,744.12-	1,210,635.00-	5	8
			Expend.	78,698.03	78,698.03	1,598,082.00	5	8
			Net	12,953.91	12,953.91	387,447.00	3	8
742 PROGRAM	Mental Health/Children Only		Revenue	100,000.97-	100,000.97-	864,383.00-	12	8
			Expend.	75,505.18	75,505.18	1,405,984.00	5	8
			Net	24,495.79-	24,495.79-	541,601.00	5-	8
750 PROGRAM	Developmental Disabilities		Revenue	54,358.26-	54,358.26-	856,835.00-	6	8
			Expend.	29,021.07	29,021.07	428,185.00	7	8
			Net	25,337.19-	25,337.19-	428,650.00-	6	8
760 PROGRAM	Adult Services		Revenue	105,992.71-	105,992.71-	1,355,500.00-	8	8
			Expend.	2,022.37	2,022.37	88,800.00	2	8
			Net	103,970.34-	103,970.34-	1,266,700.00-	8	8
765 PROGRAM	Adults Waivers		Revenue	68,206.85-	68,206.85-	680,000.00-	10	8
			Expend.	6,178.01	6,178.01	81,250.00	8	8
			Net	62,028.84-	62,028.84-	598,750.00-	10	8

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
431 DEPT	Social Services	Totals:	Revenue	654,070.87-	654,070.87-	17,599,401.00-	4	8
			Expend.	1,362,603.31	1,362,603.31	17,828,855.00	8	8
			Net	708,532.44	708,532.44	229,454.00	309	8
461 DEPT	Information Systems							
0 PROGRAM	...		Revenue	3,102.00-	3,102.00-	35,554.00-	9	8
			Expend.	34,018.39	34,018.39	401,476.00	8	8
			Net	30,916.39	30,916.39	365,922.00	8	8
461 DEPT	Information Systems	Totals:	Revenue	3,102.00-	3,102.00-	35,554.00-	9	8
			Expend.	34,018.39	34,018.39	401,476.00	8	8
			Net	30,916.39	30,916.39	365,922.00	8	8
5 FUND	Human Services Fund	Totals:	Revenue	986,454.55-	986,454.55-	26,530,600.00-	4	8
			Expend.	2,009,978.54	2,009,978.54	26,530,600.00	8	8
			Net	1,023,523.99	1,023,523.99	0.00	0	8
FINAL TOTALS	925 Accounts		Revenue	1,574,946.14-	1,574,946.14-	30,330,564.00-	5	8
			Expend.	2,345,800.48	2,345,800.48	30,330,564.00	8	8
			Net	770,854.34	770,854.34	0.00	0	8

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			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			
	2647	**604**	**3251**

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		293	59	862	17	338	453	330	2647
February												0
March												
April												
May												
June												
July												
August												
September												
October												
November												
December												
	12	**270**	**13**	**#DIV/0!**	**293**	**59**	**862**	**17**	**338**	**453**	**330**	**1324**

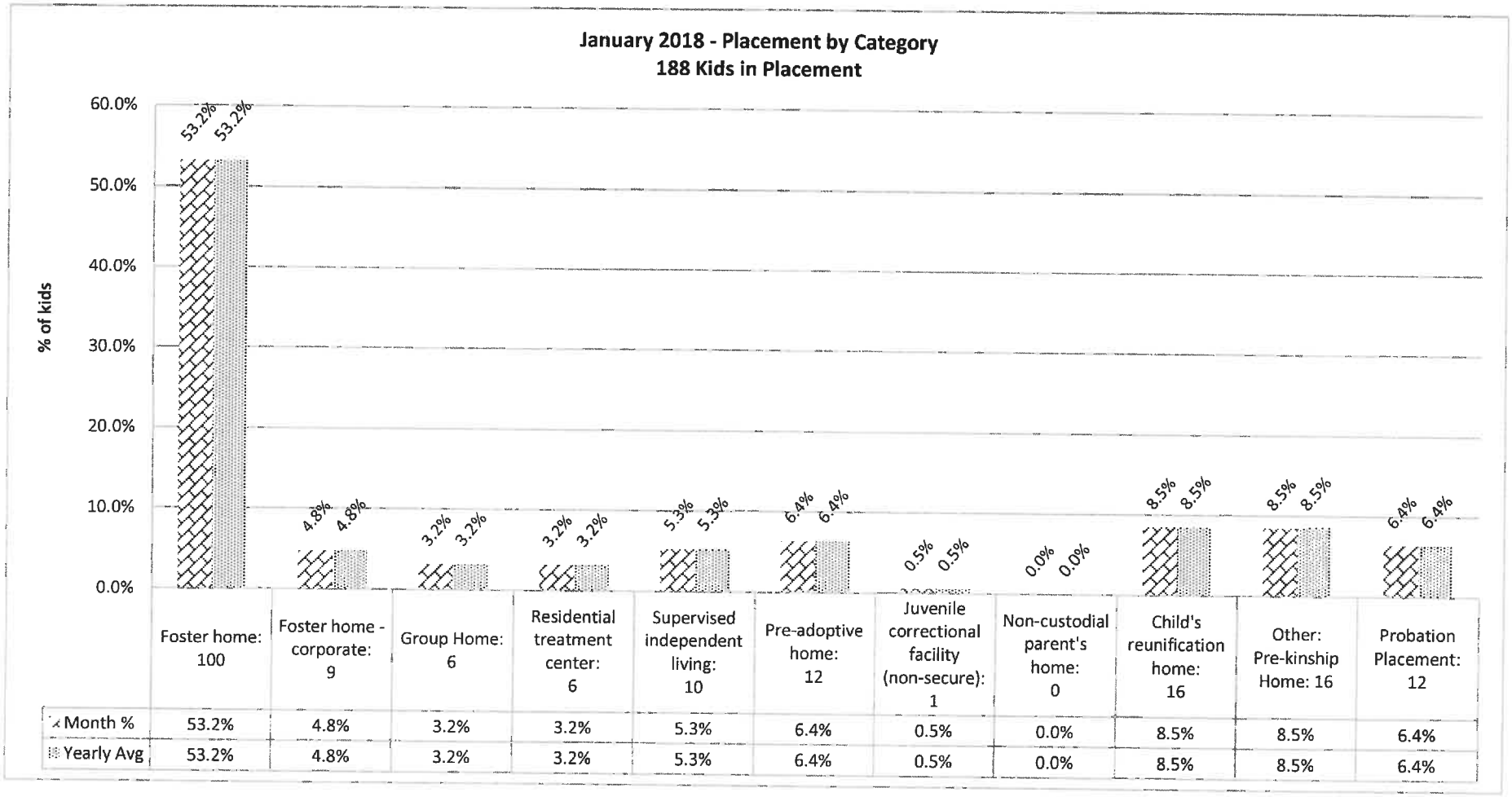
Children's - Social Services Caseload

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												0
March												
April												
May												
June												
July												
August												
September												
October												
November												
December												
	46	20	0	10	34	188	184	104	0	0	18	302

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												6	7
Lyon	46												46	38
Murray	11												11	10
Pipestone	15												15	19
Redwood	96												96	95
Rock	14												14	16
Monthly Totals	**188**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		



	Foster home: 100	Foster home - corporate: 9	Group Home: 6	Residential treatment center: 6	Supervised independent living: 10	Pre-adoptive home: 12	Juvenile correctional facility (non-secure): 1	Non-custodial parent's home: 0	Child's reunification home: 16	Other: Pre-kinship Home: 16	Probation Placement: 12
Month %	53.2%	4.8%	3.2%	3.2%	5.3%	6.4%	0.5%	0.0%	8.5%	8.5%	6.4%
Yearly Avg	53.2%	4.8%	3.2%	3.2%	5.3%	6.4%	0.5%	0.0%	8.5%	8.5%	6.4%

January 2018: Total kids in placement = 188

Total of 15 Children entered placement

1	Lincoln	Probation
6	Lyon	Foster Home
4	Redwood	Foster Home
3	Redwood	Probation
1	Rock	Probation

Total of 12 Children were discharged from placement (discharges from previous month)

2	Lyon	Adopted
2	Lyon	Child's Reunification Home
1	Lyon	Probation
1	Murray	Probation
1	Pipestone	Adopted
1	Pipestone	Child's Reunification Home
1	Redwood	Adopted
2	Redwood	Probation
1	Rock	Residential Treatment

NON IVD COLLECTIONS

JANUARY 2018

PROGRAM	ACCOUNT	TOTAL
MSA/GRH	05-420-605.5802	4,837
TANF (MFIP/DWP/AFDC)	05-420-610.5803	396
GA	05-420-620.5803	421
FS	05-420-630.5803	434
CS (PI Fee, App Fee, etc)	05-420-640.5501	651
MA Recoveries & Estate Collections (25% retained by agency)	05-420-650.5803	33,328
REFUGEE	05-420-680.5803	0
CHILDRENS		
Court Visitor Fee	05-431-700.5514	863
Parental Fees, Holds	05-431-710.5501	13,530
OOH/FC Recovery	05-431-710.5803	9,025
CHILDCARE		
Licensing	05-431-720.5502	1,650
Corp FC Licensing	05-431-710.5505	1,100
Over Payments	05-431-721&722.5803	0
CHEMICAL DEPENDENCY		
CD Assessments	05-431-730.5519	2,292
Detox Fees	05-431-730.5520	4,008
Over Payments	05-431-730.5803	1,590
MENTAL HEALTH		
Insurance Copay	05-431-740.5803	0
Over Payments	05-431-741 or 742.5803	38,007
DEVELOPMENTAL DISABILITIES		
Insurance Copay/Overpayments	05-431-750.5803	0
ADULT		
Court Visitor Fee	05-431-760.5803	663
Insurance Copay/Overpayments	05-431-760.5803	3
TOTAL NON-IVD COLLECTIONS		**112,797**

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							

	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		44	21	347	46	5	17	106	45	56	22
2/18											
3/18											
4/18											
5/18											
6/18											
7/18											
8/18											
9/18											
10/18											
11/18											
12/18											

Wilder Research

2017 Community Health Needs Assessment

Findings from Focus Groups with the Hmong Community from Tracy and Walnut Grove

In summer 2017, Southwest Health and Human Services (SWHHS) contracted with Wilder Research to conduct a community health needs assessment to identify the health needs and assets of prominent cultural groups in their 6-county region. Findings from this assessment will be used to inform the services provided by SWHHS and to help staff at SWHHS understand how to adjust or target their services to meet the health needs of these communities. For this study, Wilder Research conducted five focus groups with four cultural communities located in the Southwest region. Focus groups included individuals who are part of the American Indian (Lower Sioux), Hmong, Latino, and Somali communities in Southwest Minnesota.

