

CHIPPEWA COUNTY
HEALTH & HUMAN SERVICES BOARD
REGULAR MEETING
MAY 15, 2025
CHIPPEWA COUNTY COURTHOUSE, RM 302
7:45 AM

1. CALL TO ORDER

2. ROLL CALL

Attendee Name	Organization	Title	Status	Arrived
Kari Ives	Chippewa County	District 21, Chair	Present	
Lee Hennick	Chippewa County	District 15, Vice-Chair	Present	
Darren Kirby	Chippewa County	District 5	Present	
James Ericksen	Chippewa County	District 8	Present	
Dean Mueller	Chippewa County	District 20	Absent	
John Halbleib	Chippewa County	Citizen Rep	Present	
Nichole Wallsch	Chippewa County	Citizen Rep	Absent	
Robert Bullwinkel	Chippewa County	Citizen Rep, MD	Late	8:03 AM
Marcia Kyes	Chippewa County	Citizen Rep	Present	

Others Present: County Administrator Andy Albarado; Human Services Staff: Bobbie Jaeger, Brandi Engel, Paul Brenner, Kyra Secraw, Manda Young, and Tom Diel; Public Health Staff: Brittnay Fortuna, Audra Knowlton, Sarah McQuillan, and Stephanie Abbe

3. MEMBERS OF THE PUBLIC WISHING TO BE HEARD

There were no members of the public wishing to be heard.

4. CONSENT AGENDA

RESULT:	APPROVED [6 TO 0]
MOVER:	John Halbleib, Citizen Rep
SECONDER:	Lee Hennick, District 15, Vice-Chair
AYES:	Ives, Hennick, Kirby, Ericksen, Halbleib, Kyes
ABSENT:	Mueller, Wallsch
AWAY:	Bullwinkel

1. Approve the Agenda

2. Approve the Minutes

Health & Human Services Board - Regular Meeting - Apr 17, 2025 7:45 AM

3. Schedule Next Meeting Date - June 19, 2025

5. BUSINESS ITEMS

Health & Human Services Board

Minutes
Regular Meeting

Chippewa County Courthouse, Rm 302

May 15, 2025
7:45 AM

1. Human Services 2026 Opioid Fund Request - Tom Diel

Recovery and Wellness Consortium Manager Tom Diel is asking the Board to approve the Opioid Fund Request to support the community with harm reduction services, and to continue to offset the contracted peer support/recovery coach specialist position.

RESULT:	APPROVED [6 TO 0]
MOVER:	Lee Hennick, District 15, Vice-Chair
SECONDER:	Darren Kirby, District 5
AYES:	Ives, Hennick, Kirby, Ericksen, Halbleib, Kyes
ABSENT:	Mueller, Wallsch
AWAY:	Bullwinkel

2. Human Services 2024 Annual Report - Bobbie Jaeger

Human Services Director Bobbie Jaeger presented the Human Services 2024 Annual Report for Board approval. Jaeger thanked Brandi Engel for compiling the content and creating the new format. Jaeger reviewed information on community partnerships, services and programs, funding, achievements, and challenges.

A discussion was held on how the Board can support potential federal cuts. Jaeger recommended talking with State representatives about the impact on the community.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	Marcia Kyes, Citizen Rep
SECONDER:	Lee Hennick, District 15, Vice-Chair
AYES:	Ives, Hennick, Kirby, Ericksen, Halbleib, Bullwinkel, Kyes
ABSENT:	Mueller, Wallsch

3. Human Services 2025 Program Prioritization Results - Bobbie Jaeger

Human Services Director Bobbie Jaeger presented the 2025 Program Prioritization Results for review and approval.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	John Halbleib, Citizen Rep
SECONDER:	Darren Kirby, District 5
AYES:	Ives, Hennick, Kirby, Ericksen, Halbleib, Bullwinkel, Kyes
ABSENT:	Mueller, Wallsch

4. Human Services Administrative Policy 44 - Telehealth - Bobbie Jaeger

Human Services Director Bobbie Jaeger presented the Telehealth Policy for review and approval. The policy was created by the County HIPAA Compliance team. Jaeger reviewed the purpose of the Telehealth Policy.

Health & Human Services Board

Minutes
Regular Meeting

Chippewa County Courthouse, Rm 302

May 15, 2025
7:45 AM

RESULT:	APPROVED [UNANIMOUS]
MOVER:	Lee Hennick, District 15, Vice-Chair
SECONDER:	Marcia Kyes, Citizen Rep
AYES:	Ives, Hennick, Kirby, Ericksen, Halbleib, Bullwinkel, Kyes
ABSENT:	Mueller, Wallsch

5. Public Health Policy - APH-Telehealth - Brittney Fortuna

Public Health Director Brittney Fortuna stated the policy is the same as the Telehealth Policy presented by Human Services except on Public Health's template. The County HIPAA consultant and the County HIPAA Compliance team put the policy together, along with the IT Director Andy Bauer, Human Resources Director Toni Hohlfelder, Human Services staff, and Public Health staff.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	Lee Hennick, District 15, Vice-Chair
SECONDER:	Darren Kirby, District 5
AYES:	Ives, Hennick, Kirby, Ericksen, Halbleib, Bullwinkel, Kyes
ABSENT:	Mueller, Wallsch

6. Public Health 2026 Opioid Fund Request – Brittney Fortuna

Public Health Director Brittney Fortuna stated the Opioid Fund Request is an extension of the work completed over the past years. They will continue to provide services in the jail and education on harm reduction in the community. This is being funded from the Opioid Settlement dollars from the Johnson & Johnson lawsuit.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	Marcia Kyes, Citizen Rep
SECONDER:	James Ericksen, District 8
AYES:	Ives, Hennick, Kirby, Ericksen, Halbleib, Bullwinkel, Kyes
ABSENT:	Mueller, Wallsch

6. REPORTS

1. Human Services Success Story - Youth Justice - Kyra Secraw

Manda Young, Ongoing Youth Justice Worker, shared background information on a young man who had received services. She shared information on his numerous referrals, different services he received, his out-of-home placements, and his challenges. His last out-of-home placement focused on independent services. Once he reached adulthood, staff saw the need to continue working with the individual and saw how the continued support and services turned into a positive outcome. He successfully earned his high school diploma and moved into an apartment. He is living independently and is currently seeking a higher level of education.

2. Public Health Policy, Practice, and People – Nutrition Division - Stephanie Abbe

Nutrition Division Manager Stephanie Abbe informed the Board about the Women, Infants and Children (WIC) program. The vacant LTE Nutritionist position was accepted by Tammy Sloniker, a retired Clark

Health & Human Services Board

Minutes
Regular Meeting

Chippewa County Courthouse, Rm 302

May 15, 2025
7:45 AM

County WIC Director. Abbe highlighted the benefits of WIC, including birth outcomes, increased nutrition, and improved cognitive development. She reviewed the qualifications, services, nutrition education, nutritious foods, and the Farmers Market Nutrition Program. The program will not start in June this year. It is delayed due to potential federal funding cuts. The senior farmers market program will begin in June as scheduled.

A discussion was held to explore options to receive money from the community to continue this program. It was recommended to talk with representatives to let them know how detrimental cuts would be to health and well-being. There was a recommendation to send a message to the government on behalf of Chippewa County or Public Health.

Abbe shared the benefits of the Breastfeeding Peer Counselor program, infant feeding program, health and community services referrals, a typical WIC visit in-person or virtual, clinic locations and schedule, outreach opportunities, and changes through 2026. They are working with Kwik Trip to become an authorized venue and making updates to the WIC app and food package changes. She closed with statistical data from the program.

3. Human Services Director's Program and Financial Report – Bobbie Jaeger

Human Services Director Bobbie Jaeger presented the Human Services Program and Financial Report. She thanked Brandi Engel for the new format of the Director's Report. Jaeger highlighted several items from her report:

- WCHSA is working through the proposed governor's budget.
- Congratulations and thank you to the staff celebrating work anniversaries.
- May is Aging and Disability Resource Center Month, Older Americans Month, Mental Health Awareness Month, and Economic Support Week. Thank you to all the staff for their hard work.
- The vacant Child Protective Services position will transition to a Youth Justice position to help lower caseloads.
- The State received the Children's Long Term Support improvement plan, and they continue to work on the action steps.
- Leah Luther, Economic Support Administrative Assistant, will start in May.

Brenner reviewed the Children & Youth Out-of-Home placement data. The outlook for the year is high if acute children remain in the high-cost placement facilities. Halbleib congratulated the staff on their hard work to keep kids at home and not in out-of-home placements.

4. Public Health Director's Program and Financial Report – Brittney Fortuna

Public Health Director Brittney Fortuna presented the Public Health Program and Financial Report. Fortuna highlighted from her Director's Report:

- Administration: The Doris Vennard Scholarship Committee's recipient is Cornell High School student, Sorik Spangler. Staff attended Healthy Kids Day at the YMCA.
- Community Health: Rabies and animal bite information and the investigation process, tickborne disease involvement with the Tick Inventory via Citizen Science project, UW-Eau Claire student Mik Devereaux's accomplishments, and communicable disease data.
- Environmental Health: Data on routine inspections and new ownerships, second school inspections completed, and campground inspections and water sampling continue.
- Nutrition: A Red Cross Blood Drive will be held on May 27.
- Planning and Strategy: Prom Positive Campaign at Bloomer High School, schools report their substance

Health & Human Services Board

Minutes
Regular Meeting

Chippewa County Courthouse, Rm 302

May 15, 2025
7:45 AM

usage has reduced among students, Drug Take Back Day, and Public Health is accepting sharps disposal during May at no cost.

- CRC: Caring for Yourself While Caring for Your Child is designed to help parents and guardians support their mental health and well-being. One in 31 children is diagnosed with autism, and single point of entry data.
- Congratulations to Maryn and Brittnay on their work anniversaries. Tori Lammar accepted the Planning & Promotion Specialist position, and a UW-Eau Claire Environmental Health Intern will begin in June to work on water quality, Tourist Rooming House inspections, and beach water testing.

7. AGENDA ITEMS FOR FUTURE CONSIDERATION

8. ADJOURN

The meeting adjourned at 9:29 AM.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	James Ericksen, District 8
SECONDER:	Marcia Kyes, Citizen Rep
AYES:	Ives, Hennick, Kirby, Ericksen, Halbleib, Bullwinkel, Kyes
ABSENT:	Mueller, Wallsch

CHIPPEWA COUNTY
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1. CALL TO ORDER

2. ROLL CALL

Attendee Name	Organization	Title	Status	Arrived
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Darren Kirby	Chippewa County	District 5	Present	
James Ericksen	Chippewa County	District 8	Present	
Dean Mueller	Chippewa County	District 20	Present	
John Halbleib	Chippewa County	Citizen Rep	Absent	
Nichole Wallsch	Chippewa County	Citizen Rep	Absent	
Robert Bullwinkel	Chippewa County	Citizen Rep, MD	Late	8:09 AM
Marcia Kyes	Chippewa County	Citizen Rep	Present	

Others Present: Human Services Staff: Bobbie Jaeger, Brandi Engel, Paul Brenner, Caleb Johnson, Daniel Erickson, and Sarah Zielke; Public Health Staff: Brittney Fortuna, Audra Knowlton, Allie Isaacson, Jenny Lenbom; UW-Eau Claire Nursing Students: Abby Weber, Sienna Mader, Allison Wing, Ashley Maier, Paige Tofson, Rose McKouen, Amanda Iverson, Nic Burgdorf, and Cassandra Ndlovu, MSN, RN, CNE - UWEC College of Nursing Clinical Instructor

3. MEMBERS OF THE PUBLIC WISHING TO BE HEARD

There were no members of the public wishing to be heard.

4. CONSENT AGENDA

RESULT:	APPROVED [UNANIMOUS]
MOVER:	Marcia Kyes, Citizen Rep
SECONDER:	Darren Kirby, District 5
AYES:	Ives, Kirby, Ericksen, Mueller, Bullwinkel, Kyes
ABSENT:	Hennick, Halbleib, Wallsch

1. Approve the Agenda

2. Approve the Minutes

Health & Human Services Board - Regular Meeting - Mar 20, 2025 7:45 AM

March 13, 2025 ADRC Board Minutes

3. Schedule Next Meeting Date - May 15, 2025

Minutes Acceptance: Minutes of Apr 17, 2025 7:45 AM (Consent Agenda)

Health & Human Services Board

Minutes
Regular Meeting

Chippewa County Courthouse, Rm 302

April 17, 2025
7:45 AM

5. REPORTS

1. **Public Health Success Story - Community Health Division - Allie Isaacson/Jenny Lenbom**
Community Health Division Manager Allie Isaacson and Community Health Nurse Jenny Lenbom shared successes within the preparedness program. Successes included:
 - Attended the annual regional exercise to bring community partners together to work through a mock simulation.
 - COVID-19 strengthened the partnership between Public Health and community members. Check in Chippewa was rolled out to aid in the mental health of community members.
 - Staff followed up on foodborne outbreaks, severe weather events, Avian Influenza, and provided education to the plain clothes community.
 - The recovery phase after an event builds on the partnerships and the community's trust in Public Health.
2. **Human Services Policy, Practice, and People - RWC - Tom Diel/Caleb Johnson**
Social Worker Caleb Johnson and Daniel Erickson, of Milkweed Connections, provided information on the Community Support Program's services. Services are provided in-house with a few outside contracts for special services. Erickson provides peer support and recovery coaching based on lived experiences. The services he provides are based on the consumer's needs. RWC Manager Tom Diel gave a brief history of the Community Support Program. He shared the importance of a mental health clinician and their responsibilities. He reviewed the funding sources for the Community Support Program and the Community Recovery Services. Seventy-five percent of the visits happen in the community versus in the office. The goal of the program is to keep the consumers in their own homes and achieve success within the community.
3. **Public Health Director's Program and Financial Report – Brittney Fortuna**
Public Health Director Brittney Fortuna presented the Public Health Program and Financial Report. Fortuna highlighted several items from her report:
 - Administration - Attended Child Development Days, processed community well water invoices, supported peer breastfeeding contacts, and streamlined the tourist rooming house application process.
 - Community Health - No confirmed measles cases in Wisconsin, Child Development Days in Cadott, Tuberculosis types, and World TB Day.
 - The UW-Eau Claire BSN students shared information on the projects they completed. One team worked on an anti-stigma campaign surrounding harm reduction. The Second team worked on Access to Care. They collaborated with the school districts of Stanley/Boyd and Chippewa Falls to host a table trivia game during their lunch periods, provided a QR Code for the clinic, and information on public health services.
 - Environmental Health - Inspection data, free Nitrate screening testing events, and the increase in tourist rooming houses.
 - Nutrition - LTE Nutritionist vacancy posted, WIC caseload increases, Fit Families and the 2024 evaluation data, and the May 27 Blood Drive.
 - Planning and Strategy - Children's Resource Center numbers have increased, outreach events for the region, and the Coalition's campaign, "Prom Positive". The Risk Youth Behavior Survey showed that more students are not drinking alcohol. National Drug Take Back Day will be on April 26, the Planning and Promotion Specialist position has been filled, and Single Point of Entry data.

Fortuna provided an update on funding sources.
4. **Human Services Director's Program and Financial Report – Bobbie Jaeger**

Minutes Acceptance: Minutes of Apr 17, 2025 7:45 AM (Consent Agenda)

Health & Human Services Board

Minutes
Regular Meeting

Chippewa County Courthouse, Rm 302

April 17, 2025
7:45 AM

Human Services Director Bobbie Jaeger presented the Human Services Program and Financial Report. Jaeger highlighted several items from her report:

- Jaeger congratulated the Nursing students.
- Division of Children's and Families (DCF) and the DCF PAC are monitoring federal government actions and the Governor's Budget.
- Congratulations to Human Services staff for their years of service.
- ADRC statewide campaign to increase awareness of services.
- Child Protective Services closed one child's case and reunified two children.
- All vacancies are filled in the Children with Differing Abilities Unit.
- Youth Justice is seeing high-cost placements.
- Ericka Zillmer was promoted to the Economic Support Coordinator position.
- David Pfeiffer was promoted to the Mental Health Clinician position.

Senior Fiscal Manager Paul Brenner highlighted the Children and Youth Out-of-Home Placement data, the high-cost youth placement facilities, Adult Mental Health Out-of-Home placement is on budget, and the IMD (Winnebago) is under budget.

5. **Human Services Education for 2025 Program Prioritization – Bobbie Jaeger**

Human Services Director Bobbie Jaeger reviewed the 2025 Program Prioritization, which shows the programs and services as Mandatory, Essential, and Optional. Board members are asked to complete the ranking and return it to Brandi Engel by May 2. The Program Prioritization form will be emailed to Board members.

6. **BUSINESS ITEMS**

7. **AGENDA ITEMS FOR FUTURE CONSIDERATION**

8. **ADJOURN**

Meeting adjourned at 8:47 AM.

Minutes Acceptance: Minutes of Apr 17, 2025 7:45 AM (Consent Agenda)



**STATEMENT OF EXPLANATION
HUMAN SERVICES 2026 OPIOID FUND REQUEST - TOM DIEL**

5.1

Per resolution 54-21, Chippewa County has funding available from the Opioid settlement with distributors and Johnson & Johnson. These funds are being made available to departments within Chippewa County for approved uses. The program was implemented in 2024 with outreach, education, and community impact.

Human Services is requesting approval for the expansion of the Human Services Peer Support Program & Recovery Coach with this funding for 2026. The requested recommendation is to allocate \$46,000 to this initiative.

Opioid Fund Request Form

- **All programs/projects must be requested by April 15th each year** in order to be considered for an approved program/project for the following calendar/budget year.
- If the CA supports the project after the initial review, then DH have 60 days to complete Section 3 and review it with the policy committee to get their feedback. The completed Opioid Fund Request Form, with the committee feedback, is then submitted back to the CA to be incorporated into the next year's budget by June 15th.
- **All training requests may be requested throughout the year but must be approved by the CA.**
 - * Each individual attending training must complete an Opioid Fund Request Form.
- The following documents are attached for reference when completing this form:
 - * Exhibit E – List of Opioid Remediation Uses – Schedule A: Core Strategies
 - * Exhibit E – List of Opioid Remediation Uses – Schedule B: Approved Uses



SECTION 1 – To Be Completed by DH Before Submitting to the CA for Initial Review

Project Requester/Department: DHS Date: 4/3/2025

Identify the Budget Year Funds are Requested For: 2026

Name of Opioid Program/Project/Training: Peer Support/Recovery Coach in RWC

☐ New Program ☒ Reoccurring Opioid Program *(identify below)* ☐ Expansion of Existing Program *(identify below)*

Identify: Peer Support/Recovery Coach in RWC

Estimated Start Date of Project: 1/126 Estimated Date of Completion: 12/31/26

☐ Training Request Date of Training: _____ Location of Training: _____

Identify the Core Strategy from Schedule A: *(see Exhibit E – List of Opioid Remediation Uses)*

- ☐ Naloxone or Other FDA-Approved Drug to Reverse Opioid Overdoses
- ☐ Medication-Assisted Treatment (“MAT”) Distribution and Other Opioid Related Treatment
- ☐ Pregnant & Postpartum Women
- ☐ Expanding Treatment for Neonatal Abstinence Syndrome (“NAS”)
- ☐ Expansion of Warm Hands-Off Programs and Recovery Services
- ☐ Treatment for Incarcerated Population
- ☐ Prevention Programs
- ☐ Expanding Syringe Service Programs
- ☐ Evidence-Based Data Collection & Research Analyzing the Effectiveness of Abatement Strategies w/in the State

Identify the Approved Use from Schedule B: *(see Exhibit E – List of Opioid Remediation Uses)*

- ☒ Treat Opioid Use Disorder (OUD)
- ☒ Support People in Treatment and Recovery
- ☒ Connect People Who Need Help to the Help They Need (Connections to Care)
- ☒ Address the Needs of Criminal Justice-Involved Persons
- ☐ Address Needs of Pregnant/Parenting Women & Their Families, Including Babies with Neonatal Abstinence Syndrome
- ☐ Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids
- ☐ Prevent Misuse of Opioids
- ☐ Prevent Overdose Deaths and Other Harm (Harm Reduction)
- ☐ First Responders
- ☐ Leadership, Planning and Coordination
- ☐ Training
- ☐ Research

List the Subcategory as Shown in Exhibit E:

Note: The Subcategories are the numbered items listed under the Core Strategies from Schedule A or the Approved Uses from Schedule B

- A) Treat Opioid Use Disorder # 5
- B) Support People in Treatment and Recovery # 3
- C) Connections to Care # 10
- D) Address the Needs of Criminal Justice-Involved Persons

Description – Provide an explanation about what the program/project/training entails.

Peer support is an evidence-based practice approved by the Center for Medicare and Medicaid Services in 2007. Peer support is generally cost-effective and cost saving. A managed care company, has shown substantial reductions in average inpatient days for people receiving peer support. They saw an average 80.5 percent reduction of inpatient days, and a 32 percent reduction of involuntary hospitalizations for people receiving peer run respite services (Bergeson, 2013).

Peer-delivered services generate superior outcomes in terms of engaging “difficult to reach” individuals, reduce rates of hospitalization and days spent as inpatient, and decrease substance use among persons with co-occurring substance use disorders.

Inclusion of a peer support/recovery coach) on the RWC team helps reduce stigma associated with mental illness and increase our appreciation of the hard work and effort involved in supporting the recovery community.

The total amount is \$96,380 (\$73/hr) RWC will supplement the opioid funding with the DHS Substance Abuse Block Grant dollars.

How does this program/project/training help with the Opioid use abatement efforts in Chippewa County?

It utilizes an evidenced based practice to improve outcomes for those who have a OUD or co-occurring substance use disorder.

Has this program/project/training utilized Opioid funds in the previous year? ☒ Yes ☐ No

If yes, then identify some of the measurable impacts the program/project/training has had on abatement efforts.

In 2024 the contracted peer/recovery coach specialist worked directly with 16 participants who are dealing with substance use disorder. 14 participants reside independently in the community. 2 participants are in placement, requiring structure and supervision. The peer/recovery coach provides guidance as the individual creates their personal journey in recovery through developing hope, community connection, a sense of self In 2024 peer/recover provided 670 hours of direct services.

Estimated Annual Cost of Program/Project/Training: \$ \$91,584.

Amount of Annual Chippewa County Opioid Funds Requested: \$ \$46000.

Will matching funds be used by another organization/municipality? ☐ Yes ☒ No

If yes, identify who and amount: _____

Is there a current program/service that will no longer be offered? ☐ Yes ☒ No

If yes, please identify the program, costs and revenue source of the current program.

Are you able to manage and implement this new program/project/training with existing staff within your department?

☐ Yes ☒ No

If yes, how many staffing hours annually are anticipated? _____

If no, are you able to contract with an organization/individual to provide the service? ☒ Yes ☐ No

Return completed form to the County Administrator

Bobbie Jaeger
Signature of Project Requester/Department Head

4/9/25
Date

SECTION 2 – To Be Completed by the County Administrator

- ☒ Approved for Committee Review and Feedback
 ☐ Denied
 ☐ More Information Needed
☐ Training Approved – Committee Review Not Needed

Total Amount of Chippewa County Opioid Funds Recommended by County Administrator: \$ 46,000.00

Lori Zwiefelhofer (CA Vacancy)
County Administrator

4/9/2025

Date

Comments:

This Opioid request can be forwarded to your policy committee. Remember this year is unique because the new County Administrator, Andy Albarado, will have final approval after your policy committee review of this request.

SECTION 3 – Additional Action and/or Comments from Committee

Note: It should be emphasized to the Policy Committee that not all programs/projects may be approved due to the limited funds available in the Opioid Abatement Account.

Committee Meeting Date: _____ ☐ Approved ☐ Denied ☐ More Information Needed

Department Head Recommended Ranking: _____ Committee Approved Ranking: _____

Total Amount of Chippewa County Opioid Funds Approved by Committee: \$ _____

Comments:

- Submit completed form back to the County Administrator after policy committee has reviewed/approved by June 15th.

EXHIBIT E**List of Opioid Remediation Uses****Schedule A****Core Strategies**

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies (“Core Strategies”).¹⁴

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and
2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. **MEDICATION-ASSISTED TREATMENT (“MAT”) DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT**

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;
2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;
3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and
4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

¹⁴ As used in this Schedule A, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs.

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment (“*SBIRT*”) services to non-Medicaid eligible or uninsured pregnant women;
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder (“*OUD*”) and other Substance Use Disorder (“*SUD*”) / Mental Health disorders for uninsured individuals for up to 12 months postpartum; and
3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME (“*NAS*”)**

1. Expand comprehensive evidence-based and recovery support for NAS babies;
2. Expand services for better continuum of care with infant-need dyad; and
3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

E. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;
2. Expand warm hand-off services to transition to recovery services;
3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;
4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and
5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. TREATMENT FOR INCARCERATED POPULATION

1. Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and
2. Increase funding for jails to provide treatment to inmates with OUD.

G. PREVENTION PROGRAMS

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);
2. Funding for evidence-based prevention programs in schools;
3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);
4. Funding for community drug disposal programs; and
5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. EXPANDING SYRINGE SERVICE PROGRAMS

1. Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE

Schedule B
Approved Uses

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder (“OUD”) and any co-occurring Substance Use Disorder or Mental Health (“SUD/MH”) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:¹⁵

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (“MAT”) approved by the U.S. Food and Drug Administration.
2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (“ASAM”) continuum of care for OUD and any co-occurring SUD/MH conditions.
3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.
4. Improve oversight of Opioid Treatment Programs (“OTPs”) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.
5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.
6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.
7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

¹⁵ As used in this Schedule B, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs.

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.
9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.
10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.
12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (“DATA 2000”) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.
13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry’s Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.
14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry’s Provider Clinical Support Service for Medication–Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the programs or strategies that:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.
2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.
3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved medication with other support services.
5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.
6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.
7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.
8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.
9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.
10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.
11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.
12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.
13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.
14. Create and/or support recovery high schools.
15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED
(CONNECTIONS TO CARE)

Provide connections to care for people who have—or are at risk of developing—OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.
2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.
3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.
4. Purchase automated versions of SBIRT and support ongoing costs of the technology.
5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.
6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.
7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.
8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.
9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.
10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.
11. Expand warm hand-off services to transition to recovery services.
12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.
13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.
15. Engage non-profits and the faith community as a system to support outreach for treatment.
16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:
 1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (“*PAARI*”);
 2. Active outreach strategies such as the Drug Abuse Response Team (“*DART*”) model;
 3. “Naloxone Plus” strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;
 4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (“*LEAD*”) model;
 5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or
 6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.
2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.
3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.
5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.
6. Support critical time interventions (“CTI”), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.
7. Provide training on best practices for addressing the needs of criminal justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (“NAS”), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.
3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.
4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; and expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.
6. Provide child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.
7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.
8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.
9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.
10. Provide support for Children's Services—Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. **PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS**

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).
2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.
3. Continuing Medical Education (CME) on appropriate prescribing of opioids.
4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.
5. Supporting enhancements or improvements to Prescription Drug Monitoring Programs ("PDMPs"), including, but not limited to, improvements that:

1. Increase the number of prescribers using PDMPs;
2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or
3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.
6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.
7. Increasing electronic prescribing to prevent diversion or forgery.
8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding media campaigns to prevent opioid misuse.
2. Corrective advertising or affirmative public education campaigns based on evidence.
3. Public education relating to drug disposal.
4. Drug take-back disposal or destruction programs.
5. Funding community anti-drug coalitions that engage in drug prevention efforts.
6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (“SAMHSA”).
7. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.
9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.
10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.
11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.
12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.
2. Public health entities providing free naloxone to anyone in the community.
3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.
4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.
5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.
6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.
8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.
9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.
10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.
11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.
12. Providing training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.
13. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.
2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.
3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, those that:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.
2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.
2. Research non-opioid treatment of chronic pain.
3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.
5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.
6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (*e.g.*, Hawaii HOPE and Dakota 24/7).
7. Epidemiological surveillance of OUD-related behaviors in critical populations, including individuals entering the criminal justice system, including, but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (“ADAM”) system.
8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.
9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.



**STATEMENT OF EXPLANATION
HUMAN SERVICES 2024 ANNUAL REPORT - BOBBIE JAEGER**

5.2

The 2024 Human Services Annual Report will be presented for review and approval.