The study was sponsored in part by the participating counties' grants from the Minnesota Department of Health's Statewide Health Improvement Partnership (SHIP), which aims to help Minnesotans live longer, healthier lives by reducing the burden of chronic disease. Additional funding from United Way of Southwest Minnesota made it possible to conduct a second focus group with Hmong residents. Community partners including the Lower Sioux Community Health staff, United Community Action Partnership, and individuals; Khou Lor, Tina Quinones, Samira Sheikh, and Kara Thul provided space and helped with recruitment for the focus groups.

Focus group participants were asked questions about their definition of health; what helps them to be healthy, and what makes it difficult to be healthy; as well as any suggestions they have for how SWHHS can support health in their community. They were also asked specific questions about physical activity, healthy eating, and tobacco use.

This report summarizes findings from two focus groups conducted in the Hmong community in Tracy and Walnut Grove. A total of 10 individuals participated. Six participants were female and four participants were male. The age of participants ranged from early 20s to late 50s.

Definition of health

Southwest Health and Human Services defines health and wellness as a state of complete physical, mental, and social well-being rather than merely the absence of sickness. Focus group participants were invited to share what being healthy means to them.

When talking about the definition of health, participants shared a common Hmong saying *noj qab nyob zoo* [eat good, live well] which translates to health. Other common responses included physical fitness through exercise, the absence of illness, and eating healthy foods.

> *Healthy to me means preventing it if it runs in your family.*

Participants also discussed that being healthy means being happy, both mentally and physically, with their bodies.

> *Mental health is being happy with what you physically are. For physical, there are obviously some limitations to people. For example, I have high blood pressure so there are certain exercise regimes that I can't do. My body may not be super skinny…but I'm totally fine because I know my body has certain limitations. As long as I don't have no chronic diseases or anything like that, I feel healthy.*

Primary health concerns

Common health concerns among participants include chronic diseases such as stroke, diabetes, kidney failure, and high blood pressure. Other health concerns specific to different ages and sexes were: gout among men, infertility among women, obesity among youth, and fibromyalgia among elders.

> *Fertility is a huge issue among Hmong people here. Few people in town that I feel [were infertile and had trouble getting pregnant]...younger ladies too [in their 20s]. I was one of them.*

Due to the type of health insurance most of the participants have, they are not receiving dental care locally. Rather, they have to travel 1-2 hours out of town to receive services that are covered by insurance. As a result, many do not receive preventive dental care.

> *Insurance only covers dental care further away from town. Anything in town is private so a lot of the private dental places don't accept Medical Assistance. They either have to travel to Walnut Grove, [which] is a small family practice and doesn't take any new patients or they have to go further out to get dental care in Mankato or Sleepy Eye.*
>
> *And honestly, a lot of parents in this area don't work high paying jobs...even planning an appointment to the cities is hard. It has to be on a Friday or weekend only.*

Also, different generations value health care differently. For example, elders often wait until they are in physical pain to seek medical care. Whereas, the younger people seek medical care right away to prevent a bigger health problem.

> *I notice, working in dental office, that they [young people] would say, "Oh, I have a tooth ache, so I came in." They [older adults] always wait until there's an issue and then come in versus a young person who comes in to prevent it.*

Barriers to health

When asked what makes it difficult to be healthy, participants talked about a lack of health education and distrust in government agencies.

> *It's always about if they get enough education. We're a very Asian community, so if you throw them into a participation session they think the government is after them. They're on SSI so if they participate, they think the government is going to take that away from them.*

Other barriers to health were challenges related to getting exercise. Barriers ranged from lack of time, motivation, places to exercise, and transportation to gym membership costs and limited knowledge of gym equipment.

> *They don't ever use these equipment so when they do go use it, they don't know how to use it. They're afraid to use [it] because they might be embarrassed by not knowing how to use the machine. Stuff that is supposed to be done this way, but you don't know how to do it so that limits you from wanting to go because they are timid about the equipment that the gyms have.*

A lack of access to child care is also a barrier that keeps parents and elders going to a gym.

> *A lot of young folks would use the older folks as a day care center so they [older folks] don't have the luxury to go out and exercise. That creates anxiety and a lot of stress on them. It creates depression that leads to diabetes and high blood pressure for older folks. If SWHHS gives vouchers for day care we can take the parents out of the picture and offer an alternative where both the young and older folks can exercise and child care is provided.*

Resources and supports

For participants, sources of health information and support include the local clinic, social media, and classes provided by University of Minnesota Extension. Resource fairs or other events were also mentioned as potential resources. However, many members in the Hmong community cannot attend the events because it

conflicts with their work schedule. For example, events usually take place around 5pm, but that is when people are still at work or getting ready to go to work. Also, on the weekend, there are other family obligations that take precedence over a resource fair.

> *....it [resource fairs] just doesn't fit everybody's schedule because people always work late; 2nd shift or 3rd shift.*

Furthermore, participants noted that when hosting a health resource fair or an event to share health information, it is very important to get the interest and approval of the elder leaders in the community.

> *When you appease them [elder leaders] and they think what you want to present to them is valuable, they will invite others to participate. If they don't think it's valuable, they will just dismiss it and not bother to inform others.*

Participants agreed that people in their community need more health-related information and education on healthy living in terms of food and exercise. They mentioned that they have never seen health literature on tobacco use, physical activity, or nutrition at any health care offices or clinics. When asked about the best way to be provided health information, most participants said they would prefer to receive it in-person and from an expert.

> *[There are] no resources to access health information. [The] problem is that if they can read Hmong, they're more likely to be able to read English, but in our community 10% can read and write in Hmong and English. So even if it's print, it's not that accessible. So it's more visual learning; to have somebody come and teach.*

Physical activity

Participants talked about hunting and gardening as ways people in the Hmong community get physical activity.

> *I know a lot of folk do gardening. They can do that all day long if they have time for it. I don't see them participate in anything else.*

For many, there is a lack of physical activity among participants due to the types of jobs they have.

> *At my job, we sit all day, for 10-12 hours. If we do overtime we're allowed to do 14 hours...When we work, we can only sit. We are not allowed to get up.*

Additionally, children, other life responsibilities, and a lack of time and energy prevent people from engaging in physical activity.

> *I only exercise when I can because lot of youth here start working at a young age. We started when we were 12-15 years old. Family over here is more low income, so as soon as we know that we can go out and get our own money and not use our parents' money, we would go through that stage where we work and go to school at the same time. Doing that made us very tired so we stop worrying about our health because we are more worried about the money and bills at a young age. Honestly, I am that way now. Now I work at a corporation working 8-4:30 but I have to make a 30 minute drive home and then it's 5 o'clock and I'm tired. There's still things at home that I need to take care of and then I have a one or two hour window for myself. I would rather just relax because I know the next day I am going to repeat the same thing again. Working out is not a relaxation for me.*

The local fitness center was described by participants as an uncomfortable place for them. They would prefer to go to a community space where they can gather to workout with other Hmong people. Moreover, the membership is too expensive, the gym hours conflict with their work schedule, and the gym equipment is outdated.

> *The mainstream population has fitness centers, but our community doesn't have that. They could access that but they want to be more on their turf.*

Participants said that people in the Hmong community enjoy the outdoors and that there is a need for trails and parks in which people can be active. Having outdoor spaces that feel safe and are accessible could promote physical activity in the Hmong community. Additionally, participants said they would be more likely to engage

in physical activity if a financial incentive were offered through their employer or Medical Assistance.

Healthy eating

The main barriers to healthy eating for participants are affordability and access. Although many Hmong families preferred to garden and plant their own vegetables during the summer months, it is hard to find farm land for that purpose.

> *I notice that Hmong people like to eat stuff that is grown rather than buying it at the store. We farm, but we run into issues of not having land to farm our own vegetables. When that happens, we eat more meat than vegetables. Now we're limited. We're surrounded by farm land, but to find a farm land that you can use to plant your own food, we can't find that. It's hard to buy organic vegetables and it's more expensive than getting meat. If we have land where we can plant garden it'd be easier to eat healthier.*

Also, when it comes to cooking, Hmong people cook based on their knowledge, rather than following a recipe. What is considered healthy food by American standards is different from what Hmong people like to eat.

> *Obviously a hamburger is not as healthy as an apple. But with Hmong people, we don't eat apples, we eat mustard greens and that's healthy for us. In terms of healthy food, for us it's different from Americans. We don't eat apples, but it doesn't mean we don't eat healthy.*

Suggestions for increasing healthy eating in the Hmong community included providing vouchers for farmers market where low-income families can purchase fresh vegetables or connecting people to farm land where they can garden and harvest their own vegetables. Another recommendation would be to offer healthy cooking classes that educate people about smaller portions and other strategies for having a healthy diet.

Tobacco use

Through first-hand experience and education, participants felt that there is a difference in tobacco use depending on the age and generation.

> *Our generation was fresh off the boat kind of deal. You didn't know better. You never saw or never really heard about the facts of cancer. Just being educated, we are able to teach our kids. When I was young, my dad just said don't smoke. They didn't mention why. For our generation, we went through it and have seen people go through cancer from smoking. We can see how bad it is and it allows us to go back and teach our kids that it's not good.*

For the younger generation, as a result of accessibility to health education through social media, participants felt that youth today are less likely to smoke than past generations. Also, it is not as socially acceptable to smoke compared with the generation before when smoking was seen as cool.

> *With the generation that I see now, a lot of them don't smoke. I think the smoking generation started with mine and older, but a lot of these younger generation, the millennials, you don't see a lot of them smoking. So either school is doing an awesome job of teaching or everybody realizes smoking is not cool anymore and is going away from it. Down here [Walnut Grove] you can say 90% of the teens here don't smoke.*

Elders are aware of the health risks associated with tobacco use, but still choose to smoke because many do not believe in secondhand smoke and the impact it can have on others.

Participants suggested education-related materials be translated into Hmong and that the community would benefit from classes to educate people about how to quit smoking. Specifically, grants that fund community outreach efforts should be used towards educating Hmong elders about the health effects of smoking.

Mental health

Mental health was mentioned as a health concern among participants, however, this topic was not discussed because it is viewed as a sensitive subject and a private family matter that can have a negative association. For example, participants shared that the Hmong community is very small in rural Minnesota and if someone admits to seeking mental health help, everyone will know and will no longer befriend that family. Also, the Hmong language does not have a term to accurately describe mental health.