Human Services

2024 ANNUAL REPORT

Chippewa County Department of Human Services

Preparation and Coordination of Report

Human Services Director: Bobbie Jager

Leadership Team: Amy Doman, Ashley Brott, Ashley Yang, Beth Nyhus, Brandi Engel, Elizabeth Patten, Erika Ferrin, Hannah LaBelle, Jessica Buckli, Jordan Hallingstad, Kayla Colbenson, Kerry Krista, Kyra Secraw, Nichole Velie, Paul Brenner, Sarah Zielke, Tom Diel

Table of Contents

MESSAGE FROM THE LEADERSHIP TEAM.....	4
ABOUT US.....	5
FISCAL AND CONTRACTS	7
Achievements/Successes	7
Challenges.....	7
HUMAN SERVICES BUDGET COMPARISON 2020-2024	8
ADRC BUDGET COMPARISON 2020-2024	9
AGING AND DISABILITY RESOURCE CENTER	10
Achievements/Successes	11
Challenges.....	11
Service Delivery Data.....	12
CHILDREN, YOUTH, AND FAMILY SERVICES.....	13
BIRTH TO THREE EARLY INTERVENTION SERVICES.....	13
Achievements/Successes	13
Challenges.....	13
CHILD PROTECTIVE SERVICES.....	14
Achievements/Successes	14
Challenges.....	15
Service Delivery Data.....	15
CHILDREN WITH DIFFERING ABILITIES.....	15
Achievements/Successes	15
Challenges.....	16
Service Delivery Data.....	16
YOUTH JUSTICE SERVICES	16
Achievements/Successes	16
Challenges.....	17
Service Delivery Data.....	17
ECONOMIC SUPPORT	18
Achievements/Successes	18
Challenges.....	19
Service Delivery Data.....	19

RECOVERY AND WELLNESS CONSORTIUM	20
Achievements/Successes	20
Challenges.....	21
Service Delivery Data.....	21
WESTERN REGION RECOVERY AND WELLNESS CONSORTIUM.....	22
Achievements/Successes	22
Challenges.....	23

MESSAGE FROM THE LEADERSHIP TEAM

We are pleased to provide the 2024 Annual Report for Chippewa County Department of Human Services. As you will see, it highlights our achievements, challenges, and investments in support of our mission.

While we celebrate our achievements, we look forward to continuing to meet challenges with creativity, collaboration, community engagement, and fiscal responsibility.

One important focus in 2025 is our ongoing commitment to building a healthy workplace and a culture of service. We have assembled an incredible Human Service team that utilizes client and family-centered service models and data driven decision making to achieve operational efficiencies while delivering high quality services to the citizens of Chippewa County.

We will continue building on this foundation of demonstrated success to continue to meet the needs of those we serve.

DHS Leadership Team

ABOUT US

The Chippewa County Department of Human Services (DHS) is dedicated to enhancing the well-being of individuals and families across the county. Guided by its vision – “Everyone reaching their full potential to live their best life” – DHS upholds core values of advocacy, compassion, empowerment, partnership, and respect. Our mission is to strengthen our community through partnerships and services to promote dignity, increase resilience, and provide hope.

DHS offers a comprehensive range of services through several key divisions:

- Aging and Disability Resource Center
- Children, Youth, and Families
- Economic Support
- Fiscal and Contracts
- Recovery and Wellness Consortium
- Western Region Recovery and Wellness Consortium

Top L-R: James Ericksen, Dean Mueller, Dr. Robert Bullwinkel, John (Jack) Halbleib, Darren Kirby, Bottom L-R: Lee Hennick (Vice-Chair), Kari Ives (Chair), Marcia Kyes, Not Pictured: James Ericksen, Nichole Wallsch



Thank you to our HHS and ADRC Board Members!

L-R: Patricia German, Yvonne Hedrington, Darren Kirby, Cindy Spaeth, Renee Thompson, Not Pictured: Don Hauser, Larry Marquardt



FISCAL AND CONTRACTS

The Fiscal and Contracts Division supports the Department of Human Services, Aging and Disability Resource Center, and the nine-county Western Region Wellness and Recovery Consortium with a variety of activities including:

- Medicaid and Consumer Billing
- Grant Claiming and Reconciliation Reporting
- Financial Accounting and Reporting
- Budget Planning and Analysis
- Vendor Contracting and Payments

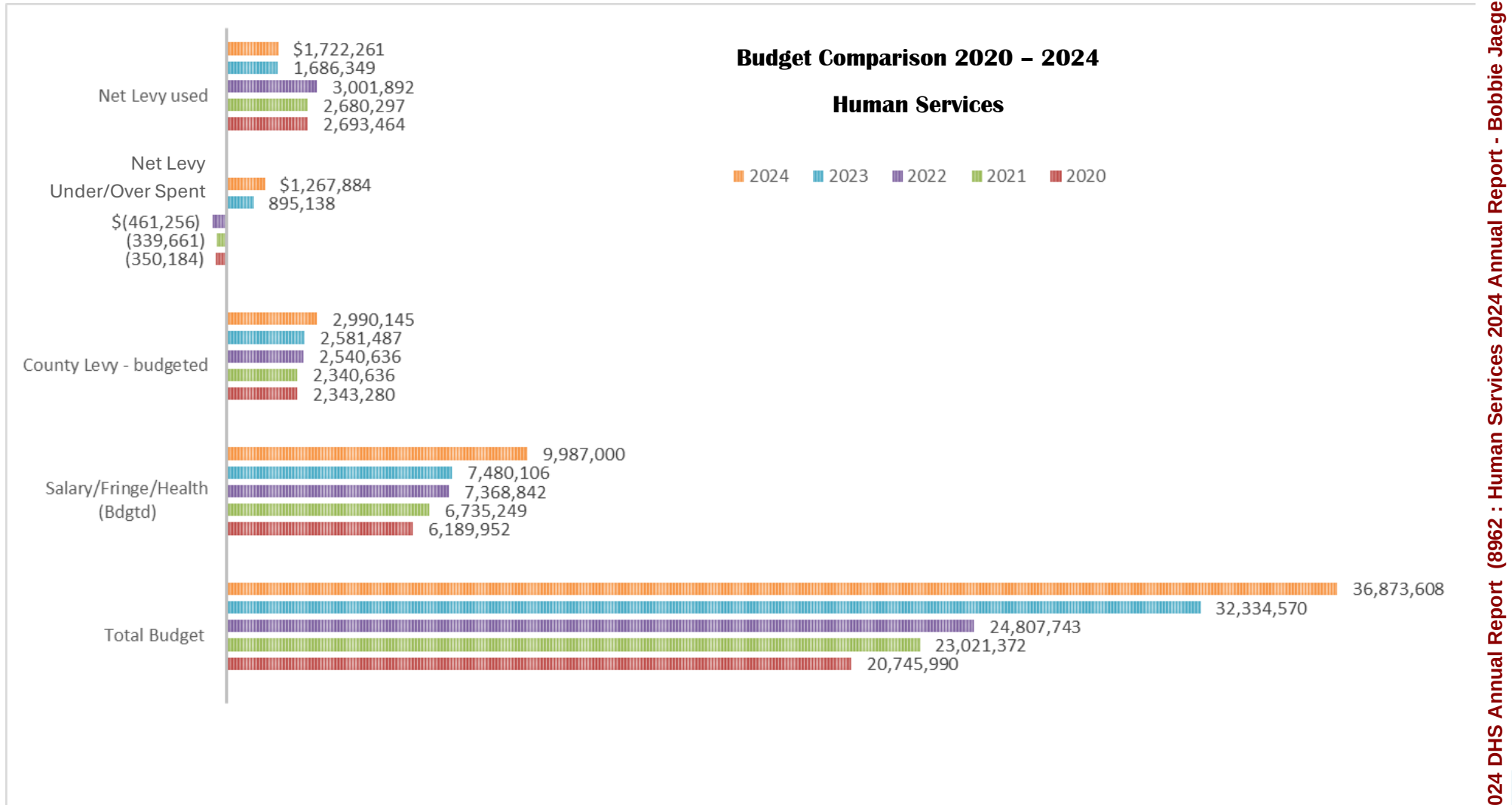
Achievements/Successes

- Decreased child placements resulted in a \$1.25 million-dollar (unaudited) surplus
 - The majority of the surplus was the result of decreased child placement costs
 - The second largest contribution to the surplus was indirect costs recovered by the Western Region Wellness and Recovery Consortium (\$483,780)
- In October 2024, we filled an account position approved by the County Board for 2024. Our division has not had any turnover since a previous retirement in March 2023.
- The fiscal team dedicated themselves to billing Medicaid for reimbursement sooner, decreasing the Accounts Receivable days to 33 days and continuously beating billing deadlines.

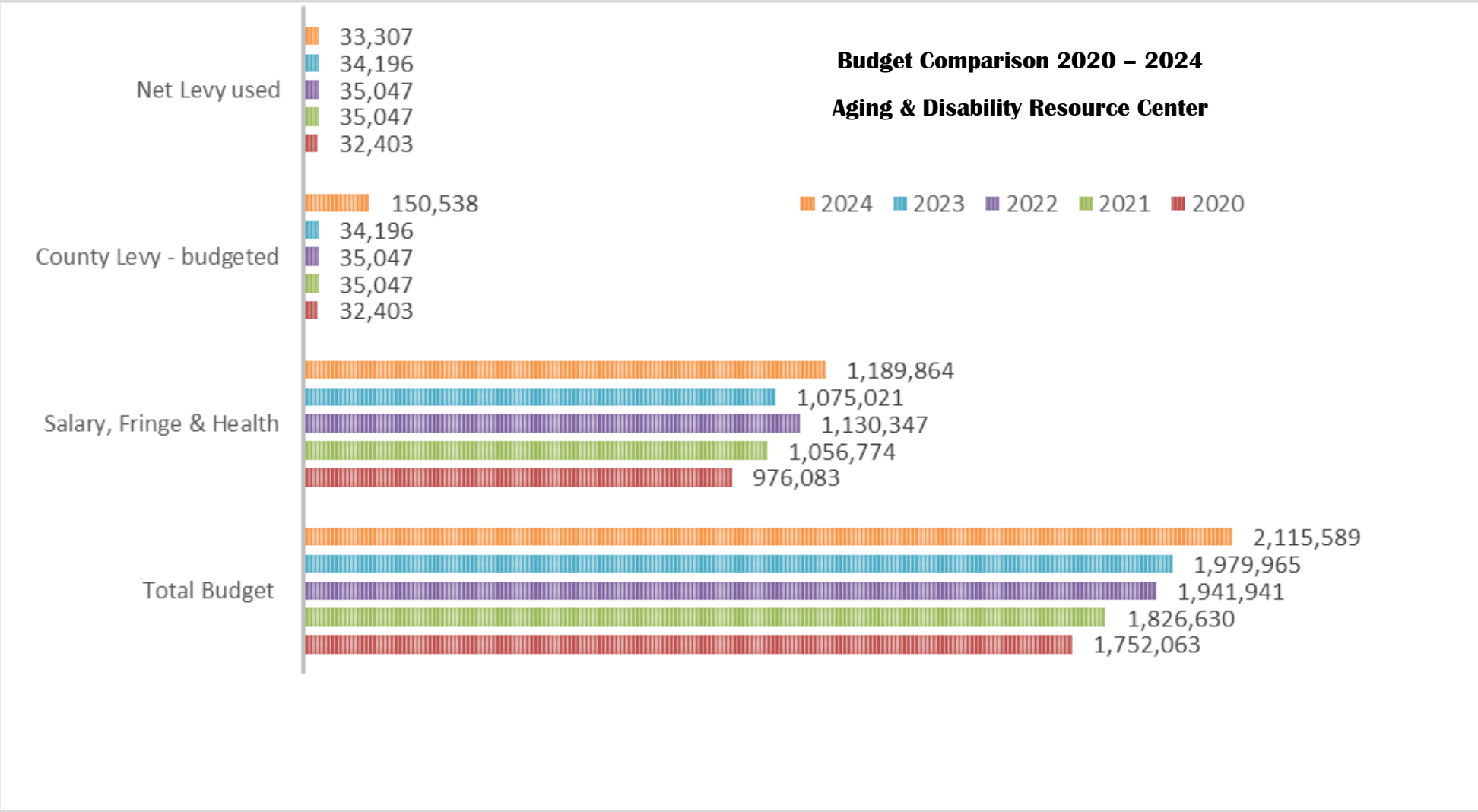
Challenges

- IMD (Winnebago and Trempealeau) costs continue to increase and exceeded the budgeted cost by \$181,067 (unaudited)
- Birth to Three costs increased due to new vendor after the HSHS closure

HUMAN SERVICES BUDGET COMPARISON 2020-2024



ADRC BUDGET COMPARISON 2020-2024



AGING AND DISABILITY RESOURCE CENTER



The simplest version of the ADRC mission is to say that we are here to help older people and people with disabilities remain as independent as possible in the setting of their choosing. Aging and Disability Resource Centers (ADRCs) are the first place to go to get accurate, unbiased, and timely information on all aspects of life related to aging or living with a disability. ADRCs are friendly,

welcoming places where anyone – individuals, concerned families or friends, or professionals working with issues related to aging or disabilities – can go for information tailored to their situation. It isn't about what we feel is best for the individual, but rather it's about presenting options so they can make an informed choice.

We also recognize that people don't always know what they need. That's okay too because ADRC staff have extensive training in asking the right questions. The questions not only help people figure out what they need or want but also help to identify their strengths. When help is requested with applying or connecting to programs or services, ADRC staff will assist.

The ADRC of Chippewa County provides more than information and assistance. We also have programs that can help people remain in their homes. Meals on Wheels, Senior Dining, Transportation Coordination, Caregiver Respite, In-Home Support, Healthy Living workshops, Memory Screening, and Dementia-related programs are just some of the programs our agency offers. Our Options Counselors present customers with an array of choices that can help with their situation, along with assistance in accessing if needed. We also have highly trained Benefit Specialists that assist with Medicare, Social Security, Consumerism, Medical Assistance, and other private and public benefit questions. Complicated issues require extensive training, and our Benefit Specialists work directly with attorneys who specialize in all these areas as they relate to older people and people with disabilities.

One thing that sets ADRCs apart from other governmental agencies is the fact that we are legislatively required to provide advocacy on behalf of the people we serve. Sometimes that means talking to local businesses and sometimes that means connecting with legislators. But, most importantly, it means providing people with information empowering them to advocate on their own behalf.

Achievements/Successes

- Our Senior Farmers Market Voucher program again exceeded all previous records. We provided more vouchers than ever before, and it is the first time over 50% applied online. A total of 358 consumers served, resulting in \$11,736 in local fresh produce being redeemed with this program.
- Developed and implemented Café 60, a modern model for senior dining providing meals in a restaurant setting in rural areas which are too small to support a formal congregate meal site
- Streamlined nutrition program processes and reduced the number of vendors, resulting in improved customer satisfaction with meals.
- Increased number of “Medicare and You” offerings in a virtual format while maintaining our in-person offerings as well.
- Staff and board members participated in several advocacy events.
- Expanded our outreach into the community, which included participating in Farm Technology Days held in Chippewa County this year.
- Developed transportation procedures ensuring we would be able to provide rides through the end of the year and assisted several dialysis transportation participants in applying for benefits that would help cover the cost of their rides.
- Added two Health Promotions Programs: Eat Smart, Move More, Weigh Less, as well as Staying Active and Independent for Life (S.A.I.L.).
- Nutrition Program volunteer participation increased by 12.5%.
- Participated in the Independent Living Support Pilot program with Dunn and Eau Claire counties with \$558,000 worth of goods and services provided to low-income Chippewa County residents.

Challenges

- A change in the statewide system for recording services we provide created a significant learning curve that affected every staff member and all services.
- Turnover in the two leadership positions in the ADRC – Manager and Nutrition and Transportation Programs Supervisor.
- Closure of HSHS and the impact of that on our transportation program.
- The increase in the aging population continues to create stress points for our Elder Benefit Specialist program, particularly related to Medicare and Medicare Advantage plans.
- Turnover of Nutrition Program staff, combined with the challenges of hiring those very part-time positions, created challenges in service delivery.
- Decrease in funding of several of our programs supported by the Older Americans Act. We were able to utilize ARPA funds to mitigate the impact of these decreases.

Service Delivery Data

ADRC Service/Program	Consumer Data for 2024
Bridging Chippewa County	21,247 copies distributed†
Caregiver Respite	39 consumers 2,969 hours of respite
Dementia Related Services*	51 consumers 69 programs/services
Disability Benefits^	136 consumers 364 cases
Elder Benefits**	665 consumers 1,478 cases/contacts
Healthy Living Workshop Sessions	92 consumers 1,134 classes/sessions
Information and Assistance/Options Counseling (does not include information provided by reception)	5,507 consumer contacts 1,396 unduplicated consumers
In-home Supports (housekeeping)	44 consumers 1,267 service units
Nutrition Program	470 consumers 39,448 meals
Transportation	3,847 rides 190,209 miles

†Includes print and email distribution. Does not include the number of online views of the newsletter.

*Dementia consumers do not include the number of people who attended various presentations or workshops. The number of programs/services reflects separate programs or presentations.

**Due to database migration, we do not have figures for November and December.

^These figures are October 2023 to October 2024

CHILDREN, YOUTH, AND FAMILY SERVICES

BIRTH TO THREE EARLY INTERVENTION SERVICES

Birth to Three is Wisconsin's early intervention program for infants and toddlers, with developmental delays and disabilities, and their families. Once a child is found eligible and enrolled, a primary coach works with the family to provide support, strategies, and education related to the child's development. The ultimate goal is for the child to be a full participant in their family routines and in their community. Services are provided in a way that makes sense for each family, in the child's natural environment. This family-centered program recognizes the importance of parents, family, and friends in a young child's life and empowers them to be the child's best teachers.

Achievements/Successes

- The Birth to Three Program received 237 referrals in 2024. On average, between 75-85 children are enrolled in the program at any given time. On October 1, 2024, there were 78 children enrolled in the program.
- The Birth to Three program was awarded a grant from Essential Resource Purchase Program. The program was able to purchase an iPad to be able to explore modeling how families can use it to bridge communication gaps with children who are nonverbal. The program was also able to purchase books for our lending library and other therapy tools that can be loaned out to families.
- 2024 was a year filled with lots of change for our Birth to Three program. With HSHS/Prevea closing, we needed to find a new therapy contract. We were successful in finding a new agency to contract with and were able to keep the same great team of therapists, including one full-time Speech Therapist along with three part-time positions for Speech Therapy, Occupational Therapy, and Physical Therapy. We had an additional staff change, as the Birth to Three Program Coordinator/Teacher/Service Coordinator resigned due to a family move. A new team member with years of Birth to Three experience was hired in April 2024. The team moved through the changes with very little glitches, and families did not have any disruptions in services.
- In Fall 2024, the Birth to Three program completed outreach by sending packets out to all licensed in-home and center-based childcare businesses in Chippewa County. We are hoping to build better connections and strengthen our partnerships. We did receive a couple of referrals from Early Head Start and a childcare provider.
- Chippewa County Birth to Three received a Determination Status of "Meets Requirements" from the State Department of Health Services for the 2022-2023 reporting year, with 93.75 percent of indicators met. This indicates strong compliance with reporting and timeline measures and increased child outcomes.

Challenges

- Families struggled to find appropriate and affordable daycare for children, along with resources for their family while continuing to work; trying to balance providing for their family and caring for their children who may have additional needs can be very difficult. The impacts on parents mental

health has changed the dynamic of the Birth to Three program over the years. We have shifted from providing one-on-one therapy to children to providing support for the entire family. These changes require staff to remain versatile in their roles outside the intended scope of services of the Birth to Three program.

CHILD PROTECTIVE SERVICES

The Child Protective Services (CPS) unit assesses families whose children may have been abused or neglected. When an intensive approach is necessary, ongoing services are provided to families. Services may include foster care, parenting support, or other resources to keep children safe. CPS works closely with law enforcement, community organizations, courts, schools, and other community providers to keep children safe and empower families. CPS also provides foster care licensing, foster care placement, and the Kinship program. When safety cannot be reached with a family, the unit works with the court system to find alternative permanency for a child, such as adoption or guardianship.

Achievements/Successes

- CPS served 310 children. Twenty children were removed in 2024, compared to thirty-nine that were removed in 2023. Of those twenty children, four children were able to be placed with their protective parent, eight children were able to be placed with relatives, and four children were able to be placed with “like-kin providers” (i.e. adults who had a previous relationship with the child). That means that only four children were placed in foster care in 2024.
- Thirty-three children achieved permanency; of those thirty-three children, seventeen children achieved permanency through reunification with their parent(s), seven children achieved permanency through guardianship, and nine children achieved permanency through termination of parental rights/adoption.
- CPS was able to close forty-two open cases.
- At the end of 2024, only nineteen children were in out-of-home care.
- CPS applied for and was awarded the Targeted Safety Support Funding (TSSF) grant and the Promoting Safe and Stable Families (PSSF) grant. These two grants help social workers keep children in their homes with services or help social workers reunify children quicker as services can be implemented in the home to mitigate safety concerns. CPS also applied for and was awarded the Relative Caregiver Support grant. The Relative Caregiver Support grant can be used to assist relatives with extra fees they may incur due to daycare, sports, or other activities for the children in their care. The grant can also be used for concrete supports (gas gift cards, grocery gift cards, and clothing gift cards) at the discretion of CPS to support children placed with relatives.
- CPS was also awarded the Family First grant. This grant, similar to the Relative Caregiver Support grant, can be used to help keep children in their relative caregivers’ homes or be used for services to move families towards reunification more quickly.
- CPS spent a significant amount of time on community education throughout 2024. Presentations were given on Mandated Reporting and the CPS Process, which has led to increased collaboration and access reports that embody the information needed to make solid screening decisions.

- CPS added a part-time Family Interaction Worker LTE. This position is partially funded by grant funding and has saved CPS a significant amount of money due to the high costs of contracted fees for family interaction services. This is a necessary/mandated service, and the increased collaboration and communication between CPS and the Family Interaction Worker has had a positive impact on cases.
- CPS stayed relatively stable in 2024. Caseloads finally reached a manageable number, and the team has grown to have a healthy and open culture. This has been imperative in helping workers feel supported and preventing burnout, therefore, making CPS an area where workers want to stay. Historically, CPS has seen position turnover after working in the unit for approximately one to two years.

Challenges

- Chippewa County is in dire need of foster homes for teenagers. The county has many foster homes willing to take infants or children from ages zero to five; however, there is currently only one foster home willing to take teenagers, and they are at capacity due to current placements, as well as relative/adopted children residing in the home.

Service Delivery Data

CYF Service/Program	Consumer Data for 2024
Birth to Three Program	237
Child Protective Services	310

CHILDREN WITH DIFFERING ABILITIES

Children with Differing Abilities (CWDA) is the unit that provides services and support to children who have been diagnosed with a physical, developmental, or mental health disability and determined to be functionally eligible in accordance with federal and state standards. Services within the Children with Differing Abilities Unit are voluntary and designed to assist families to maintain their children safely in the community and at home.

The Children with Differing Abilities Unit is comprised of one manager, one supervisor, three Children's Long-Term Support Waiver (CLTS-Waiver) Support and Service Coordinators, and nine Children's Comprehensive Community Services (CCS) Service Facilitators.

Achievements/Successes

- Due to the substantial growth in this unit, we were approved by the County Board to hire two additional supervisors. There will be three supervisors in 2025 to meet the needs and demands of providing Children's CCS and CLTS-Waiver programs to Chippewa County residents.
- We successfully transitioned staff to telecommuting status due to outgrowing space available at the Courthouse.
- From July to December staff worked diligently to significantly reduce and eliminate our waitlists in both programs.

- Our partnership with Public Health as our Single Point of Entry (SPOE) continues to be strong. A new initial screener was successfully onboarded after a retirement in that position.

Challenges

- Provider waitlists continue to impact our ability to provide services to consumers in a timely manner.
- Despite reducing and eliminating our waitlists to enroll children into CLTS, we have been asked to complete a Corrective Action Plan (CAP) as our rolling 6-month average as of this fall, did not meet expectations of the State. We expect to successfully complete our CAP no later than June 2025.

Service Delivery Data

CYF Service – CWDA/Program	Consumer Data for 2024
Children’s Long-Term Support (CLTS)	109 Cases Opened
Children’s Comprehensive Community Services (CCS) (Includes children dually enrolled in CCS and CLTS)	114 Cases Opened

YOUTH JUSTICE SERVICES

Youth Justice is the unit that works with youth referred to court under Wisconsin Statutes 938. These youth have either committed a delinquent act, are habitually truant from school, or have uncontrollable behavioral issues. Youth Justice social workers work in conjunction with the legal system, the youth, and parents by developing a plan to reduce risk factors such as substance abuse, negative peer associations, truancy, and other risk factors that negatively influence youth behavior and provide the youth with competencies for a successful future.

Chapter 938 or 48 are the only statutes that allow for placing children out of the home in foster care, group home, or residential treatment level of care. When complex needs youth require one of these out-of-home placements, they typically come through the court system in our unit via Chapter 938-Juvenile in Need of Protection and/or Services-Uncontrollable. Ongoing Youth Justice workers work diligently with families and service providers to keep youth in the community.

The Youth Justice Unit is comprised of one Juvenile Court Intake social worker, plus three full-time social workers and one half-time social worker providing ongoing services.

Achievements/Successes

- We were awarded the Community Intervention grant again, continuing and enhancing our ability to deliver Aggression Replacement Training (ART) and Girls Moving On (GMO) skills group for medium to high-risk youth. Additionally, with this grant, we have been able to continue to support our partnership with Restorative Justice to provide more services to Chippewa County youth.
- We were also awarded a \$100,000 innovation grant for 2025 to work on reducing the number of youth justice referrals. Through this grant, we are building a county-wide coalition with the school districts and law enforcement to implement a consistent practice of behavior threat assessment within the schools of Chippewa County.
- Youth Justice out-of-home placements met a milestone “all time lowest” out of home placements for 4 months during the 2024 calendar year! We demonstrated that with a caseload size of 12-14 per full time worker, that staff had the time to successfully case manage, build relationships to

keep kids in the community and out of placement.

Challenges

- Statewide, we continue to see youth being served in the youth justice system, when their needs are mental health. This is primarily because in Wisconsin, Chapter 938 (the Youth Justice code) is the only means for placing youth out of their home when and if the need arises to that level.
- Staff spend a significant amount of time addressing truancy matters with minimal success, as there is yet to be identified an evidence-based intervention to address high need truancy behaviors. For this reason, it is important for multi-level prevention and engagement to occur at home, in the community and at school.
- Contrary to our success with low out-of-home placements in the first half of the year (highlighted above), as our caseloads increased, so did our out-of-home placement numbers. This can be devastating to the Department budget as these placements range in cost from \$450 per day to \$950 per day. Historically, we have not been able to bring forth an opportunity to acquire sufficient staffing levels in Youth Justice, therefore that will be a primary focus of 2025.

Service Delivery Data

CYF Service – YJ/Program (Juvenile Court Intake Referrals)	Consumer Data for 2024
Total Referrals	227
Delinquents	191
Truants	62
Runaways	22
Uncontrollable	2
Total Citations	80

ECONOMIC SUPPORT



The Economic Support Division administers programs and services that assist eligible Chippewa County consumers, empowering them to achieve positive outcomes when they face economic challenges. The Economic Support Division helps families in need become self-sufficient and independent from public assistance. This is done by assessing each family's financial situation to determine eligibility for public assistance programs. Chippewa County Economic Support is part of the Great Rivers ten-county consortium (GRC).

Achievements/Successes

Operations

- Continued efforts to improve accuracy and consistency in Lead Teams through regular meetings and Policy, Procedure, Process manual updates.
- Successfully migrated to the Genesys Cloud CX platform (call center) for all staff.
- Conducted quarterly reviews of training opportunities (errors) creating a "TO page" to display important information for staff.
- GRC staff completed the ProQOL (Professional Quality of Life) Assessment and participated in a Start, Stop, Continue activity with a goal to improve staff satisfaction.
- Removed No call No show appointments in the call center time (linked to ProQOL).
- GRC call center performance was impressive, ranking 4th in answer rates for 7 out of 12 months, 5th for one month, 3rd for one month, 2nd for two months, and 1st for one month statewide.
- Average Speed of Answer for the GRC Call Center ranged from 2.88 minutes to 7.71 minutes, outperforming the state performance standard of 10 minutes.
- Wisconsin continues to be a nationwide leader in timeliness and accuracy, with the state being the only one maintaining a low FoodShare Active error rate and case and procedural error rate. GRC played a key role in this success.
- Held two GRC All-Staff Q&A sessions presented by Leads.
- Completed the COVID policy unwinding process.

Staffing - Across the GRC

- GRC currently has 129 total positions.
- Resignations: 13 (9% of total positions)
- New Staff: 13
- Promotions: 0
- Chippewa County Economic Support had one retirement in 2024

Benefit Recovery (BR)

- Implemented Compromising Claims policy
- Completed BRITS Phase II (fraud and overpayment system)
- SWICA (case discrepancies) saw an increase, leading to more referrals.

Childcare

- Successfully completed the Annual Subsidy & Certification Review.
- Rolled out Child Care Phase 2 PT/FT subsidy
- Navigated a shift in thinking regarding authorizations for staff, caretakers, and providers.

IM Programs

- Successfully passed the Foodshare Management Evaluation Review (MER), with an Active Error Rate of 1.67% and a Case and Procedural Error Rate of 20.37%.
- Developed a Hub “TO page” for staff to track current trends.
- Conducted a staff survey on training topics.
- Rolled out DEAR (36-month Foodshare eligibility for certain households)
- Reintroduced MAPP premiums.
- Resumed FoodShare interviews.
- Added “*Katie Beckett*” program to CARES worker Web, introducing more alerts and manual processes.

Challenges

- Increased number of reports to process due to system issues.
- External federal/state policy changes and their impact on technology and procedures.
- Inefficient systems that are unable to accommodate policy changes.
- Integration of additional programs (e.g., Katie Beckett) into CWW, requiring staff to adapt.
- Potential changes to federal funding match.