> *Older people doesn't want to be labeled mentally ill or disabled. Their egos drop. They don't see that it's okay to be mentally ill.*

Recommendations

Based on findings from these focus groups, Southwest Health and Human Services might consider:

- Hiring Hmong-speaking health care professionals and community health workers.
- Increasing access to services (human services, medical, dental, mental, and public health) near Walnut Grove and Tracy.
- Negotiating with local health clinics to accept government insurance, particularly for dental care.
- Working with regional employers to implement workplace wellness programs.
- Collaborating with community/school to create and sustain community gardens.
- Connecting existing resources/services to the community in a culturally appropriate manner.

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Saint Paul, Minnesota 55104
651-280-2700
www.wilderresearch.org

For more information
For more information about this report, contact Anna Bartholomay at Wilder Research 651-280-2701.
Authors: Pa Nhia Yang & Anna Bartholomay
September 2017

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2017 Community Health Needs Assessment

Findings from a Focus Group with the Somali Community from Marshall, MN

In summer 2017, Southwest Health and Human Services (SWHHS) contracted with Wilder Research to conduct a community health needs assessment to identify the health needs and assets of prominent cultural groups in their 6-county region. Findings from this assessment will be used to inform the services provided by SWHHS and to help staff at SWHHS understand how to adjust or target their services to meet the health needs of these communities. For this study, Wilder Research conducted five focus groups with four cultural communities located in the Southwest region. Focus groups included individuals who are part of the American Indian (Lower Sioux), Hmong, Latino, and Somali communities in Southwest Minnesota.

The study was sponsored in part by the participating counties' grants from the Minnesota Department of Health's Statewide Health Improvement Partnership (SHIP), which aims to help Minnesotans live longer, healthier lives by reducing the burden of chronic disease. Additional funding from United Way of Southwest Minnesota made it possible to conduct a second focus group with Hmong residents. Community partners including the Lower Sioux Community Health staff, United Community Action Partnership, and individuals; Khou Lor, Tina Quinones, Samira Sheikh, and Kara Thul provided space and helped with recruitment for the focus groups.

Focus group participants were asked questions about their definition of health; what helps them to be healthy, and what makes it difficult to be healthy; as well as any suggestions they have for how SWHHS can support health in their community. They were also asked specific questions about physical activity, healthy eating, and tobacco use.

This report summarizes findings from a focus group conducted in Marshall, Minnesota with 15 individuals from the Somali community. Eight participants were female and seven were male. The age of participants ranged from mid-20s to mid-60s with the majority of participants over age 40.

Definition of health

Southwest Health and Human Services defines health and wellness as a state of complete physical, mental, and social well-being rather than merely the absence of sickness. Focus group participants were invited to share what being healthy means to them. Common responses included a combination of aspects of physical and mental health.

> *[Health] means I can do everything I need to do physically. I can walk, work, and play without pain. It also means your whole body is healthy not only some parts of your body but the whole body.*

Being healthy mentally was described as being with friends and family and maintaining a job to support oneself and one's family. Participants also referred to economic health, which was described as being gainfully employed and earning enough money to pay for their expenses.

> *I can pay my rent, food, and phone bill, and support my family here and back home.*

Primary health concerns

The greatest health concern for participants is a lack of health care professionals that speak Somali and understand Somali culture.

> *There is no single health professional from the Somali community in the Lyons County area. Many young people graduate from the University here, but they get better opportunities in the cities.*

Additionally, there is a lack of clinics in the area that accept government health insurance, such as Medicaid, Medicare, and Medical Assistance.

> *I live in Marshall and the closest place that would accept my government health and dental insurance is one-hour drive away. There are clinics in town, but they don't accept my card.*

Participants also talked about health concerns among elders in their community. Elders were described as often isolated, particularly those who are not working and it was noted that there is no facility they can use to be physically active during the winter months.

Barriers to health

The main challenges that make it difficult for people in the Somali community to be healthy include the long winter, access to healthy food, access to culturally competent health care and culturally trained health care professionals, and access to clinics that are in close proximity to their home.

Recent immigrants from Somalia are accustomed to warm weather year round. Participants mentioned that it is difficult to be physically active when it is cold outside because it is not appealing to go on walks. People do not leave the house as much in the winter and, as a result, are not as active.

> *We are used to warm weather all year long, but here in Minnesota it is cold six months of the year. It is difficult to get enough sun and vitamin D.*

Most people in the Somali community eat Halal foods. Halal foods are that which adheres to Islamic law, as defined in the Koran. The Islamic form of slaughtering animals or poultry, dhabihah, involves a specific set of rules that are thought to ensure the health of the animal to be slaughtered. Unfortunately, many of these foods are processed and frozen for long periods of time. Frozen and processed foods are often the most affordable products to buy at the grocery store.

> *We eat halal meats, which mostly comes frozen from Australia. It is possible that these meats have been frozen for months or even years. We don't have a lot of good food choices in Lyons County.*

A lack of access to health care providers that speak Somali makes it difficult for community members, particularly elders, to receive the health care they need. When language is a barrier and individuals rely on translators, there is often miscommunication and physicians can miss important information regarding their patients' health.

> *Many of our community members, especially the elderly, rely on translators to communicate with health professionals. In that process, a lot gets lost in translation.*

Additionally there is a shortage of clinics nearby, which means that people have to spend a significant amount of time transporting to and from clinics to receive health care services. It also requires access to transportation, which many people in the Somali community are lacking.

> *A lot of times, when I want to go to get my teeth cleaned, I have to wait longer than I would because the clinic is too far away. [It] requires a lot of my time to go and come back.*

Lastly, the current political climate has caused stress and anxiety among members of the Somali community. Many people have family who live overseas and a proposed travel ban from President Donald Trump, barring Somalis from entering the United States has become a source of frustration and hardship among members of the Somali community.

> *The current president is trying to keep many of our families from reuniting. This causes a lot of anxiety and stress. My wife and children have been waiting for a visa to come join me for three years now and every other day, there is a news about banning immigrants and refugees from coming to the United States.*

Resources and supports

Social networks were described as a primary resource and support for health among people in the Somali community. When seeking health-related information, people from the Somali community often turn to their friends and co-workers.

When referring to where they get emotional support, participants said that they often turn to religious leaders and their religious community. The mosque was mentioned as a reliable place to receive helpful information and emotional support.

> *The Somali is oral society and we share information about good clinics and good doctors. I also rely on my community and religious leaders for emotional support. We are Muslims and we believe that only things that God prescribe will happen. I attend the mosque regularly to get information and support.*

Other resources and sources of support included community and social gatherings that are held at someone's home or elsewhere. At these gatherings people listen to music and hear storytelling from elders.

If people feel like they do not have access to the information they need they rely on technology and social media to access and share information. One participant said that if they need to they can always drive to Minneapolis to get more accurate information.

Physical activity

Participants said that many people in their community work in jobs that are physically demanding.

> *I work 8 hours a day at the Turkey plant and I am standing the whole time except my break time. I am also working with machines to process the meat and lift sometimes heavy meat.*

Additionally, many people in the Somali community do not have cars and have to walk a lot to get to where they need to go.

In order to engage in more physical activity, participants said there is a need for a gender-specific fitness center for women. It is also important that the fitness center is affordable, because they are often too expensive for people with low incomes.

> *Many Somali men and women will not exercise in a public gym because of religious observations. For example, I am a Muslim woman and I dress modestly, so I cannot go to the gym because there is no culturally appropriate sportswear for Muslim women. I don't want to take off my hijab in front of men that are not related to me. I would love to go to the YMCA and swim, but I cannot because there are men and I would be seen without my hijab.*

Healthy eating

The availability and high cost of healthy foods make it difficult for people in the Somali community to maintain a healthy diet.

> *We live in kind of rural area with few food options. We do have the big stores and some little ones, but the options are not great.*
>
> *Where you can find good quality healthy foods, the price is high. For a lot of our families, we are poor and try to buy bulk for cheap. We are always price conscious. Everyone I know is on limited budget and they are trying to make sure it lasts the whole month. Most of our families are large families and our incomes are low.*

Participants said that people in their community lack education about nutrition. People are starting to learn about which foods can cause health issues.

> *In Somalia or in the refugee camps, we did not used to get abundance of food like we do here in the United States. However, we are now realizing a lot food can cause health issues too. The Somali community traditionally uses sugar, oil, and salt a lot and we have a lot of people developing diseases such high blood pressure, diabetes, and weight issues. In Africa, we used to walk everywhere and get enough exercise, but here we use cars everywhere we go, even if we have to visit our neighbors.*

To support healthy eating in the Somali community, participants suggest that SWHHS provide education and training from culturally competent health professionals at schools and community centers. They also suggested targeting education at youth and providing healthy food and encouraging healthy eating at schools.

Use of tobacco and other substances

Tobacco use was not a concern among focus group participants. Additionally, when asked about the use of e-cigarettes or hookah, participants did not have experience seeing people using those types of tobacco products.

> *We have individuals who smoke, but we don't have community wide tobacco problem. Very few people smoke and even fewer chew tobacco.*

Participants felt like people in their community have fewer problems with alcohol and drug addiction than other communities. Some participants attributed the low incidence of addiction to the guidance their community receives from religious leaders about how to be healthy.

Additional community concerns

Participants said that they would like to attend health-related workshops for their community where they can be educated about how to improve their health. They are currently unaware of available resources and would like to be connected.

Participants also would like social service agencies and other government agencies to hire people from their community.

> *[We need] more places to host internships so that Somali college graduates can get a job and stay in the city. Our young people are easily assimilated and have better opportunities for education, but they are fleeing the small town and going to the big cities where better paying jobs are available to them. It would be great if we can have social services and government agency to hire some people from the community.*

Recommendations

Based on findings from this focus group, Southwest Health and Human Services might consider:

- Hiring Somali-speaking health care professionals and community health workers.
- Working with the Islamic Society of Marshall to provide health-related education and information.
- Negotiating with local service providers to accept government insurance.
- Working with community to create policy, systems, and environmental changes that make healthy choice the easy choice.
- Connecting existing resources/services to the community in a culturally appropriate manner.
- Partnering with local fitness centers to provide better access for Somali residents (e.g., create private workout spaces for women, offer discounts on gym memberships).

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For more information about this report, contact Anna Bartholomay at Wilder Research 651-280-2701.
Author: Anna Bartholomay
September 2017

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2017 Community Health Needs Assessment

Findings from a Focus Group with the Latino Community from Marshall, MN

In summer 2017, Southwest Health and Human Services (SWHHS) contracted with Wilder Research to conduct a community health needs assessment to identify the health needs and assets of prominent cultural groups in their 6-county region. Findings from this assessment will be used to inform the services provided by SWHHS and to help staff at SWHHS understand how to adjust or target their services to meet the health needs of these communities. For this study, Wilder Research conducted five focus groups with four cultural communities located in the Southwest region. Focus groups included individuals who are part of the American Indian (Lower Sioux), Hmong, Latino, and Somali communities in Southwest Minnesota.

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Focus group participants were asked questions about their definition of health; what helps them to be healthy, and what makes it difficult to be healthy; as well as any suggestions they have for how SWHHS can support health in their community. They were also asked specific questions about physical activity, healthy eating, and tobacco use.

This report summarizes findings from a focus group conducted in Marshall, Minnesota with 11 individuals from the Latino community. Four participants were male and seven were female.

Definition of health

Southwest Health and Human Services defines health and wellness as a state of complete physical, mental, and social well-being rather than merely the absence of sickness. Focus group participants were invited to share what being healthy means to them.

Participants talked about the activities that make people healthy, like having a balanced and nutritional diet, exercising regularly, drinking a lot of water, and getting enough sleep. People also talked about avoiding drugs and alcohol. Being healthy allows people to be active and shows the degree to which one respects themselves and their body. Some participants described aspects of health in other ways.

> *Good health is important. With good health I am able to stay active. Also, I think good health is to be able to laugh.*

Primary health concerns

Participants shared a variety of health concerns in the Latino community. The largest number of participants mentioned diabetes and depression. Other concerns included Alzheimer's disease and high cholesterol.

Two participants discussed their personal challenges and successes related to diabetes and talked about what they have learned about eating a healthy diet from their doctor.

> *I had diabetes, but after following a diet I don't have diabetes any longer. I think it was pre-diabetes. The doctor told me that I could eat everything, but in moderation. It is knowing how to eat and the amount of food I eat [that helps].*

Participants discussed depression in their community, particularly for middle-aged people and school-aged children.

> *I think depression is brought on by financial problems, work, and immigration situations. I think between 30 and 40 years of age it's more predominant.*

Two women in the group were concerned about depression among youth due to bullying and, for recent immigrants, challenges with adapting to a new environment and social landscape.

> *Depression among some of the school-age children could be brought by adaptation to the social environment as recent newcomers. I have wanted someone [government or human services organization] to come to town and address the problems and help Hispanic children. The need for help is mostly for children. Children should be the focus of help for depression*

One participant felt that men with a family (wife and children) experience depression because of the long hours they spend working to support their family and, as a result, the limited amount of time they have to spend with their family.

Barriers to health

When asked about what makes it difficult to be healthy, participants named a number of barriers. One participant said that their community lacks education about nutrition and that many people do not have the information or discipline needed to be able to choose a healthy diet. Additionally, people have formed bad habits based on what they were fed as children. Working long hours can also make it difficult to make healthy choices.

While some people in the Latino community do not have health insurance, many of those who have health insurance said that it is not accepted at clinics nearby. This is particularly true at dental clinics.

Accessing transportation to get to a medical appointment is also a challenge for many people in the Latino community. Also, participants stated that there are many employers that do not allow time off or a flexible work schedule for doctor visits.

Although there is a place that provides mental health services, there are no providers that have Spanish speaking therapists.

> *Also, lack of knowledge of English or not knowing how to read and write [is a barrier]. Medical appointments could be hard or impossible to do.*

According to participants, people in their community often wait too long to address health issues, which leads to health problems that could have been prevented.

Resources and supports

When asked about what resources or supports people in the Latino community use to be healthy and where they get health-related information, most participants mentioned specific health care facilities.

- Western Mental Health Center
- Avera Marshall Regional Medical Center
- Open Door Health Center
- Johnson Family Dental Care
- ACMC Health (known by community members as La Clinica)
- School nurse

> *Information about health is given by doctors. Also, there is some information given by SWHHS and WIC where some pamphlets are handed out, but in English. There is not a community clinic. The Johnson Family Doctor helps, but is limited to once a week.*

Physical activity

According to participants, group activities, like soccer leagues, group aerobics, or group bike rides, make it easier for people to participate in physical activity. One person said that owning a bike makes them more likely to go on bike rides.

Challenges to getting exercise include lack of time, often due to long work hours at local factories where many Latino people are employed, general motivation/ willingness, and stress. One participant felt that participating in group activities would help people who are experiencing depression.

To increase physical activity in the Latino community, participants said it is helpful if activities are free or low cost. Additionally, people are more likely to attend information sessions and other events if the information is presented in Spanish and by a Spanish speaker.

> *One of the problems is the language. They need to communicate in Spanish.*

Healthy eating

Participants agreed that it is healthier to cook and eat at home rather than out at restaurants. Planting their own vegetables or buying produce from farmers markets was one way participants felt they could improve their eating habits. Most participants focused on individual-level changes rather than environmental factors to increase healthy eating, however, some participants said that food support from WIC, a Special Supplemental Nutrition Program for Women, Infants, and Children, has helped their family access healthy foods.

> *WIC helps. With food stamps you can only buy healthy food. We have also the farmers market.*

Frequent eating at restaurants or fast food places and lack of time for grocery shopping and cooking are the main factors that make it difficult for participants to have a healthy diet.

Tobacco use

Participants were well aware of the harmful health consequences of tobacco use. Tobacco use was described as affecting lungs and causing cancer. Several participants described the negative effects on appearance (e.g., causes wrinkles) and the unattractive smell of those who smoke. Secondhand smoke was also understood as detrimental to one's health.

> *The mouth of smokers smell, it affects the lungs, and from a religious point of view, the body is God's temple. Smoking (cigarettes or marijuana) also affects mental health.*

People are seen smoking most frequently outside of bars, dance halls, the work place, and the casino. Most people said they mostly see young people smoking, but some felt that older folks smoke as well.

Addiction, the lack of advice to quit, and internal motivation make it difficult for people to quit according to participants.

Participants shared a lot of ideas about how to prevent youth in the Latino community from using tobacco. Some participants suggested providing educational programs at schools and emphasizing the importance and benefits of extracurricular activities, while others suggested fear-inducing strategies (e.g., showing the negative consequences of tobacco use: cancer, unattractive appearance, etc.)

> *Less number of commercials where smoking is shown as glamorous.*
>
> *[Involvement in] sports, different activities.*
>
> *Help make young people feel good about being in sports.*

According to participants, e-cigarettes are not commonly used in the Latino community.

Recommendations

Based on findings from this focus group, Southwest Health and Human Services might consider:

- Working with local employers to implement workplace wellness programs.
- Negotiating with local health clinics to accept government insurance.
- Hiring Spanish-speaking health care professional and community health workers.
- Offering free or low-cost group fitness activities.

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For more information
For more information about this report, contact Anna Bartholomay at Wilder Research 651-280-2701.
Author: Anna Bartholomay
September 2017

Wilder Research

2017 Community Health Needs Assessment

Findings from a Focus Group with the Lower Sioux Community from Lower Sioux Reservation

In summer 2017, Southwest Health and Human Services (SWHHS) contracted with Wilder Research to conduct a community health needs assessment to identify the health needs and assets of prominent cultural groups in their 6-county region. Findings from this assessment will be used to inform the services provided by SWHHS and to help staff at SWHHS understand how to adjust or target their services to meet the health needs of these communities. For this study, Wilder Research conducted five focus groups with four cultural communities located in the Southwest region. Focus groups included individuals who are part of the American Indian (Lower Sioux), Hmong, Latino, and Somali communities in Southwest Minnesota.

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Focus group participants were asked questions about their definition of health; what helps them to be healthy, and what makes it difficult to be healthy; as well as any suggestions they have for how SWHHS can support health in their community. They were also asked specific questions about physical activity, healthy eating, and tobacco use.

This report summarizes findings from a focus group conducted on the Lower Sioux Reservation with 13 individuals from the Lower Sioux community. Eight participants were female and five participants were male. The age of participants ranged from early 20s to mid-60s.

Definition of health

Southwest Health and Human Services defines health and wellness as a state of complete physical, mental, and social well-being rather than merely the absence of sickness. Focus group participants were invited to share what being healthy means to them.

Common responses included comments about being physically fit, exercising, and avoiding unhealthy foods. Some participants mentioned making regular visits to the doctor and taking preventive measures to avoid developing chronic diseases. Others suggested spending time with family, being able to take care of oneself, and having access to basic needs like clean water and nutritious food.

> *Taking care of yourself in every aspect: sober, mental health, taking of yourself spiritually as well. Sundance is part of our way of taking care of ourselves with our prayer.*

Participants also discussed mental health, spiritual health, and sobriety as key components of health in the Lower Sioux community. Most viewed physical, mental, and spiritual health as interconnected.

Primary health concerns

Common health concerns among participants include chronic diseases such as diabetes and high blood pressure, addiction (e.g., drugs, alcohol, tobacco, sex, gambling, abuse), and mental health problems. Several participants discussed the co-occurrence and interconnectedness of mental health and addiction.

In response to laughter from another participant:

> *You have to learn how to educate more on mental health. It's serious. It's not something to laugh about or joke about. A lot of us have it really bad so it's not a funny thing.*

There are currently not enough resources on the reservation to keep up with the demand for mental health care and treatment, particularly among youth.

> *[The clinic] needs [to add] a mental health provider [to their staff]. I went through a lot and for 5 years I probably can count 20 different therapists and providers. I usually have to wait 6 [weeks] just to get one appointment. It gets tiring and you just want to quit. You need something stable and [to] refer us somewhere that isn't already packed.*

Some participants felt that mental health problems stem from spiritual problems. Others talked about changes in culture and daily life that have led to changes in mental health and well-being in the community. Suggestions to improve mental health issues in the community included training for police officers to address mental health issues when making arrests, visiting a medicine man to treat mental illness, and having access to consistent and available mental health professionals who are from the native community and understand trauma that has been passed down through generations.

There are many families who foster children on the reservation. Some participants talked about the importance of good parenting on the health of children and the needs for education on how to be a good parent.

Barriers to health

When asked what makes it difficult to be healthy, participants talked about individual-level challenges, such as the time and discipline needed to change habits or the effect an addiction has on a person's health. They also talked about challenges that they felt were outside of their control. One participant discussed the difficulties of taking multiple medications and the side effects they have experienced as a result. Another participant said they were unable to afford healthy food.

The health-related consequences of tobacco use are a significant health concern in the Lower Sioux community. Participants talked about the challenge of quitting smoking when many people in their household and living on the reservation use tobacco regularly.