Service Delivery Data

Service/Program	Consumer Data for 2024
FoodShare	6,191
Medical Assistance	13,546
Child Care	348
Total	20,085

RECOVERY AND WELLNESS CONSORTIUM

Chippewa County Recovery Wellness Consortium (RWC) is a part of the nine county Western Region Consortium. The RWC is a resource hub for individuals experiencing mental health emergency (crisis), mental illness and/or substance use disorders. Programs available include Crisis Services (including case management of mental health commitments), Community Support Program (CSP), and Comprehensive Community Services (CCS). A service facilitator is assigned to each consumer who becomes their advocate and assists them in their recovery journey. Functional and financial criteria determine program eligibility. Based on assessed need, the following are examples of some services available: psychiatry, mental health and substance abuse counseling, supported employment and individual skill development. Chippewa County maintains a collaborative relationship with Buffalo and Pepin Counties. Referred to as regionalization, this collaboration means we all act as one entity with Chippewa (Lead County) providing administrative and clinical oversight of the Medicaid certified programs (CSP and Crisis). This relationship allows citizens in Buffalo and Pepin counties access to these certified programs.

Achievements/Successes

- Comprehensive Community Services (CCS) and Community Support Program (CSP) are psycho-social rehabilitation services that promote personal recovery, successful community integration and improve the quality of life for persons with mental health struggles. In 2024 CCS had 17 participants graduate from the program and CSP program had 2 participants graduate. Graduation references that the participant no longer qualified for services as determined by the mental health functional screen. These participants have sustained the skills and resources to increase their capacity to be successful and satisfied in the living, working, and social environments of their choice.
- In 2024 service facilitators began implementing wraparound principals in their practices. This included the use of meeting agendas, frequent recovery team meetings, identifying short term goals with assigning tasks to team members to report out at the next recovery team meeting. Any changes in the recovery plan are discussed with the entire team before implementing any updates/changes.
- In December RWC began implementation of rotation with staff to take shifts for handling initial mental health and APS referrals. This allows staff to schedule time in their calendar for this purpose and avoids the disruption that happens when a particular staff person is asked to complete unscheduled intake. Additionally, this allows APS staff to be out in the field completing investigation in a timely manner. Implementation of this process is a clear example of the level of commitment and teamwork by each member of the RWC team.
- The Chippewa Valley has seen a drop in the number of drug overdoses after years of steady increases. RWC partner with Public Health Department to pay for the installation of vending machine in the lobby of the Chippewa County Jail. Along with Narcan, fentanyl and xylazine test strips the vending machine will distribute gun locks.

Challenges

- In 2023, Chippewa County's total population was 66,558, 19.1% of this population is 65 years or older. Adult Protective Services (APS) field 218 referrals of which 92 were for self-neglect, 52 for financial abuse, 39 neglect by others, physical abuse (16), emotional (10) and sexual (9). A total of 67 guardianships were completed, of which 19 were result of emergency protective placement. Every action taken by APS must balance the duty to protect the safety of the vulnerable adult with the right to self-determination. All competent people have the right to self-determination, choose their own values, principles and lifestyle. All adults are presumed to have competency unless determined differently by the court.
- The Chippewa Valley lacks psychiatric hospital beds, resulting in 43% of all emergency detentions placement at Winnebago Mental Health Institute (WMHI). The daily rate is \$1632. RWC actively pursues reimbursement for patients that do not have legal residency in Chippewa County. 47% of detentions are dismissed. There has been an increase in court approved Settlement Agreement. In essence the participant agrees to participate in recommended mental health services for 90 days. In 2024 there were 29 orders with need to revoke 4 cases due to poor compliance and elevated safety risk in the community. Community resources to manage someone experiencing a mental health crisis are needed.
- Mental Health service needs in the county jail are lacking. In 2024, 31% of all adult crises calls to Northwest crisis line originated from the county jail. Of the 212 crisis calls 81 required clinical follow up by the RWC and 6 admissions to WMHI.
- People who use drugs and those struggling with addiction face multiple challenges including the harmful effects of the drug themselves, stigma and discrimination they endure, and often harsh and ineffective response to their situation.

Service Delivery Data

Service/Program	Consumer Data for 2024
Adult Crisis Services	690
Adult Emergency Detentions/Petitions	125
Adult Protective Services	218
Comprehensive Community Services (Adults)	72
Community Support Program	43
New Guardianships	67
Protective Placements	14
Substance Abuse Services	37
Youth Crisis Services	133
Youth Emergency Detentions	20
Total	1266

WESTERN REGION RECOVERY AND WELLNESS CONSORTIUM



Lead County Agency - The Western Region Recovery & Wellness Consortium (WRRWC) is a nine-county consortium that provides Comprehensive Community Services (CCS) Program Services.

The WRRWC is comprised of Buffalo, Burnett, Chippewa, Dunn, Pepin, Pierce, Polk, Rusk, and Washburn Counties. Chippewa County is the Lead County Agency which supports the overall program operations, fiscal and quality assurance/quality improvement processes for the consortium.

Chippewa County also is a part of a collaborative partnership with Buffalo and Pepin Counties for the provision of Crisis, Community Support (CSP), Community Recovery Services (CRS) and Coordinated Services Teams (CST) Program Services. This relationship allows citizens in Buffalo and Pepin Counties to have access to these certified Medicaid and grant funded programs.

What is CCS? Comprehensive Community Services (CCS) is a voluntary, state Medicaid-funded program directed under the DHS 36 Wis. Admin Code, which defines what services are CCS-appropriate and outlines the rules and regulations required for service reimbursement. CCS is a recovery-focused, integrated behavioral health program for adults and children with mental health and/or substance use conditions. CCS provides a coordinated and comprehensive array of psychosocial rehabilitation services (designed to facilitate recovery by achieving the highest possible level of functioning, stability, and independence) which is authorized by a mental health and/or substance use professional. Coordinated efforts include utilizing professional, community, and natural supports to address consumer's needs. The program is person and/or family-centered and uses a consumer directed approach to recovery services. Each CCS consortium in the state of Wisconsin is led by a CCS Coordinating Committee that provides oversight and direction to the program. The Coordinating Committee has representations from consumers and their family members, individuals with lived experience, county personnel, community members, and service providers. Their role is to give service recipients a voice by providing input in the development of policies, procedures, and quality assurance.

Achievements/Successes

- The Lead Agency was excited to add two new positions in 2024. An Administrative Specialist and a Contracts Management & Provider Relations Coordinator. These new positions have allowed for increased program support for program staff and providers. Processes have been implemented to have more streamlined communication within the program, and increased provider support during the initial onboarding, contracting and contract renewal process.
- WRRWC implemented the Wisconsin Wraparound Model of System Care. Wisconsin's system of care is a way of helping children, youth, their families, and adults receive the right help, at the right time, in the right amount by connecting and coordinating the work of:
 - Individuals, Families, youth, and advocates
 - Counties, tribes, and Coordinating Committees
 - Care providers (physical health, mental health, education)

- Health plans and coverage
- Child-serving and adult-serving agencies
- Officials who influence or make acts, laws, or rules
- All the participants focus on community-based and culturally responsive services while prioritizing and intentionally eliciting individual, family and youth voice and choice.
- WRRWC launched new policy and procedures to support provision of quality services to consumers, ensure state requirements were being met and to support good stewardship of Medicaid dollars. Some of these policies and procedures include a Provider Travel Policy, Provider Incident Reporting Procedure and the Clean Claim Policy.
- The “Clean Claim” initiative was implemented the end of 2023, to ensure state requirements were being met before paying providers. There was a drastic improvement in providers uploading their training and certification documents as required. The total number of payments withheld started at \$100,501.04 in December 2023 and decreased to 1,078.15 by December 2024.
- In 2024 WRRWC across the nine counties served a combined total of 934 adults and children.
- In 2024, WRRWC contracted with 102 Service Providers across the nine counties, and Medicaid reimbursed providers \$16,818,485.57 for costs of services.

Challenges

- The WRRWC experienced several changes in leadership in 2024. The Lead Agency Operations Administrator position was vacant twice. The Lead Agency Director and other Director positions within member counties also had vacancies.
- WRRWC identified the continued need to improve quality assurance and fiscal systems. Some of these needs include more efficient ways to bill Medicaid for provider billing. The current process requires many steps and is time consuming. Continued work is being done to upgrade WRRWC’s current electronic health record system (AVATAR). This upgraded system will mitigate risk for billing errors and increase process efficiency for fiscal and quality assurance staff. It is anticipated that full implementation will occur mid-year 2025.
- To address challenges identified by program staff, a Score Card Project was conducted, which involved participation by providers, member counties, fiscal and quality assurance staff. The outcome of this project did result in some provider contracts ending. Overall, this project allowed the team to identify which providers needed more support with meeting program requirements in addition to those who were contracted but no longer providing services.
- The consortium continues to experience a shortage of clinicians and mental health providers. This has resulted in some counties needing to utilize providers outside of their typical geographical area, or consumers being waitlisted for psychotherapy services. The WRRWC continues to seek additional psychotherapy providers.

Alisha Meinen	English Lutheran Church of	One Fest
BD Angel Packs	Bateman	Other Chippewa County
Blue Diamond Family	Family Fare	Staff
Dental	Family Support Center	Our Saviors Lutheran
Cailyn Rykal, FBLA	Fill Inn Station	Church Quilters Auction
Camp Nawakwa	Forgotten Initiative	Rachel Faber
Central Lutheran Church	Fries Financial	River Country Co-op
CESA Head Start	Hewlett Packard	Rock 'n Roll To Go Plus
Chi Hi FBLA	Employees	Royal Credit Union
Chippewa County Bar	Howard/Wheaton 4-H	Sam's Club
Association	Human Services -	Sarah Severson, FBLA
Chippewa County DHS	CWDA/Birth to Three	Security Financial Bank
Staff	Jayna Kelley Memorial	Bloomer Staff
Chip. County Parks & Rec	Foundation	Stanley-Boyd HS FCCLA

We are deeply grateful to the many community partners who collaborated with us throughout 2024 and/or generously supported our Foster Care Program or other initiatives. THANK YOU for your commitment to the community and your dedication to serving others!

Chippewa County Public	Kiwanis Club	Tilden Lion's Club
Health	Knights of Columbus Hall	TTM Technologies Outreach
Chippewa County Sheriff's	Members	Committee
Department	Krystal's Kuts & Kurls	Twice Blessed Resale Shop
Chippewa Falls Police	Kwik Trip - Woodward Ave	Valley Vineyard Church
Department & Alumni	Lotts A Meats	We Mow Lawn Care/The
Chippewa Falls YMCA	Mason Companies	LaBelle Family
Community Members	Mayo Clinic - Chippewa	Wisconsin Foster Closet
County Board Members	Falls Staff	Zion United Methodist
Dan the Moving Man	McDonnell Student	Women
Drewmark Boutique	Ambassadors	
Eagleton Snow Flyers	Mykle Buhrow, Chi Hi	
Elaine Starck	National Honor Society	
	Northwestern Bank	



STATEMENT OF EXPLANATION
HUMAN SERVICES 2025 PROGRAM PRIORITIZATION RESULTS - BOBBIE
JAEGER

5.3

The 2025 priority ranking of Human Services programs/services by the Board members will be presented for review and approval.

MANDATORY

Division/Unit	Name	Description	2024 HHSB Rank	2025 Ldrshp Rank	2025 HHSB Rank
Children, Youth, & Families	Placements	When health and safety cannot be assured for children and youth. Includes foster care, treatment foster care, group home, residential, youth shelter, secure detention, and youth corrections.	1	1	1
Children, Youth, & Families – Child Protective Services	Child Protective Services	Ensures that all children and youth are safe in their own homes. Includes information referral, alternative response, access and screening, initial assessment, and ongoing services.	2	2	2
Children, Youth, & Families – Children with Differing Abilities	Chapter 51 Case Management	A child or youth is mentally ill, drug dependent, or developmentally disabled. Evidence exists for a significant probability of physical harm as exhibited by recent threats of or attempts at suicide or serious bodily harm.	3	4	3
Children, Youth, & Families – Birth to Three	Early Intervention Services for Children from Birth to Three with Developmental Needs	An early intervention program for infants and toddlers with developmental delays and mental health needs. Opportunities are provided for a child to increase skills and abilities by using a coaching model with parents and caregivers.	4	6	4
Children, Youth, & Families – Children with Differing Abilities	Children's Long-Term Support Waivers – Physical, Developmental, and Mental Health Disability; Autism	Provides Medicaid funding to support children, youth, and families who are living at home or in a community and have severe limitations in daily activities.	5	5	5
Children, Youth, & Families – Youth Justice	Youth Justice	Ensures community safety, impose accountability for law violations, and equip youth with the skills to live responsibly and productively contribute to the community.	7	8	7
Economic Support	Food Share	FoodShare Wisconsin was created to help stop hunger and to improve nutrition and health. FoodShare helps people with limited money buy the food they need for good health.	10	10	11
Economic Support	Income Maintenance	Medical Insurance for single adults, parents, and children.	11	11	9
Economic Support	Wisconsin Shares Child Care	Provides childcare assistance for working low-income families.	12	12	12
Recovery & Wellness Consortium/Children with Differing Abilities	Mental Health Inpatient Services Acute and Long-Term Care (Includes Alcohol/Drugs)	When health and safety cannot be assured for adults and children. Typical locations include Winnebago Mental Health Institute, and Mayo Clinic Health System.	6	3	6
Recovery & Wellness Consortium	Chapter 51 Case Management	An adult is mentally ill, drug dependent, or developmentally disabled. Evidence exists for a significant probability of physical harm as exhibited by recent threats of or attempts at suicide or serious bodily harm.	8	9	8
Recovery & Wellness Consortium	Adult Protective Services	Conduct investigation and assessment of reported abuse, neglect or exploitation of vulnerable adults. Assure those in need of protection are living in a safe and stable situation; Process protective placements for persons under guardianship who require specific placements to ensure their safety or are required by state statute; Process guardianships for residents of Chippewa County deemed to be indigent and who are believed to be incompetent and unable to safely provide care for themselves.	9	7	10

Attachment: Program Ranking Updated (8963 : Human Services 2025 Program Prioritization Results -

ESSENTIAL

Division/Unit	Name	Description	2024 HHSB Rank	2025 Ldrshp Rank	2025 HHSE Rank
Children, Youth & Families – Child Protective Services	Kinship	Kinship care helps a family support a child in the home of a relative when the child has experienced abuse or neglect. With this support, placing a child in a foster home or another out-of-home care setting may be avoided.	4	4	4
Children, Youth, & Families – Children with Differing Abilities	Children's Community Options Program	Services for children and youth with developmental, physical, and mental health disabilities that require long- term care to remain in the home and community. Its purpose is to provide funding alternative services rather than placement out-of-home.	6	6	5*
Children, Youth, & Families – Youth Justice	Community Based Services	Provide services to offending youth that have evidence in reducing the risks associated with committing future crime, repair harm to a victim, monitor youth behavior in order to meet their legal obligations and remain crime free.	7	7	5*
Children, Youth, & Families – Youth Justice	Electronic Monitoring	Confines the movement of a youth. This service allows a youth to remain in their home, run errands, and go to school. The range of restriction varies depending on the health and safety risk the youth possess.	8	8	8
Recovery & Wellness Consortium	Mental Health Emergency Services (Crisis Services)	Provides immediate assistance to adults and children experiencing a mental health crisis. The outcome is to reduce the adult or child's immediate distress and prevent hospitalization.	1	1	1
Recovery & Wellness Consortium/Children with Differing Abilities	Comprehensive Community Services (CCS) – Adults/Children	Provides adults and children with psychosocial rehabilitation services that focus on recovery. Needs are determined through an assessment of life satisfaction, basic needs, social network/family involvement, community living skills, housing issues, employment, education, finances, mental health, physical health, substance use, trauma/life stressors, medications, crisis prevention and management, legal status, and any other as identified by CCS. Services are person-centered and developed in partnership with the customer.	2	2	2
Recovery & Wellness Consortium	Community Support Program for the Chronically Mentally Ill	Provides services to seriously mentally ill adults. The program includes a wide range of services designed to maintain an adult in the community rather than in placement.	3	3	3
Recovery & Wellness Consortium	Adult Placements	When health and safety for adults cannot be assured in the community. Includes adult family home, group home, and residential.	5	7	7

*Tied for Ranking

OPTIONAL

Division/Unit	Name	Description	2024 HHSB Rank	2025 Ldrshp Rank	2025 HHSE Rank
Children, Youth & Families – Child Protective Services	Kinship	Kinship care helps a family support a child in the home of a relative when the child has experienced abuse or neglect. With this support, placing a child in a foster home or another out-of-home care setting may be avoided.	1	1	1
Children, Youth, & Families – Children with Differing Abilities	Children's Community Options Program	Services for children and youth with developmental, physical, and mental health disabilities that require long- term care to remain in the home and community. Its purpose is to provide funding alternative services rather than placement out-of-home.	2	2	2



STATEMENT OF EXPLANATION
HUMAN SERVICES ADMINISTRATIVE POLICY 44 - TELEHEALTH - BOBBIE
JAEGER

5.4

This policy applies to medical care provided to client/consumers using Telehealth Technologies for the client/consumer and the employee interaction, maintaining confidentiality, privacy, and security.

Chippewa County Department of Human Services Administrative Policy and Procedure 44

Title: Telehealth Policy and Procedures

- I. **PURPOSE OF PROCEDURE:** The purpose of this policy and related procedures is to:
 1. Define Telehealth services, define when Telehealth services may be provided as an alternative to an office visit for services, and communicate the requirements and conditions the employee must follow when conducting such services on behalf of Chippewa County.
 2. Provide a framework for privacy and security-related controls specifically related and unique to providing Telehealth services.
 3. Describe reasonable and appropriate measures utilized to maintain confidentiality, integrity, and availability of protected health information (PHI) in the Telehealth environment.
 4. Establish a mechanism to obtain client/consumer consent for use of Telehealth services.
 5. Provide a privacy and security Telehealth workflow.

- II. **APPLICABILITY:** This policy and related procedures apply to medical care provided to clients/consumers using Telehealth Technologies for the client/consumer and the employee interaction (it does not include remote client/consumer monitoring (i.e. monitoring physiology and behavior)). This policy and procedure also apply to:
 1. Employees providing Telehealth services that can meet the conditions of this policy and related procedures as part of their assigned job responsibilities.
 2. Workforce and others assigned to set up, maintain, and/or use Telehealth Technologies.
 3. Business Associates with whom our organization has engaged to provide Telehealth services, support Telehealth Technologies, and/or delegated responsibilities under this policy.

- III. **DEFINITIONS:**
 - **Telehealth:** Any type of Telehealth or telehealth service using approved Telehealth Technologies to provide medical services. As defined by Wisconsin Forward Health, Telehealth enables a provider who is located at a distant site to render the service remotely to a member located at an originating site using a combination of interactive video, audio, and externally acquired images through a networking environment (refer to WI Stat. §24.02 or https://www.forwardhealth.wi.gov/kw/html/510_Telehealth.html Telehealth definitions).
 - **Telehealth Technologies:** Technologies and devices enabling secure electronic communications and information exchange between a licensee (e.g. the employee) in one location and a client/consumer in another location with or without an intervening healthcare employee. There are several types of Telehealth Technologies that may be synchronous or asynchronous, including but not limited to the following:

- Real-time, such as a virtual video visit between an employee and client/consumer (video conferencing via a virtual meeting platform).
 - Store and forward messages between an employee and client/consumer (e.g. a secure client/consumer portal communication, email, text, instant message, and other store-and-forward software).
 - Landline and wireless communications (i.e. audio only).
 - Remote client/consumer monitoring (i.e. monitoring physiology and behavior).
- Synchronous Technology: Allows for a real-time/live interaction to take place between an employee and a client/consumer.
 - Asynchronous Technology: Is not a real-time/live interaction. For example, transmission of health history, symptoms, images, etc. by a client/consumer to an employee, and that employee assesses and provides treatment at a later time.

For other capitalized terms, refer to the HIPAA Privacy and Security Definitions document.

IV. **POLICY:** It is the policy of Chippewa County to:

1. Comply with HIPAA Privacy and Security regulations, as well as other local, State, and Federal regulations while providing Telehealth services.
 - a. Define the type of Telehealth Technologies that may be utilized to provide Telehealth services.
 - b. To obtain contracts and, as applicable, Business Associate Agreements for Telehealth Technology and services.
 - c. Obtain consent from clients/consumers prior to providing Telehealth services.
 - d. To maintain accurate and thorough records for Telehealth services.

PROCEDURE:

Disclosures and Functionality of Online Services:

The following shall be provided to clients/consumers upon request:

1. Specific services provided;
2. Name, licensure, qualifications, and contact information of employee providing services;
3. Fees for services and how payment is to be made;
4. Financial interests, other than fees charged, if any information, products, or services are provided by the employee;
5. Appropriate uses and limitations of the site, including emergency health situations;
6. Uses and response times for e-mails, electronic messages, and other communications transmitted via Telehealth Technologies;
7. How to obtain interpreter services;
8. Information collected and any passive tracking mechanisms utilized;
9. How to provide feedback regarding the site and quality of the information and services;
10. How to register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s), licensing board, etc.
11. Telehealth Complaint Management Process – how to get a complaint to a distant site to the consulting site and vice versa.

12. Accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity; and
13. Hours of operation to clients/consumers.

Standard of Care and Professionalism:

1. The standard of care for Telehealth services provided is the same as that of providing medical care in person. This also requires thoroughly documenting the medical evaluations, collection of relevant clinic history, diagnosis, prescribed treatment, etc.
2. The employees are responsible for determining whether treatment should be provided via Telehealth services.
3. This determination is based upon a client's/consumer's history, referral, diagnosis, other information obtained, and reason for the visit.
4. The highest degree of professionalism and competency is maintained and:
 - a. Places the welfare of clients/consumers first;
 - b. Maintains acceptable and appropriate standards of practice, accountability, responsibility, and documentation and are the same as applicable to in-person services;
 - c. Adheres to recognized ethical codes governing the medical profession;
 - d. Employees are properly supervised; and
 - e. Includes knowledge of how to use Telehealth Technology.

Establishment of the Employee-Client/Consumer Relationship & Continuity of Care:

1. The employee-client/consumer relationship is established once the employee agrees to diagnose and treat the client/consumer, and the client/consumer agrees to be treated. The employee-client/consumer relationship is established whether or not an in-person encounter has occurred between the employee (or any other appropriately supervised health care practitioner) and client/consumer. This is done by:
 - a. Verifying the location and identity of the client/consumer;
 - b. Providing and validating the employee's credentials to the client/consumer (i.e. medical license or other clinical qualifications); and
 - c. Providing and obtaining a signed Telehealth Informed Consent from client/consumer, as well as Patient Electronic Directly Observed Therapy (eDOT) Agreement Form and Text Messaging and Email Informed Consent Form as applicable.
 - d. Also refer to payer reimbursement requirements.
2. The client/consumer may seek follow-up care and information from the employee (or his/her designee) who conducted the Telehealth visit.
3. The employee provides the client/consumer with an emergency plan when a referral is made to an acute care facility or emergency room for necessary treatment. The emergency plan includes a formal, written protocol appropriate to the services being rendered.
4. For services provided solely using Telehealth Technologies and for which a prior existing employee-client/consumer relationship was not in place, documentation of

the Telehealth visit is made available immediately after the encounter to the client/consumer, subject to the client's/consumer's consent.

Billing, Coding, and Reimbursement:

1. Billing for Telehealth services shall comply with State and Federal laws as well as third-party payer requirements.
2. Claims are processed for Telehealth visits in the same manner as in-person clinical visits, although reimbursement may differ. Client/consumer responsibility will apply to these services according to the client's/consumer's insurance benefit.
3. Maintain a list of services, codes, originating sites, and modifiers that are eligible for Telehealth reimbursement. Identify what place of service code to use as well.
4. Medicare reimbursement guidelines. The client/consumer must have a prior established relationship with the employee providing services and:
 - a. The client/consumer must be in a designated rural area, leave his/her home, and go to a clinic, hospital, or certain other types of medical facilities to receive telehealth service;
 - b. Brief communications called Virtual Check-Ins – refer to the definition; or
 - c. Medicare Part B separately pays for E-visits (i.e. non-face-to-face client's/consumer's-initiated communications through an online client's/consumer's portal).
 - d. Also refer to 42 C.F.R. §410.78 Telehealth services for additional requirements.
5. Wisconsin Medicaid reimbursement guidelines:
 - a. Coverage of a service provided via telehealth is subject to the same restrictions as when the service is provided face-to-face (e.g., allowable employees, multiple service limitations, PA).
 - b. The following are not covered as telehealth services:
 - i. Written electronic communications (e.g., email, texts).
 - ii. Store and forward services (defined as the asynchronous transmission of medical information to be reviewed at a later time by an employee at a distant site); and
 - iii. Services that are not covered when delivered face-to-face.
 - c. Employees may not require the use of telehealth as a condition of treating a member.
6. Some services may not be reimbursable, such as the following:
 - a. Prescription renewals;
 - b. Scheduling a test or appointment;
 - c. Calls to nurse line for questions or standing orders, e.g. sinusitis or conjunctivitis;
 - d. Clarification of issues from previous visit;
 - e. Other non-clinical communication;
 - f. Updating client/consumer demographic information;
 - g. Reporting test results;
 - h. Requesting a referral;
 - i. Phone calls other than Scheduled Telephone Visits (STV) or email;
 - j. Interactive video visits not initiated by the member;
 - k. Reminders; and
 - l. Providing educational materials.

General Privacy and Security Controls and Requirements:

1. Data back up
 - a. Data that is backed up includes, but is not limited to:
 - i. Messages, chats, etc.
 - ii. Email
 - iii. Security event logs
 - iv. User audit trails
 - b. Data is backed up and retained in accordance with the County's IT Policy Manual.
2. Telehealth security settings are set up and managed by the IT Division. Users are not able to change these settings.
3. Remote client/consumer monitoring Telehealth Technologies are on separate network segment or VLAN.
4. Telehealth Technologies and the provision of Telehealth services are required to meet, and all employees are required to follow, the minimum administrative, physical, and technical controls as described in the County's IT Policy Manual and other privacy and security-related policies, procedures, and standards at all locations where Telehealth services are provided.
5. The Privacy Officer and Security Officer, along with the DHS Director, Public Health Director, DHS Fiscal Manager, and/or Public Health Fiscal Manager shall develop, coordinate, and provide training to the IT Division and all staff that utilize and set up the Telehealth Technologies to ensure the proper use and security of the Telehealth Technologies, setting up Telehealth visits with only the correct individual(s), as well as incorporating documentation into the designated record set.
6. Approved Telehealth Technologies
 - a. Public-facing technologies may not be used for Telehealth visits.
 - b. Only the following approved Telehealth Technologies, managed by the IT Division, are approved to be utilized:
 - i. Virtual Meeting Platform: Microsoft Teams.
 - ii. Stored and forwarded messages between the employee and the client/consumer (e.g. a secure client/consumer portal communication, email, text, instant message, and other store-and-forward software): Microsoft Outlook; county-issued smartphone and technologies for appointment confirmations and other general communications.
 - iii. Landline and wireless communications (i.e. audio only): the County telephone system and County issued smartphones and technologies.
 - c. Personal equipment/Workstations shall not be used for providing Telehealth services.

Privacy-Related Controls Specific to Telehealth:

1. Designated record set
 - a. All services provided via Telehealth are thoroughly documented in the client's/consumer's designated record set in the same manner as services provided face-to-face.
 - b. Following are examples of what to document in the client's/consumer's designated record set specific to the provision of Telehealth services:

- i. Copies and/or summaries of all client/consumer-related electronic communications, including client/consumer communications with employees (e.g. emails and client/consumer portal messages), prescriptions, laboratory and test results, evaluations, and consultations, clinical history, records of past care, instructions obtained or produced in connection with the utilization of Telehealth Technologies, and prescribed treatment.
 - ii. Physical location and presence of the client/consumer.
 - iii. Client's/consumer's current phone number and emergency contact.
 - iv. Physical location of the employee (e.g. office or Telehealth billing code).
 - v. Everyone involved with the clinical encounter, including those who may not be on the camera.
 - vi. Health-related images, photos, screenshots, emails, messages, and other electronic communications.
 - vii. Consents for Telehealth Services and Technologies.
 - c. Following are examples of information that is not included in a designated record set:
 - i. Audio of telephone calls, including those recorded for training purposes;
 - ii. Recorded Telehealth visits (audio and video) with clients/consumers/family that are not considered Psychotherapy Notes; and
 - iii. Messages/chats sent and received in a virtual meeting platform (note: copies and/or summaries may be incorporated into the designated record set by the employee).
 - d. Refer to the Designated Record Set procedures for additional documentation requirements.
2. The Notice of Privacy Practices adequately addresses the provision of Telehealth services.
 3. Users may not change, amend, or delete PHI from Telehealth Technologies unless authorized as part of their assigned job responsibilities and allowed by the County's policies and regulatory requirements. Refer to the County's IT Policy Manual and other privacy and security-related policies, procedures, and standards.
 4. Refer to existing privacy and security-related policies and procedures to determine when PHI may be accessed, used, and/or disclosed and whether a signed authorization is required.

Telehealth Privacy and Security Workflow:

1. Telehealth services may only be provided by authorized employees as outlined in this policy and related procedures.
2. As applicable, prior to or when scheduling a Telehealth visit, verify the client/consumer is able to utilize the Telehealth Technology (e.g. has the appropriate equipment available to them and is able to connect to and use the Telehealth Technology).
3. Verify and set up interpreter or translator services for the Telehealth visit, as needed.