> *I think with environment, especially on the rez [makes] it difficult. My whole family smokes. So being a smoker myself and trying to quit smoking, I come home and everyone is smoking a cig, so it's hard to...I don't necessarily say hold yourself accountable, but you don't have role models to show you other ways.*

Resources and supports

The main sources of health information and supports are the local clinic, newsletter, social media, and schools.

The group shared specific experiences about what supports their health. For example, one woman enjoys attending a group called 'Diabetes Bingo,' despite not having diabetes, because healthy food is served at each event and it is a social gathering. Another participant talked about the benefit of past events held at the recreation center such as health fairs and Cooking Matters© cooking classes provided by University of Minnesota Extension.

Despite some of these efforts, participants agreed that people in their community need more health-related information and education.

Physical activity

Participants felt that a lack of time and money often prevented them from engaging in physical activity. They also mentioned barriers such as a lack of paved trails, transportation issues, and low motivation.

> *Honestly, we do have a lot of programs like that here on our reservation, but we don't have a lot of time to participate, maybe due to illness, being too old, not motivated.*

Participants identified the recreation center as a place where people could exercise, but felt there was a need for childcare in order to make this option practical for parents. Participants also said they would be more motivated to exercise at the recreation center's facilities if a personal trainer were available and if they had other people to exercise with. One participant talked about how the discount they get on their health insurance motivates them to visit the local gym.

Participants suggested that SWHHS work with the Lower Sioux community to organize exercise groups and provide opportunities and events for people to engage in active living (e.g., walking groups, nature walks, and fishing activities by the river). SWHHS might also consider funding activities for children. Children in the Lower Sioux community often lack the necessary sports equipment because it is too expensive. It is particularly challenging for families to pay for fees or equipment when there are several children in a household.

Healthy eating

The main barriers to healthy eating for participants include affordability and access. The only store on the reservation (C-Store) does not sell produce or other healthy grocery items. The closest grocery store is located in Redwood Falls, and for individuals with limited transportation and low incomes it can be difficult to get there frequently enough to have a consistently healthy diet. Children especially spend their money on the cheapest and most readily available items, which are often unhealthy, processed foods available in the C-Store.

Participants did say that they were sometimes able to access healthy foods though dinners provided by the local clinic, but noted that children are often not willing to eat healthy food.

> *[The] best healthy dinners are the ones they put on at the clinic. Some of those healthy foods they provide a lot of kids don't like it, but I make my kids try it.*

Overall, participants expressed a desire to eat healthier foods and to learn about gardening, cooking, and other ways to increase their access to healthy foods.

> *Personally, I want to learn how to start my own garden and how to can. It'd be better for us too. It's just that, where do you find that education piece besides Pinterest?*

Suggestions for increasing healthy eating included having an end-of-season farmers market where people who have gardens or hunt can sell their food, or working toward getting a Kwik Trip or similar store to open on the reservation. Participants noted that there is a free summer lunch program available to children in Redwood Falls and felt that children on the reservation would benefit from similar programming. Participants also felt their community would appreciate information, education, and programming from SWHHS about healthy eating and would like to learn more about potential services that they may not know about.

Tobacco use

Despite the prevalence of tobacco use in their community, participants felt that people understand the health risks associated with tobacco use. An understanding of the negative health effects of tobacco use has increased in the community as a result of programs and commercials that educate people about the harms of secondhand smoke.

> *My mom had lung cancer and my step-mom had COPD from smoking cigs. As far as second-hand smoke, I've seen commercials, but I don't know anybody who got sick from secondhand smoke. I believe it's real. I think in our community we have more knowledge nowadays since we started the tobacco programs.*

Participants believe that youth are less likely than past generations to start smoking cigarettes, but are more likely to use e-cigarettes or vaporizers.

Tobacco use is most commonly seen among people at casinos, elders, young people, and drinkers. Several participants talked about the use of tobacco to self-medicate and avoid difficult emotions or to cope with mental illnesses like anxiety and depression. One participant felt that quitting one addictive behavior had caused them to start another.

> *One habit leads to another habit. I stopped drinking. It's been years now [since I drank], but [now] I smoke.*

Traditional and commercial tobacco are different in the way that they are planted, harvested, prepared, and used. Two participants felt that they became addicted to tobacco during ceremonies due to the use of commercial tobacco instead of traditional tobacco, known as "Cansasa" by the Lower Sioux community. Although commercial tobacco is easier to access than traditional tobacco, participants said that they have been to many ceremonies where only traditional tobacco is used.

The lack of support from family and friends and within the environment, where they are surrounded by others who smoke, are what make is most difficult for people in the Lower Sioux community to quit smoking.

> *Environment and lack of support. They have AA (Alcoholics Anonymous) stuff for alcohol and NA (Narcotics Anonymous), but nothing for tobacco. We need a support group to get through this.*

Suggestions for helping people quit smoking include taxation, smoking cessation programs and products, and making Jackpot Casino a smoke-free building. Ideas to prevent youth from smoking include making tobacco products less visible in the C-Store and providing activities for youth.

E-cigarette use

According to participants, youth use e-cigarettes more often than regular cigarettes. Because the health effects of e-cigarettes are not yet known they are not viewed as negatively as regular cigarettes, and 'vaping' (smoking e-cigarettes) is viewed as a cool activity among youth in the community. One participant thought that youth are enticed by the flavors and intrigued by e-cigarettes because they are electronic and battery-operated.

> *Smoking [used to be] glamorous; I guess now it's vaping.*

Recommendations

Based on findings from this focus group, Southwest Health and Human Services might consider:

- Partnering with the Lower Sioux Health Care Center to provide additional mental health supports for Lower Sioux residents.
- Working with the Redwood Area School District to provide mental health services, specifically for American Indian youth.
- Providing parenting classes to help parents to model healthy behaviors and make healthy decisions for their children.
- Offering group fitness activities and corresponding child care at the Lower Sioux recreation center.
- Providing funds for children's athletic equipment.

Recommendations (continued)

- Working with community partners to organize a weekly or monthly farmer's market during the summer months.
- Working with the C-Store to provide some healthier food options and to adjust their product placement so that flavored tobacco products are less visible.
- Continuing to support policy systems, and environmental (PSE) initiatives for long-term health outcomes.
- Collaborating with community to create and sustain community gardens and provide educational opportunities for community members to learn gardening and food preparation and preservation skills.
- Connecting existing resources/services to the community in a culturally appropriate manner.

For access to other reports, visit http://www.swmhhs.com/public-health-assessment-and-planning/

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Saint Paul, Minnesota 55104
651-280-2700
www.wilderresearch.org

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For more information
For more information about this report, contact Anna Bartholomay at Wilder Research 651-280-2701.
Author: Anna Bartholomay
September 2017

SOUTHWEST HEALTH AND HUMAN SERVICES
QUALITY COUNCIL CHARTER

I. Purpose of the Quality Council

The Quality Council (QC) is chartered by the Governing Board of Southwest Health and Human Services to create, implement, maintain, and evaluate the quality improvement efforts at Southwest Health and Human Services and to support the Executive Team ~~Committee~~ in building a culture of continuous quality improvement (QI) throughout the organization.

II. Glossary of Terms

Quality Improvement: an integrative process that links knowledge, structures, processes, and outcomes to enhance quality throughout an organization.

Continuous Quality Improvement: an intentional, ongoing effort to improve the efficiency, effectiveness, quality or performance of services, processes, capacities and outcomes. QI efforts can include evaluation and improvement of all processes and programs that have either direct or indirect impact on the quality experience by both internal and external customers.

Quality Improvement Plan: a document that outlines the ~~quality improvement~~QI activities of the agency and how the ~~quality improvement~~QI program is integrated into the daily activities of the agency.

Quality Council Work Plan: a log that identifies and prioritizes specific areas of current performance for improvement, establishes targets and timelines, and assigns responsibility for carrying out the improvement efforts.

Goals: What you are trying to do with your activity?

Objectives: What is the percent or number that you are targeting with your change?

Outcome: Did you meet your objective?

III. Council Responsibilities and Scope

The Quality Council's work is not intended to replace quality improvement and program evaluation responsibilities of the agency leadership or staff; rather it is to support leadership and staff by providing training, resources, and structures to support ~~quality improvement~~QI efforts performed by leaders and staff. The ~~Council~~QC will draft an annual work plan with specific activities, timelines and accountabilities to achieve these objectives:

A. Identify and/or approve quality improvement projects and create an annual QI plan; monitor plan performance; analyze performance gaps; and make recommendations for closing gaps.
B. Review the QI plan at least annually and adjust as required to reflect current and emerging priorities.
C. Review National Accreditation Standards at least annually and make recommendations to improve compliance to standards.
D. Review Local Public Health Assessment and Planning Process components and submit final products to the Minnesota Department of Health by deadline.

E. Evaluate and meet QI training needs within Council capabilities; identify and seek resources needed to provide additional training.
F. Provide guidance and technical assistance to staff engaged in QI projects.
G. Communicate to all staff about QI efforts; recognize efforts and celebrate successes; provide staff access to training materials and tools.

IV. Council Membership and Meetings

The Quality Council consists of a cross sectional representation of the agency and will be composed of no more than 15 members. The agency director is a standing ex-officio member, the accreditation ~~QI~~ coordinator and the agency planner are standing members of the ~~council~~QC, and management and staff are equally represented. Members will be appointed by the Quality Council. Membership terms are two years with no more than half of total membership rotating off in any calendar year. Members can serve subsequent terms without limit. ~~The QI coordinator will serve as first chairperson for a term of two years and then T~~the ~~council~~QC will appoint a chairperson for two year terms. The ~~Council~~QC will meet quarterly or more often as needed for approximately one hour.

V. Guiding Principles

The ~~Council~~QC will operate using the following principles:

A. It will ground its work on the ~~CQI (~~Continuous Quality Improvement~~)~~ (CQI) methodology and employ CQI tools to understand and improve outcomes.
B. Its decisions will be data-driven and evidence-based, but will also use and respect people's knowledge and experience.
C. It will make the customer perspective central to its decision-making and strive to consistently meet or exceed customer expectations.
D. Its processes will be transparent, collaborative and inclusive.
E. It will foster engagement and accountability with all persons involved in the CQI effort.
F. It will focus on learning and improvement over judgment and blame, and value prevention over correction.

VI. Team Norms

A. ~~Council~~QC members will participate at meetings and will respectively allow participation of all members.
~~B. Decisions will be made via motion, second and vote of aye or nay.~~
B. The QC will come to consensus on decisions that are needed to move the work forward.
C. Members will miss no more than 25% (3) of meetings.
D. Members will review materials and be prepared for meetings.
E. Members will respect confidentiality of meeting discussions and member discussions, as appropriate.