4. Prior to providing Telehealth services, verify the client/consumer was provided and signed the following documents:
 - a. Received and signed the Telehealth Informed Consent (herein consent). Note that documented consent is not required for family members or others who join a client's/consumer's Telehealth visit;
 - b. Received the Notice of Privacy Practices and signed the Acknowledgement Form;
 - c. Patient Electronic Directly Observed Therapy (eDOT) Agreement Form if applicable; and
 - d. Text Messaging and Email Informed Consent Form if applicable.
5. Safeguard PHI from unauthorized intentional or unintentional as well as limit incidental uses and disclosures:
 - a. Telehealth services may be provided on and off the premises.
 - b. Avoid using speakers unless certain the conversation will not be overheard by unauthorized individuals.
 - c. Keep voices quiet when discussing PHI to limit exposure to unauthorized individuals.
 - d. Be mindful that anyone listening to or observing the conversation can record the audio and/or visual.
 - e. Clear the work area that is viewable by the camera of papers, monitors, and other media that have a different client's/consumer's PHI on them.
 - f. Telehealth services may not be provided in public areas (e.g. cafeterias, hallways used by unescorted visitors, elevators, parking lots, etc.).
 - g. Provide all client/consumer care in closed rooms (when possible). When this is not possible, close curtains and blinds, and turn monitors so they cannot be seen by unauthorized individuals.
 - h. Refer to the County's IT Policy Manual and other privacy and security-related policies, procedures, and standards for additional requirements.
6. How to schedule, join, and leave meetings is documented and available on the Employee Portal under IT Resources.
7. Telehealth Technology meeting set up and use:
 - a. Users may not make meetings or meeting links public.
 - i. When setting up a meeting:
 1. Only include the client/consumer's first name or initials in the calendar invite.
 2. Make the meeting require non-County user accounts to wait in the "Lobby" area until admitted by the County host
 3. Use the system's auto-generated meeting passwords/passcodes for each scheduled meeting
 4. Share the meeting link, password, and PIN through County's email system using a County email address
 - ii. Users shall not share connection/access information for a Telehealth visit on an unrestricted publicly available social media post.
 - iii. Provide the information directly to the specific people who will participate in the Telehealth visit.
 - b. Ensure that the Telehealth Technology is in proper working condition well in advance of any scheduled visit. Check all power cords and cables for

- proper attachment and activate power to verify that it is in working condition.
- c. Mute the microphone before initiating the connection.
 - d. When the client/consumer joins the visit:
 - i. Verify the client's/consumer's location as well as his/her identity.
 - ii. Verify the identity of other individual(s) that is with the client/consumer or in the Telehealth visit on behalf of the client/consumer.
 - iii. Ask the client/consumer to agree to receive Telehealth services in the presence of this other individual(s).
 - e. Only individuals approved by the client/consumer, legal guardian, or court-ordered practitioner and assisting with their care may participate in Telehealth services. This includes persons who might be included electronically or off-camera.
 - i. Pan the room with the camera to show the client/consumer (legal guardian) who is in the room prior to starting to provide Telehealth services.
 - ii. Should technical support staff be needed to help with technical problems during the Telehealth visit, obtain consent from the client/consumer first.
 - f. If a recording will be made, obtain permission from the client/consumer (legal guardian) present to record the Telehealth visit and/or capture any images. Document this consent in the visit notes.
8. Verify attendee count matches the number of invites so that unknown or unauthorized participants are not in attendance.
- a. Be careful when authorizing participants/attendees to join a Telehealth visit and selectively specify who may:
 - i. Share their camera, microphone, or screen; and
 - ii. Have other individuals in the background.
 - b. Remove bad actors/intruders immediately or terminate the session.
 - i. Change the meeting ID, password, and pin if a bad actor/intruder gains access to it.
 - ii. Report this as a security incident as required by the IT Policy Manual – Privacy and Security Incident Response.
 - c. Non-County recording applications shall be removed from the meeting (i.e., fireflies.ai, otter.ai, etc.).
9. When a group Telehealth visit is being held:
- a. Verify all clients/consumers/legal guardians signed an informed consent for group visits.
 - b. Provide group guidelines (e.g. verbally and/or post them in the chat).
 - c. Group guidelines include, but are not limited to, the following:
 - i. Attend group sessions in a space that is:
 1. Private; do not allow anyone else that may be near you to hear or see the group Telehealth visit; and
 2. Free of distractions.
 - ii. Use only the login information provided directly to you by our organization.

- iii. Wear earbuds or headphones when not able to be in a private setting.
 - iv. Mute the speaker when not speaking.
 - v. Keep the camera centered on you and steady.
 - vi. Dial in by telephone if the internet signal degrades and keep the video connection open.
 - vii. If agreed upon in advance, use a nickname or fictitious name.
- 10. Use extreme caution when using a weblink shared in a chat during a video-conferencing meeting.
- 11. If there are technical problems (e.g. equipment or transmission), conduct basic troubleshooting. If the problem continues:
 - a. Hang up/cancel the visit/session and restart it, request the client/consumer do this at the same time.
 - b. Submit an IT Help Desk ticket to the IT Division for assistance.
- 12. As soon as the Telehealth visit ends, users are required to “End meeting” to disconnect the Telehealth Technology.
- 13. Replace the camera lens cover, if applicable.
- 14. Document the client’s/consumer’s location, names, and relationships of other individuals(s) in the visit, any images, as well as the evaluation and services provided in the designated record set. Refer to additional documentation requirements in the “designated record set” section in these procedures.
- 15. Clear all client/consumer images and documentation from the work area at the end of the Telehealth visit so that it may not be viewed or accessed by any unauthorized individual.

Reporting and Compliance:

Refer to the Chippewa County Information Privacy and Security Policy for requirements to report suspected and known non-compliance of this policy and procedure as well as potential outcomes for violations.

V. **Resources:** HIPAA COW Telehealth Policy and Procedures, Version 1, 6/24/2020.

VI. Applicable Standards/Regulations

- 1. HIPAA Final Omnibus Rule, January 25, 2013
- 2. Wis. Chapter 49 Public Assistance and Children and Family Services, June 2, 2020, <https://docs.legis.wisconsin.gov/statutes/statutes/49>
- 3. 2019 Senate Bill 380, August 29, 2019, <http://docs.legis.wisconsin.gov/2019/related/proposals/sb380>
- 4. 2019 Wisconsin Act 56, November 25, 2019, <https://docs.legis.wisconsin.gov/2019/related/acts/56>
- 5. Wis. Stat. §51 Mental Health Act
- 6. Wis. Chapter DHS 92 Confidentiality of Treatment Records
- 7. Wis. Stat. §146 Miscellaneous Health Provisions
- 8. Wisconsin Telehealth for Dates of Service Before January 1, 2020; WI Forward Health, https://www.forwardhealth.wi.gov/kw/html/510_Telehealth.html.
- 9. Wisconsin Medicaid Program Telehealth/Telehealth Definition. WI Forward Health, Wisconsin Medicaid Provider Manual, Physician, p. 135 (Jan. 31, 2014).

10. Telehealth topic (#510), Forward Health Online Handbook,
<https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=50&s=2&c=61&nt=Telehealth&adv=Y>

Prepared by: Chippewa County Human Resources and Brandi Engel, DHS Admin IV

Director/Manager Approval:
(Signature Required)



Date: 04/14/2025

Effective:

Revised:



STATEMENT OF EXPLANATION
PUBLIC HEALTH POLICY - APH-TELEHEALTH - BRITTNAY FORTUNA

5.5

This policy applies to medical care provided to client/consumers using Telehealth Technologies for the client/consumer and the employee interaction, maintaining confidentiality, privacy, and security.



Telehealth

SCOPE

All Public Health

PURPOSE

1. Define Telehealth services, define when Telehealth services may be provided as an alternative to an office visit for services, and communicate the requirements and conditions the employee must follow when conducting such services on behalf of the Chippewa County Department of Public Health (CCDPH).
2. Provide a framework for privacy and security-related controls specifically related and unique to providing Telehealth services.
3. Describe reasonable and appropriate measures utilized to maintain confidentiality, integrity, and availability of protected health information (PHI) in the Telehealth environment.
4. Establish a mechanism to obtain client/consumer consent for use of Telehealth services.
5. Provide a privacy and security Telehealth workflow.

This policy and related procedures apply to medical care provided to clients/consumers using Telehealth Technologies for the client/consumer and the employee interaction (it does not include remote client/consumer monitoring (i.e., monitoring physiology and behavior). This policy and procedure also apply to:

1. Employees providing Telehealth services that can meet the conditions of this policy and related procedures, as part of their assigned job responsibilities.
2. Workforce and others assigned to set up, maintain, and/or use Telehealth Technologies.
3. Business Associates with whom our organization has engaged to provide Telehealth services, support Telehealth Technologies, and/or delegates responsibilities under this policy.

DEFINITIONS & EXPLANATIONS OF TERMS

Telehealth: There are a variety of definitions for Telehealth and telehealth. For purposes of this document, the term "telehealth" is used and essentially means any type of Telehealth or telehealth service using approved Telehealth Technologies to provide medical services. As defined by Wisconsin Forward Health, Telehealth enables a provider who is located at a distant site to render the service remotely to a member located at an originating site using a combination of interactive video, audio, and externally acquired images through a networking environment (refer to WI Stat. §24.02 or (https://www.forwardhealth.wi.gov/kw/html/510_Telehealth.html) Telehealth definitions).

Telehealth Technologies:

1. Means technologies and devices enabling secure electronic communications and information exchange between a licensee (e.g., the employee) in one location and a client/consumer in another location, with or without an intervening healthcare employee.
2. Note that there are several types of Telehealth Technologies that may be synchronous or asynchronous, including but not limited to the following:

APH - POLICY

- a. Real-time, such as a virtual video visit between an employee and client/consumer (videoconferencing via a virtual meeting platform).
- b. Store and forward messages between an employee and client/consumer (e.g., a secure client/consumer portal communication, email, text, instant message, and other store-and-forward software).
- c. Landline and wireless communications (i.e., audio only).
- d. Remote client/consumer monitoring (i.e., monitoring physiology and behavior).

Synchronous Technology: Allows for a real-time/live interaction to take place between an employee and a client/consumer.

Asynchronous Technology:

- 1. It is not a real-time/live interaction.
- 2. For example, transmission of health history, symptoms, images, etc. by a client/consumer to an employee, and that employee assesses and provides treatment at a later time.

For other terms, refer to the HIPAA Privacy and Security Definitions document.

POLICY

It is the policy of the Chippewa County Department of Public Health to:

- 1. Comply with HIPAA Privacy and Security regulations, as well as other local, State, and Federal regulations while providing Telehealth services.
 - a. Define the type of Telehealth Technologies that may be utilized to provide Telehealth services.
 - b. To obtain contracts, and as applicable, Business Associate Agreements for Telehealth Technology and services.
 - c. Obtain consent from clients/consumers prior to providing Telehealth services.
 - d. To maintain accurate and thorough records of Telehealth services.
- 2. Disclosures and Functionality of Online Services
 - a. The following shall be provided to clients/consumers upon request:
 - i. Specific services provided.
 - ii. Name, licensure, qualifications, and contact information of the employee providing services.
 - iii. Fees for services and how payment is to be made.
 - iv. Financial interests, other than fees charged, if any information, products, or services are provided by the employee.
 - v. Appropriate uses and limitations of the site, including emergency health situations.
 - vi. Uses and response times for e-mails, electronic messages, and other communications transmitted via Telehealth Technologies.
 - vii. How to obtain interpreter services.
 - viii. Information collected and any passive tracking mechanisms utilized.

APH - POLICY

- ix. How to provide feedback regarding the site and quality of the information and services.
 - x. How to register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s), licensing board, etc.
 - xi. Telehealth Complaint Management Process – how to get a complaint at a distant site to the consulting site and vice versa.
 - xii. Accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.
 - xiii. Hours of operation for clients/consumers.
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- a. The standard of care for Telehealth services provided is the same as that of providing medical care in person. This also requires thoroughly documenting the medical evaluations, collection of relevant clinical history, diagnosis, prescribed treatment, etc.
 - b. The employees are responsible for determining whether treatment should be provided via Telehealth services.
 - c. This determination is based upon a client's/consumer's history, referral, diagnosis, other information obtained, and reason for the visit.
 - d. The highest degree of professionalism and competency is maintained and:
 - i. Places the welfare of the client/consumers first.
 - ii. Maintains acceptable and appropriate standards of practice, accountability, responsibility, and documentation that are the same as applicable to in-person services.
 - iii. Adheres to recognized ethical codes governing the medical profession.
 - iv. Employees are properly supervised.
 - v. Includes knowledge of how to use Telehealth Technology.
4. Establishment of the Employee-Client/Consumer Relationship & Continuity of Care
- a. The employee-client / consumer relationship is established once the employee agrees to diagnose and treat the client/consumer, and the client/consumer agrees to be treated. The employee-client / consumer relationship is established whether or not an in-person encounter has occurred between the employee (or any other appropriately supervised health care practitioner) and client/consumer. This is done by:
 - i. Verifying the location and identity of the client/consumer.
 - ii. Providing and validating the employee's credentials to the client/consumer (i.e., medical license or other clinical qualifications).
 - iii. Providing and obtaining a signed Telehealth Informed Consent from client/consumer, as well as Patient Electronic Directly Observed Therapy (eDOT) Agreement Form and Text Messaging and Email Informed Consent Form as applicable.
 - iv. Refer to payer reimbursement requirements.
 - b. The client/consumer may seek follow-up care and information from the employee (or his/her designee) who conducted the Telehealth visit.

APH - POLICY

- c. The employee provides the client/consumer with an emergency plan when a referral is made to an acute care facility or emergency room for necessary treatment. The emergency plan includes a formal, written protocol appropriate to the services being rendered.
- d. For services provided solely using Telehealth Technologies and for which a prior existing employee-client / consumer relationship was not in place, documentation of the Telehealth visit is made available immediately after the encounter to the client/consumer, subject to the client's / consumer's consent.
- 5. Billing, Coding, and Reimbursement
 - a. Billing for Telehealth services shall comply with State and Federal laws as well as third-party payer requirements.
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 - c. Maintain a list of services, codes, originating sites, and modifiers that are eligible for Telehealth reimbursement. Identify what place of service code to use as well.
 - d. Medicare reimbursement guidelines. The client/consumer must have a prior established relationship with the employee providing services, and:
 - i. The client/consumer must be in a designated rural area, leave his/her home, and go to a clinic, hospital, or certain other types of medical facilities to receive the telehealth service.
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 - iii. Medicare Part B separately pays for E-visits (i.e., non-face-to-face client/consumer-initiated communications through an online client's/consumer's portal).
 - iv. Also refer to 42 C.F.R. §410.78 Telehealth services for additional requirements.
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 - i. Coverage of a service provided via telehealth is subject to the same restrictions as when the service is provided face-to-face (e.g., allowable employees, multiple service limitations, PA).
 - ii. The following are not covered as telehealth services:
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 - f. Some services may not be reimbursable, such as the following:
 - i. Prescription renewals.
 - ii. Scheduling a test or appointment.
 - iii. Call the nurse line for questions or standing orders, e.g., sinusitis or conjunctivitis.