VII. Annual Quality Council Work Plan

~~.~~ The objectives in the ~~Council~~QC work plan will mirror their responsibilities as noted in this Charter. The ~~Council~~QC will design specific activities to achieve these objectives, will assign a lead person to be responsible for each activity, and will set a deadline for completion of each activity. ~~The work plan will contain an evaluation plan to measure Council performance.~~ The work plan will take the form of a log of prioritized QI opportunities. These may have been identified by the ~~Council~~QC or recommended to the ~~Council~~QC by leadership or other staff. The log is a living document and will adapt to changes in the organization. New items will be added as others are completed. Projects will be approved following these areas of focus: ~~See below~~

~~2.~~1. ~~-~~Administrative and financial ;process improvements; fiscal audit results
~~3.~~2. Customer Experience
~~4.~~3. Accreditation performance gaps
~~5.~~4. Community Health Indicators
~~6.~~5. After-action findings from emergency preparedness exercises or other events
~~7.~~6. Quality of care
~~8.~~7. Workplace environmental/staff satisfaction
8. Individual program performance~~.~~
9. Projects identified through Performance Management process

Projects not selected for approval will be returned to the project proposer with an explanation of the ~~council~~QC decision. These projects can be pursued within the appropriate program and will receive ~~Council~~QC support, as needed.

A. The ~~Council~~QC will develop reporting forms, a file storage system and other administrative processes that support and document their work. The Executive Team will approve the ~~Council~~QC work plan annually and will receive regular work plan updates ~~quarterly~~. A current work plan and all ~~Council~~QC meeting minutes will be made available to all agency staff.
B. The ~~Council~~QC will operate under an annual schedule in which appropriate subject matter leads will attend a ~~Council~~QC meeting to report on progress for existing QI log items from their area. The subject matter expert will complete a report using the QI Project Tracking Form, and will present actual to target performance, barriers to reaching target, plans for addressing barriers and examples of successes and learning. The ~~Council~~QC will provide advice and technical assistance as needed.
C. The ~~Council~~QC will review its charter, its work plan, and all related processes annually to ensure they remain adaptive to change and meet the needs of all who are impacted by QI efforts. The evaluation will include comparison of actual results to target, problem identification and analysis for gaps in performance, and plans for improving performance. The QC w~~W~~ill conduct a Quality Maturity Survey every other year to measure progress of agency. ~~The Council will survey a representative sample of stakeholders annually to ensure the level of satisfaction with the Council's work and processes. The survey will also solicit training needs and ideas for future QI projects.~~

D. Each year, the ~~Council~~QC will submit a report to the Executive Committee summarizing:
   1. The actual to target performance of each item on the QI Work Plan~~log~~, including, as appropriate, a summary of barriers to reaching target, plans for addressing barriers and examples of successes and learning.
   2. Any recommendations of changes to the ~~Council~~QC's charter.
   3. The ~~Council~~QC work plan for the coming year.
   ~~3. The results of the Council's performance evaluation, including, as appropriate, a summary of barriers to reaching target, plans for addressing barriers and examples of successes and learning.~~

~~F.~~E. The ~~Council~~QC will execute a communication plan each year that contains CQI training and tools, the ~~Council~~QC charter and work plan, and the annual ~~Council~~QC report and survey results.

2017~~7~~8

QUALITY IMPROVEMENT

PLAN

A. *Quality Improvement (QI) is an integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization.* Through this plan the Quality Council will lead the agency in creating, implementing, maintaining, and evaluating the quality improvement efforts at Southwest Health and Human Services (SWHHS) designed to improve performance of the organization and its employees and encourage a culture of quality. This process will enhance SWHHS's ability to meet the overall mission of providing quality services in a respectful, caring, and cost-effective manner.

B. *Our vision for quality improvement is to improve the quality of services provided to customers of Southwest Health and Human Services through a structured quality improvement process.*

C. Quality Improvement activities at Southwest Health and Human Services will include:
   1. Executive Team and FOCUS Team requests
   2. Implementation of Public Health Accreditation Projects (when applicable)
   3. Other agency-wide assessments and/or surveys, such as an employee survey or customer satisfaction survey
   4. Performance measure review for Human Services and Public Health
   5. Monitoring of Department-level projects for those that have the potential to impact other program areas

II. Glossary of Terms
   A. Quality Improvement: an integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization
   B. Core Competency: the collective learning in organizations, and involve how to coordinate diverse production skills and integrate multiple streams of technologies. It is communication, an involvement and a deep commitment to working across organizational boundaries.
   C. Cross Sectional Representation of SWHHS includes representatives from both management and staff, a variety of office locations, experienced and inexperienced staff, public health and human services departments, and across program areas.
   D. Executive Team: group including the Director, the Division Directors, Management Information Supervisor, ~~and~~ the Planner, and the Fiscal Manager.
   E. Focus Team: group including the Director, Division Directors, Supervisors, and Planner
   F. Local Public Health Assessment and Planning Process: Process developed by the Minnesota Department of Health Public Health Practice Section to assess, plan, and communicate the work of local public health. The following are all part of this five-year process.

1. Community Health Assessment: An assessment of the communities' health status within the jurisdiction of SWHHS using current data or new data
2. Community Health Improvement Plan (CHIP): An agency work plan focusing on the top priorities identified in the Community Health Assessment
3. Organizational Self-assessment: An organizational assessment comparing agency practice against the National Accreditation Standards
4. Strategic Plan: A carefully devised plan of action to achieve goals identified in assessments and/or brainstorming sessions.

G. -National Accreditation Standards: Standards that health departments can put in place to ensure that they are continuously improving services to keep their communities healthy.

III. Organizational Structure

A. The Southwest Health and Human Services Boards of Directors

- The SWHHS Community Health Board is responsible for programmatic decisions facing public health as per state statute.
- The SWHHS Human Services Board is responsible for programmatic decisions facing human services as per state statute.
- The Governing Board consists of elected officials from the counties represented in the agency and is charged with making operational decisions. Their authority is driven from the Joint Powers Act in state statute.
    - The Governing Board is responsible for the overall quality of services in the organization, allocation of resources for QI processes and activities, and approval of the QI plan annually.
    - QI activities and resource allocation are delegated from the Governing Board to the Agency Director and the Quality Council.
    - The annual agency budget will reflect financial resources dedicated to Quality Improvement Activities and will be approved by the governing board.
      The agency will seek additional financial resources via local, state or federal grants, local funding streams, etc. to fund QI projects.
    - All Boards will receive periodic reports from the Quality Council and/or Agency Director related to QI activities or QI projects as the report fits the Board's level of authority.
    - Board members are asked to participate in QI projects and/or meetings as appropriate.

B. Agency Director

- The Agency Director serves as an ex-officio member of the Quality Council.
- The Agency Director gives direction to the Quality Council as determined by the Boards of Directors and is the liaison between the boards and the Quality Council.

C. QI Council
    - The Quality Council consists of cross-sectional representation from SWHHS.
    - Members are appointed by the Quality Council and serve a term of no less than two years. Less than half of the Quality Council members can rotate off each year.
    - The Quality Council is charged with carrying out the purpose and scope of quality improvement efforts at SWHHS.
    - A Quality Council Charter is developed and reviewed annually.

D. Executive Team
    - The Executive Team will be notified of the Quality Council's activities periodically and will hear recommendations for revision of the QI plan annually.
    - Through the Strategic Plan Review and other agency assessment processes, the executive team will forward recommended QI initiatives to the Quality Council to incorporate into the QI plan.

E. Program Supervisors
    - Program Supervisors are responsible for:
        - Reviewing performance measures on an annual basis with staff.
        - Initiating performance management (PM) and /or QI improvement projects.
        - Reporting to the Quality Council on their PM, QI projects, state standard gaps, and needed QI trainings.
        - Identifying and selecting areas needing improvement from performance measures to bring to the Quality Council as priorities as needed.
        - Assuring implementation of QI projects.

F. SWHHS employees
    - SWHHS employees are responsible for:
        - Working with supervisors on work plan development and reviews for their departments.
        - Compiling program data for measures.
        - Working with supervisors to identify areas for improvement and suggesting improvement projects to address these areas, including meeting the state standards.
        - Conducting quality improvement projects in conjunction with supervisors and other appropriate staff.
        - Reporting QI training needs to supervisors.

IV. -Training Plan

A. Quality Improvement trainings will be held periodically in an effort to building a quality-focused culture at SWHHS.

B. Quality Council members and supervisors will receive QI training ~~annually~~ on a regular basis.

C. New employees will receive information regarding QI ~~improvement~~ processes during new employee orientation.
D. SWHHS staff will receive QI training on an on-going basis at staff meetings or agency meetings.
E. QI project team members will receive Quality Improvement Technical Assistance from Quality Council members when their team is formed and will be specific to the position and the project.
F. SWHHS staff will complete a QI culture survey periodically. Baseline data will be used to determine if additional training is needed.

V. Communication Plan

Quality Improvement Activities will be reported to the Executive Team~~Committee~~, the Boards of Directors, and the Focus Team on a regular basis. Quality Improvement updates will be communicated to all employees periodically. Executive Team Members, Supervisors, and Quality Council members will be responsible for ongoing communication to staff about the QI plan and process established within the agency.

VI. Approval of QI Plan and Annual Evaluation

A. The Quality Council will annually review and make suggested revisions to this QI Plan.
B. The Quality Council will ensure that the plan aligns with the State (MDH) Quality Improvement Plan, the national accreditation standards, the Minnesota Local Public Health Assessment and Planning Process, and other state and national QI efforts.
C. The Quality Council will develop an annual report that includes progress towards targets and goals for program outcomes; accomplishments of QI projects and initiatives; extent of alignment with the strategic plan, the agency's mission and vision, the CHIP, and other agency-wide plans; trainings completed; and evaluations from QI project teams, leadership and board members.
D. An annual report is presented to the Executive Committee and to the Governing Board in February.
E. A revised plan is provided to the Governing Board at the February meeting each year for approval.

VII. Monitoring of the QI Plan

A. The Council will review the QI Plan and all related processes annually to ensure they remain adaptive to change and meet the needs of all who are impacted by QI efforts. The evaluation will include comparison of actual results to target, problem identification and analysis for gaps in performance, and plans for improving performance.
B. Cross-departmental QI projects will be monitored by the Council on a regular basis. After a project is initiated, the project lead will provide updates, as requested during Council meetings. The updates will include progress on reaching the project's aim, barriers encountered, strategies to address those barriers and project successes.

C. Upon completion of department-wide projects, leads will report results through presentation of a one-page project summary. If the project did not meet its aim, the team will need to determine if it will continue with a different QI project addressing the same project, or it will abandon the effort. If the project met or exceeded its aim, the project team will determine what efforts will be needed to sustain the improvements and offer suggestions on how to further implement improvements and offer suggestions on how to further implement improvements to other related areas.

D. The Council will submit an annual report to the Executive Team and Southwest Health and Human Services Board for approval which summarizes:
   1. QI projects and their outcomes
   2. A QI Work Plan for the following year
   3. Any recommended changes to the QI Plan

VIII. Information on Quality Council Work Plan

- The Council utilizes a work plan to document its meetings and current QI projects occurring across the agency. This working document describes the QI project, goals, objectives, and measures with responsible person(s)/team(s) and time-framed targets.
- The Council utilizes the work plan in conjunction with the QI Plan.

STATE OF MINNESOTA
OFFICE OF THE STATE AUDITOR

SUITE 500
525 PARK STREET
SAINT PAUL, MN 55103-2139

(651) 296-2551 (Voice)
(651) 296-4755 (Fax)
state.auditor@state.mn.us (E-Mail)
1-800-627-3529 (Relay Service)

REBECCA OTTO
STATE AUDITOR

January 29, 2018

Ms. Sarah Kirchner, Fiscal Manager
Southwest Health and Human Services
Lyon County Government Center
607 West Main Street
Marshall, Minnesota 56258

Members of the Joint Health and Human Services Board
Director
Deputy Director
Southwest Health and Human Services

We are pleased to confirm our understanding of the services we are to provide pursuant to Minnesota Laws for Southwest Health and Human Services for the year ended December 31, 2017. We will audit the financial statements of the governmental activities, each major fund, and the aggregate remaining fund information, including the related notes to the financial statements, which collectively comprise the basic financial statements, of Southwest Health and Human Services as of and for the year ended December 31, 2017. Accounting standards generally accepted in the United States of America provide for certain required supplementary information (RSI), such as management's discussion and analysis (MD&A), to supplement Southwest Health and Human Services' basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board (GASB) who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. As part of our engagement, we will apply certain limited procedures to Southwest Health and Human Services' RSI in accordance with auditing standards generally accepted in the United States of America. These limited procedures will consist of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We will not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance. The following RSI is required by U.S. generally accepted accounting principles (GAAP) and will be subjected to certain limited procedures, but will not be audited:

- Management's discussion and analysis
- Budgetary presentations for the general and major special revenue funds and related notes
- GASB-required supplementary other post-employment benefits and pension information and related notes

We have also been engaged to report on supplementary information other than RSI that accompanies Southwest Health and Human Services' financial statements. We will subject the following supplementary information to the auditing procedures applied in our audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America, and we will provide an

opinion on it in relation to the financial statements as a whole, in a report combined with our auditor's report on the financial statements:

- Combining and individual fund statements
- Schedule of intergovernmental revenue
- Schedule of expenditures of federal awards and related notes

Audit Objectives

The objective of our audit is the expression of opinions as to whether your basic financial statements are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America and to report on the fairness of the supplementary information referred to in the second paragraph when considered in relation to the financial statements as a whole. The objective also includes reporting on—

- Internal control over financial reporting and compliance with provisions of laws, regulations, contracts, and award agreements, noncompliance with which could have a material effect on the financial statements in accordance with *Government Auditing Standards.*

- Internal control over compliance related to major programs and an opinion (or disclaimer of opinion) on compliance with federal statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on each major program in accordance with the Single Audit Act Amendments of 1996 and Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance).

The *Government Auditing Standards* report on internal control over financial reporting and on compliance and other matters will include a paragraph that states that (a) the purpose of the report is solely to describe the scope of testing of internal control and compliance, and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance and (b) the report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. The Uniform Guidance report on internal control over compliance will include a paragraph that states that the purpose of the report on internal control over compliance is solely to describe the scope of testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Both reports will state that the report is not suitable for any other purpose.

Our audit will be conducted in accordance with auditing standards generally accepted in the United States of America; the standards for financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; the Single Audit Act Amendments of 1996; the provisions of the Uniform Guidance; and the legal provisions of the *Minnesota Legal Compliance Audit Guides*, and will include tests of accounting records, a determination of major program(s) in accordance with the Uniform Guidance, and other procedures we consider necessary to enable us to express such opinions and to report in conformity with the provisions of the *Minnesota Legal Compliance Audit Guides*. We will issue written reports upon completion of our single audit. Our reports will be addressed to the governing body of Southwest Health and Human Services. We cannot provide assurance that unmodified opinions will be expressed. Circumstances may arise in which it is necessary for us to modify our opinions or add emphasis-of-matter or other-matter paragraphs. If our opinions on the financial statements or the single audit compliance opinion are other than unmodified, we will discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed opinions, we may decline to express opinions or issue reports, or we may withdraw from this engagement.

Management Responsibilities

Management is responsible for the financial statements, notes, schedule of expenditures of federal awards, and all accompanying information as well as all representations contained therein. In order to meet your responsibilities for the financial statements, notes, and schedule of expenditures of federal awards, you agree to have information completed and available for audit by the dates identified in a schedule of completion document provided to auditors. If you are unable to prepare the information needed for the financial statements, notes, or schedule of expenditures of federal awards, or if the completion schedule varies significantly, we will, based on our staffing availability, provide the additional nonaudit services necessary to assist in the preparation of your draft financial statements, notes, and schedule of expenditures of federal awards in conformity with U.S. generally accepted accounting principles and the Uniform Guidance based on management's chart of accounts and other information determined and approved by management. These nonaudit services do not constitute an audit under *Government Auditing Standards* and such services will not be conducted in accordance with *Government Auditing Standards*. Any such services will be performed in accordance with applicable professional standards. Southwest Health and Human Services understands this will result in additional costs and agrees to pay for these services.

You will be required to acknowledge in the written management representation letter our assistance, if any, with preparation of the financial statements, notes, and schedule of expenditures of federal awards and that you have reviewed and approved the financial statements, schedule of expenditures of federal awards, and related notes prior to their issuance and have accepted responsibility for them. You agree to assume all management responsibilities relating to the financial statements, schedule of expenditures of federal awards, and related notes and any other nonaudit services we provide; oversee the services by designating an individual, preferably from senior management, with suitable skill, knowledge, or experience; evaluate the adequacy and results of the services; and accept responsibility for them.

Management is responsible for (a) designing, implementing, establishing, and maintaining effective internal controls, including internal controls over federal awards, and for evaluating and monitoring ongoing activities to help ensure that appropriate goals and objectives are met; (b) following laws and regulations; (c) ensuring that there is reasonable assurance that government programs are administered in compliance with compliance requirements; and (d) ensuring that management is reliable and financial information is reliable and properly reported. Management is also responsible for implementing systems designed to achieve compliance with applicable laws, regulations, contracts, and grant agreements. You are also responsible for the selection and application of accounting principles; for the preparation and fair presentation of the financial statements, schedule of expenditures of federal awards, and all accompanying information in conformity with accounting principles generally accepted in the United States of America; and for compliance with applicable laws and regulations (including federal statutes) and the provisions of contracts and grant agreements (including award agreements). Your responsibilities also include identifying significant contractor relationships in which the contractor has responsibility for program compliance and for the accuracy and completeness of that information.

Management is also responsible for making all financial records and related information available to us and for the accuracy and completeness of that information. You are also responsible for providing us with (a) access to all information of which you are aware that is relevant to the preparation and fair presentation of the financial statements, (b) access to personnel, accounts, books, records, supporting documentation, and other information as needed to perform an audit under the Uniform Guidance, (c) additional information that we may request for the purpose of the audit, and (d) unrestricted access to persons within the entity from whom we determine it necessary to obtain audit evidence.

Your responsibilities include adjusting the financial statements to correct material misstatements and confirming to us in the written management representation letter that the effects of any uncorrected misstatements aggregated

by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

You are responsible for the design and implementation of programs and controls to prevent and detect fraud, and for informing us about all known or suspected fraud affecting the entity involving (a) management, (b) employees who have significant roles in internal control, and (c) others where the fraud could have a material effect on the financial statements. Your responsibilities include informing us of your knowledge of any allegations of fraud or suspected fraud affecting the entity received in communications from employees, former employees, grantors, regulators, or others. In addition, you are responsible for identifying and ensuring that the entity complies with applicable laws, regulations, contracts, agreements, and grants. Management is also responsible for taking timely and appropriate steps to remedy fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, or abuse that we report. Additionally, as required by the Uniform Guidance, it is management's responsibility to evaluate and monitor noncompliance with federal statutes, regulations, and the terms and conditions of federal awards; take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings; promptly follow up and take corrective action on reported audit findings; and prepare a summary schedule of prior audit findings and a separate corrective action plan. The summary schedule of prior audit findings, if applicable, should be available for our review.

You are responsible for identifying all federal awards received and understanding and complying with the compliance requirements and for the preparation of the schedule of expenditures of federal awards (including notes and noncash assistance received) in conformity with the Uniform Guidance. You agree to include our report on the schedule of expenditures of federal awards in any document that contains and indicates that we have reported on the schedule of expenditures of federal awards. You also agree to include the audited financial statements with any presentation of the schedule of expenditures of federal awards that includes our report thereon or make the audited financial statements readily available to intended users of the schedule of expenditures of federal awards no later than the date the schedule of expenditures of federal awards is issued with our report thereon. Your responsibilities include acknowledging to us in the written management representation letter that (a) you are responsible for presentation of the schedule of expenditures of federal awards in accordance with the Uniform Guidance; (b) you believe the schedule of expenditures of federal awards, including its form and content, is stated fairly in accordance with the Uniform Guidance; (c) the methods of measurement or presentation have not changed from those used in the prior period (or, if they have changed, the reasons for such changes); and (d) you have disclosed to us any significant assumptions or interpretations underlying the measurement or presentation of the schedule of expenditures of federal awards.

You are also responsible for the preparation of the other supplementary information, which we have been engaged to report on, in conformity with accounting principles generally accepted in the United States of America. You agree to include our report on the supplementary information in any document that contains, and indicates that we have reported on, the supplementary information. You also agree to include the audited financial statements with any presentation of the supplementary information that includes our report thereon or make the audited financial statements readily available to users of the supplementary information no later than the date the supplementary information is issued with our report thereon. Your responsibilities include acknowledging to us in the written management representation letter that (a) you are responsible for presentation of the supplementary information in accordance with GAAP; (b) you believe the supplementary information, including its form and content, is fairly presented in accordance with GAAP; (c) the methods of measurement or presentation have not changed from those used in the prior period (or, if they have changed, the reasons for such changes); and (d) you have disclosed to us any significant assumptions or interpretations underlying the measurement or presentation of the supplementary information.

Management is responsible for establishing and maintaining a process for tracking the status of audit findings and recommendations. Management is also responsible for identifying and providing us with report copies of previous financial audits, attestation engagements, performance audits, or other studies related to the objectives discussed in the Audit Objectives section of this letter. This responsibility includes relaying to us corrective actions taken to address significant findings and recommendations resulting from those financial audits, attestation engagements, performance audits, or other studies. You are also responsible for providing management's views on our current findings, conclusions, and recommendations, as well as your planned corrective actions, for the report, and for the timing and format for providing that information.

With regard to using the auditor's report, you understand that you must obtain our prior consent to reproduce or use our report in bond offering official statements or other documents.

Audit Procedures—General

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We will plan and perform the audit to obtain reasonable rather than absolute assurance about whether the financial statements are free of material misstatement, whether from (a) errors, (b) fraudulent financial reporting, (c) misappropriation of assets, or (d) violations of laws or governmental regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity. Because the determination of abuse is subjective, *Government Auditing Standards* do not expect auditors to provide reasonable assurance of detecting abuse.

Because of the inherent limitations of an audit, combined with the inherent limitations of internal control, and because we will not perform a detailed examination of all transactions, there is a risk that material misstatements or noncompliance may exist and not be detected by us, even though the audit is properly planned and performed in accordance with auditing standards generally accepted in the United States of America and *Government Auditing Standards*. In addition, an audit is not designed to detect immaterial misstatements or violations of laws or governmental regulations that do not have a direct and material effect on the financial statements or major programs. However, we will inform the appropriate level of management of any material errors, any fraudulent financial reporting, or misappropriation of assets that come to our attention. We will also inform the appropriate level of management of any violations of laws or governmental regulations that come to our attention, unless clearly inconsequential, and of any material abuse that comes to our attention. We will include such matters in the reports required for a single audit. Our responsibility as auditors is limited to the period covered by our audit and does not extend to any later periods for which we are not engaged as auditors.

Our procedures will include tests of documentary evidence supporting the transactions recorded in the accounts, and may include tests of the physical existence of inventories, and direct confirmation of receivables and certain other assets and liabilities by correspondence with selected individuals, funding sources, creditors, and financial institutions. We will request written representations from your attorneys as part of the engagement, and they may bill you for responding to this inquiry. At the conclusion of our audit, we will also require certain written representations from you about your responsibilities for the financial statements; schedule of expenditures of federal awards; federal award programs; compliance with laws, regulations, contracts, and grant agreements; and other responsibilities required by generally accepted auditing standards.

Audit Procedures—Internal Control

Our audit will include obtaining an understanding of the entity and its environment, including internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. Tests of controls may be performed to test the effectiveness of certain controls that we consider relevant to preventing and detecting errors and fraud that are material to the financial statements and to preventing and detecting misstatements resulting from illegal acts and other noncompliance matters that have a direct and material effect on the financial statements. Our tests, if performed, will be less in scope than would be necessary to render an opinion on internal control and, accordingly, no opinion will be expressed in our report on internal control issued pursuant to *Government Auditing Standards*.

As required by the Uniform Guidance, we will perform tests of controls over compliance to evaluate the effectiveness of the design and operation of controls that we consider relevant to preventing or detecting material noncompliance with compliance requirements applicable to each major federal award program. However, our tests will be less in scope than would be necessary to render an opinion on those controls and, accordingly, no opinion will be expressed in our report on internal control issued pursuant to the Uniform Guidance.

An audit is not designed to provide assurance on internal control or to identify significant deficiencies or material weaknesses. However, during the audit, we will communicate to management and those charged with governance internal control related matters that are required to be communicated under AICPA professional standards, *Government Auditing Standards*, and the Uniform Guidance.

Audit Procedures—Compliance

As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we will perform tests of Southwest Health and Human Services' compliance with provisions of applicable laws, regulations, contracts, and agreements, including grant agreements. However, the objective of those procedures will not be to provide an opinion on overall compliance, and we will not express such an opinion in our report on compliance issued pursuant to *Government Auditing Standards.*

The Uniform Guidance requires that we also plan and perform the audit to obtain reasonable assurance about whether the auditee has complied with applicable federal statutes, regulations, and the terms and conditions of federal awards applicable to major programs. Our procedures will consist of tests of transactions and other applicable procedures described in the OMB *Compliance Supplement* for the types of compliance requirements that could have a direct and material effect on each of Southwest Health and Human Services' major programs. The purpose of these procedures will be to express an opinion on Southwest Health and Human Services' compliance with requirements applicable to each of its major programs in our report on compliance issued pursuant to the Uniform Guidance.

Audit Administration and Other

At the conclusion of the engagement, we will complete the appropriate sections of the Data Collection Form that summarizes our audit findings. It is management's responsibility to electronically submit the reporting package (including financial statements, schedule of expenditures of federal awards, summary schedule of prior audit findings, auditor's reports, and corrective action plan) along with the Data Collection Form to the federal audit clearinghouse. Additional copies of the reporting package may be required. We will coordinate with you the electronic submission and certification. The Data Collection Form and the reporting package must be submitted within the earlier of 30 calendar days after receipt of the auditor's reports or nine months after the end of the audit period.

We will provide your governing body, management, related organization representatives, and, if applicable, nonfederal grantor entities with copies of our reports. Management is responsible for all other distribution of the reports and the financial statements. Unless restricted by law or regulation, or containing privileged and confidential information, copies of our reports are to be made available for public inspection.

The audit documentation for this engagement is the property of the Office of the State Auditor. We may be requested to make certain audit documentation and appropriate individuals available to a cognizant or oversight agency for audit or its designee, a federal agency providing direct or indirect funding, or the U.S. Government Accountability Office for purposes of a quality review of the audit, to resolve audit findings, or to carry out oversight responsibilities. If requested, access to such audit documentation will be provided under our supervision. Furthermore, upon request, we may provide copies of selected audit documentation to the aforementioned parties. These parties may intend, or decide, to distribute the copies or information contained therein to others, including other governmental agencies.

The audit documentation for this engagement will be retained, pursuant to our record retention plan, for a period of ten years after the date the auditor's report is issued. If we are aware that a federal awarding agency, pass-through entity, or auditee is contesting an audit finding, we will contact those contesting the audit finding for guidance prior to destroying the audit documentation. We will be available throughout the year to answer questions, provide assistance, or assist you in implementing any of our recommendations.

Our fees are based on standard hourly rates plus travel and any out-of-pocket expenses. Our standard hourly rates vary according to the degree of responsibility involved and the experience level of the personnel assigned to your audit. Progress billings will be mailed to you every four weeks. The condition of your records and the assistance you are able to provide us affects both the timeliness and cost of the audit.

Government Auditing Standards require that we provide you with a copy of our most recent external peer review report and any subsequent peer review reports received during the period of the contract when requested by you. Our 2015 peer review report can be found on our website at www.auditor.state.mn.us.

We appreciate the opportunity to be of service to Southwest Health and Human Services and believe this letter accurately summarizes the significant terms of our engagement. If you have any questions, please contact me at (651) 282-2748 or Rick Pietrick, who will be in charge of this audit, at (651) 282-2387 or at rick.pietrick@osa.state.mn.us. If you agree with the terms of our engagement as described in this letter, please sign where provided below and return it to us at the following address:

Office of the State Auditor
607 West Main Street
Marshall, Minnesota 56258

Sincerely,

Rick Pietrick

for Dianne Syverson, CPA, Audit Manager

Approved: This letter correctly sets forth the understanding of Southwest Health and Human Services.

Chair, Joint Health and Human Services Board	Date
Director	Date
Deputy Director	Date
Fiscal Manager	Date

Morris Electronics

511 Atlantic Ave., Morris, MN 320-589-1781

To: **SWMHHS**
Karri Karvey
Phone: **320-532-1223**
E-mail:

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From: **Morris Electronics Inc**
Shawn Larsen
Phone: **320-589-1781**
Cell: **320-287-0922**
Fax: **320-589-3595**
E-mail: shawn.larsen@morriselectronics.net

Qty	Part #	Description	per unit $	extende
2	12092040	HPE ProLiant DL380 Gen9 Performance - rack-mountable - Xeon E5-2650V4 2.2 GHz	$ 7,137.40	$ 14,274.
		2 x Intel Xeon E5-2650V4 / 2.2 GHz (2.9 GHz) (12-core)		
2	12944057	Hard drive - 300 GB - hot-swap - 2.5" SFF - SAS 6Gb/s - 10000 rpm	$ 265.33	$ 530.(
12	12159644	DDR4 - 16 GB - DIMM 288-pin - 2400 MHz / PC4-19200 - CL17 - 1.2 V - registered - ECC	$ 260.61	$ 3,127.:
			Sub Total	17,932.
			Sales Tax	EXEMI
			Total	**17,932.**

FEBRUARY 2018

GRANTS ~ AGREEMENTS ~ CONTRACTS

for Board review and approval

☐ **DHS Family Group Decision Making (FGDM) Grant** – 01/01/18 to 12/31/18; State grant to provide family support, family preservation, and family reunification services, awarded $40,560 ($13,854 decrease) (renewal).
Fiscal Note: 2017 - $54,414

☐ **SWMN Private Industry Council (Montevideo, MN)** – 01/01/18 to 12/31/18; MFIP/DWP Regional Plan, regionalization of employment and training services, host county is Chippewa, allocation of $756,641 (increase $20,798) (renewal).
Fiscal Note: 2017 - $735,843

☐ **Rock County (Luverne, MN)** – 01/01/18 to 12/31/18; office lease agreement of $121,125 annually or $6,729.17/mo, utilities included (no change) (renewal).
Fiscal Note: 2017 - $121,125

☐ **Lincoln County (Ivanhoe, MN)** – 01/01/18 to 12/31/18; office lease agreement of $24,544 annually or $6,136/qtr, utilities included (small increase due to office remodeling project) (renewal).
Fiscal Note: 2017 - $29,101.25 (includes Q416)

☐ **Lamar Companies (Sioux Falls, SD)** – 03/19/18 to 03/17/19; advertising agreement for billboard posters promoting alcohol and drug prevention, P&I grant monies of $8,450 (renewal).
Fiscal Note: 2017 - $9,090