APH - POLICY

- iv. Clarification of issues from previous visit.
 - v. Other non-clinical communication.
 - vi. Updating client/consumer demographic information.
 - vii. Reporting test results.
 - viii. Requesting a referral.
 - ix. Phone calls other than Scheduled Telephone Visits (STV) or email.
 - x. Interactive video visits not initiated by the member.
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- a. Data backup
 - i. Data that is backed up includes, but is not limited to:
 - 1. Messages, chats, etc.
 - 2. Email.
 - 3. Security event logs.
 - 4. User audit trails.
 - ii. Data is backed up and retained in accordance with the County's IT Policy Manual.
 - b. Telehealth security settings are set up and managed by the IT Division. Users are not able to change these settings.
 - c. Remote client/consumer monitoring Telehealth Technologies are on a separate network segment or VLAN.
 - d. Telehealth Technologies and the provision of Telehealth services are required to meet, and all employees are required to follow, the minimum administrative, physical, and technical controls as described in the County's IT Policy Manual and other privacy and security-related policies, procedures, and standards at all locations where Telehealth services are provided.
 - e. The Privacy Officer and Security Officer, along with the DHS Director, Public Health Director, DHS Fiscal Manager, and/or Public Health Fiscal Manager shall develop, coordinate, and provide training to the IT Division and all staff that utilize and set up the Telehealth Technologies to ensure the proper use and security of the Telehealth Technologies, setting up Telehealth visits with only the correct individual(s), as well as incorporating documentation into the designated record set.
 - f. Approved Telehealth Technologies
 - i. Public-facing technologies may not be used for Telehealth visits.
 - ii. Only the following approved Telehealth Technologies, managed by the IT Division, are approved to be utilized:
 - 1. Virtual Meeting Platform: Microsoft Teams.
 - 2. Stored and forwarded messages between the employee and the client/consumer (e.g., a secure client/consumer portal communication, email, text, instant message, and other store-and-forward software): Microsoft Outlook; county-issued smartphone and technologies for appointment confirmations and other general communications.

APH - POLICY

3. Landline and wireless communications (i.e., audio only): the County telephone system and County-issued smartphones and technologies.
 - iii. Personal equipment / Workstations shall not be used for providing Telehealth services.
7. Privacy-Related Controls Specific to Telehealth
- a. Designated record set
 - i. All services provided via Telehealth are thoroughly documented in the client's/consumer's designated record set in the same manner as services provided face-to-face.
 - ii. Following are examples of what to document in the client's / consumer's designated record set specific to the provision of Telehealth services:
 1. Copies and/or summaries of all client / consumer-related electronic communications, including client/consumer communications with employees (e.g. emails and client/consumer portal messages), prescriptions, laboratory and test results, evaluations, and consultations, clinical history, records of past care, instructions obtained or produced in connection with the utilization of Telehealth Technologies, and prescribed treatment.
 2. Physical location and presence of the client/consumer.
 3. Client's / consumer's current phone number and emergency contact.
 4. Physical location of the employee (e.g., office or Telehealth billing code).
 5. Everyone involved with the clinical encounter, including those who may not be on camera.
 6. Health-related images, photos, screenshots, emails, messages, and other electronic communications.
 7. Consents for Telehealth Services and Technologies.
 - iii. Following are examples of information that is not included in a designated record set:
 1. Audio of telephone calls, including those recorded for training purposes.
 2. Recorded Telehealth visits (audio and video) with clients/consumers/family that are not considered Psychotherapy Notes.
 3. Messages/chats sent and received in a virtual meeting platform (note: copies and/or summaries may be incorporated into the designated record set by the employee).
 - iv. Refer to the Designated Record Set procedures for additional documentation requirements.
 - b. The Notice of Privacy Practices adequately addresses the provision of Telehealth services.
 - c. Users may not change, amend, or delete PHI from Telehealth Technologies unless authorized as part of their assigned job responsibilities and allowed by the County's policies and regulatory requirements. Refer to the County's IT Policy Manual and other privacy and security-related policies, procedures, and standards.

APH - POLICY

- d. Refer to existing privacy and security-related policies and procedures to determine when PHI may be accessed, used, and/ or disclosed and whether a signed authorization is required.
- 8. Telehealth Privacy and Security Workflow
 - a. Telehealth services may only be provided by authorized employees as outlined in this policy and related procedures.
 - b. As applicable, prior to or when scheduling a Telehealth visit, verify the client/consumer is able to utilize the Telehealth Technology (e.g., has the appropriate equipment available to them and is able to connect to and use the Telehealth Technology).
 - c. Verify and set up interpreter or translator services for the Telehealth visit, as needed.
 - d. Prior to providing Telehealth services, verify the client/consumer was provided and signed the following documents:
 - i. Received and signed the Telehealth Informed Consent (herein consent). Note that documented consent is not required for family members or others who join a client's / consumer's Telehealth visit.
 - ii. Received the Notice of Privacy Practices and signed the Acknowledgement Form.
 - iii. Patient Electronic Directly Observed Therapy (eDOT) Agreement Form, if applicable.
 - iv. Text Messaging and Email Informed Consent Form, if applicable.
 - e. Safeguard PHI from unauthorized, intentional, or unintentional as well as limit incidental uses and disclosures:
 - i. Telehealth services may be provided on and off the premises.
 - ii. Avoid using speakers unless certain that the conversation will not be overheard by unauthorized individuals.
 - iii. Keep voices quiet when discussing PHI to limit exposure to unauthorized individuals.
 - iv. Be mindful that anyone listening to or observing the conversation can record the audio and/or visual.
 - v. Clear the work area that is viewable by the camera of papers, monitors, and other media that have a different client's / consumer's PHI on them.
 - vi. Telehealth services may not be provided in public areas (e.g., cafeterias, hallways used by unescorted visitors, elevators, parking lots, etc.).
 - vii. Provide all client/consumer care in closed rooms (when possible). When this is not possible, close curtains and blinds, and turn monitors so they cannot be seen by unauthorized individuals.
 - viii. Refer to the County's IT Policy Manual and other privacy and security-related policies, procedures, and standards for additional requirements.
 - f. How to schedule, join, and leave meetings is documented and available on the Employee Portal under IT Resources.
 - g. Telehealth Technology meeting set up and use:
 - i. Users may not make meetings or meeting links public.
 - 1. When setting up a meeting:

APH - POLICY

- a. Only include the client/consumer's first name or initials in the calendar invite.
 - b. Make the meeting require non-County user accounts to wait in the "Lobby" area until admitted by the County host.
 - c. Use the system's auto-generated meeting passwords or passcodes for each scheduled meeting.
 - d. Share the meeting link, password, and PIN through the County's email system using a County email address.
- 2. Users shall not share connection/access information for a Telehealth visit on an unrestricted publicly available social media post.
- 3. Provide the information directly to the specific people who will participate in the Telehealth visit.
- ii. Ensure that the Telehealth Technology is in proper working condition, well in advance of any scheduled visit. Check all power cords and cables for proper attachment and activate power to verify that it is in working condition.
- iii. Mute the microphone before initiating the connection.
- iv. When the client/consumer joins the visit:
 - 1. Verify the client's/consumer's location as well as his /her identity.
 - 2. Verify the identity of other individual(s) that is with the client/consumer or in the Telehealth visit on behalf of the client/consumer.
 - 3. Ask the client/consumer to agree to receive Telehealth services in the presence of this other individual(s).
- v. Only individuals approved by the client/consumer, legal guardian, or court-ordered practitioner and assisting with their care may participate in Telehealth services. This includes persons who might be included electronically or off-camera.
 - 1. Pan the room with the camera to show the client/consumer (legal guardian) who is in the room prior to starting to provide Telehealth services.
 - 2. Should technical support staff be needed to help with technical problems during the Telehealth visit, obtain consent from the client/consumer first.
- vi. If a recording will be made, obtain permission from the client/consumer (legal guardian) present to record the Telehealth visit and/or capture any images. Document this consent in the visit notes.
- h. Verify attendee count matches the number of invites so that unknown or unauthorized participants are not in attendance.
 - i. Be careful when authorizing participants/attendees to join a Telehealth visit and selectively specify who may:
 - 1. Share their camera, microphone, or screen.
 - 2. Have other individuals in the background.
 - ii. Remove bad actors/intruders immediately or terminate the session.

APH - POLICY

1. Change the meeting ID, password, and PIN if a bad actor/intruder gains access to it.
2. Report this as a security incident as required by the IT Policy Manual – Privacy and Security Incident Response.
- iii. Non-County recording applications shall be removed from the meeting (i.e., fireflies.ai, otter.ai, etc.).
- i. When a group Telehealth visit is being held:
 - i. Verify all clients/consumers/legal guardians signed an informed consent for group visits.
 - ii. Provide group guidelines (e.g., verbally and/or post them in the chat).
 - iii. Group guidelines include, but are not limited to the following:
 1. Attend group sessions in a space that is:
 - a. Private; do not allow anyone else who may be near you to hear or see the group Telehealth visit.
 - b. Free of distractions.
 2. Use only the login information provided directly to you by our organization.
 3. Wear earbuds or headphones when not able to be in a private setting.
 4. Mute the speaker when not speaking.
 5. Keep the camera centered on you and steady.
 6. Dial in by telephone if the Internet signal degrades and keep the video connection open.
 7. If agreed upon in advance, use a nickname or fictitious name.
 - iv. Use extreme caution when using a weblink shared in a chat during a video-conferencing meeting.
 - v. If there are technical problems (e.g., equipment or transmission), conduct basic troubleshooting. If the problem continues:
 1. Hang up/cancel the visit/session and restart it, request the client/consumer to do this at the same time.
 2. Submit an IT Help Desk ticket to the IT Division for assistance.
- j. As soon as the Telehealth visit ends, users are required to "End meeting" to disconnect the Telehealth Technology.
- k. Replace the camera lens cover, if applicable.
- l. Document the client's/consumer's location, names, and relationships of other individual(s) in the visit, any images, as well as the evaluation and services provided in the designated record set. Refer to additional documentation requirements in the "designated record set" section in these procedures.
- m. Clear all client/consumer images and documentation from the work area at the end of the Telehealth visit so that it may not be viewed or accessed by any unauthorized individual.
- n.

APH - POLICY

EVALUATION

I

REFERENCES/LEGAL AUTHORITY

- HIPAA COW Telehealth Policy and Procedures, Version 1, 6/24/2020.
- HIPAA Final Omnibus Rule, January 25, 2013
- Wis. Chapter 49 Public Assistance and Children and Family Services, June 2, 2020, <https://docs.legis.wisconsin.gov/statutes/statutes/49>
- 2019 Senate Bill 380, August 29, 2019, <http://docs.legis.wisconsin.gov/2019/related/proposals/sb380>
- 2019 Wisconsin Act 56, November 25, 2019, <https://docs.legis.wisconsin.gov/2019/related/acts/56>
- Wis. Stat. §51 Mental Health Act
- Wis. Chapter DHS 92 Confidentiality of Treatment Records
- Wis. Stat. §146 Miscellaneous Health Provisions
- Wisconsin Telehealth for Dates of Service Before January 1, 2020; WI Forward Health, https://www.forwardhealth.wi.gov/kw/html/510_Telehealth.html.
- Wisconsin Medicaid Program Telehealth/Telehealth Definition. WI Forward Health, Wisconsin Medicaid Provider Manual, Physician, p. 135 (Jan. 31, 2014).
- Telehealth topic (#510), Forward Health Online Handbook, <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=50&s=2&c=61&nt=Telehealth&adv=Y>

RELATED PROCEDURES

NA

DOCUMENT PROPERTIES

Prepared by: Chippewa County HIPAA Team, Allie Isaacson, and Sarah McQuillian

Authorized by: Brittnay Fortuna

Board Approval Date: [Click to Enter Date](#)

Reviewed:

DOCUMENT HISTORY

Board Approval Date	Revision Description	Revised By	Authorized By



STATEMENT OF EXPLANATION
PUBLIC HEALTH 2026 OPIOID FUND REQUEST – BRITTNAY FORTUNA

5.6

Per resolution 54-21, Chippewa County has funding available from the Opioid settlement with distributors and Johnson & Johnson. These funds are being made available to departments within Chippewa County for approved uses. The program was implemented in 2024 with outreach, education, and community impact.

Public Health is requesting approval for the expansion of the Public Health Harm Reduction Program- Overdose Fatality Review with this funding for 2026. The requested recommendation is to allocate \$35,000 to this initiative.

Opioid Fund Request Form

- **All programs/projects must be requested by April 15th each year** in order to be considered for an approved program/project for the following calendar/budget year.
- If the CA supports the project after the initial review, then DH have 60 days to complete Section 3 and review it with the policy committee to get their feedback. The completed Opioid Fund Request Form, with the committee feedback, is then submitted back to the CA to be incorporated into the next year's budget by June 15th.
- **All training requests may be requested throughout the year but must be approved by the CA.**
 - * Each individual attending training must complete an Opioid Fund Request Form.
- The following documents are attached for reference when completing this form:
 - * Exhibit E – List of Opioid Remediation Uses – Schedule A: Core Strategies
 - * Exhibit E – List of Opioid Remediation Uses – Schedule B: Approved Uses



SECTION 1 – To Be Completed by DH Before Submitting to the CA for Initial Review

Project Requester/Department: Public Health Date: 3/25/2025

Identify the Budget Year Funds are Requested For: 2026

Name of Opioid Program/Project/Training: Public Health Harm Reduction Program

☐ New Program ☐ Reoccurring Opioid Program (*identify below*) ☒ Expansion of Existing Program (*identify below*)

Identify: Expansion of the Overdose Fatality Review Team recommendations to include current programming

Estimated Start Date of Project: 1/1/2026 Estimated Date of Completion: 12/31/2026

☒ Training Request Date of Training: TBD Location of Training: TBD - harm reduction/opioid focus

Identify the Core Strategy from Schedule A: (*see Exhibit E – List of Opioid Remediation Uses*)

- ☒ Naloxone or Other FDA-Approved Drug to Reverse Opioid Overdoses
- ☐ Medication-Assisted Treatment (“MAT”) Distribution and Other Opioid Related Treatment
- ☐ Pregnant & Postpartum Women
- ☐ Expanding Treatment for Neonatal Abstinence Syndrome (“NAS”)
- ☐ Expansion of Warm Hands-Off Programs and Recovery Services
- ☐ Treatment for Incarcerated Population
- ☒ Prevention Programs
- ☐ Expanding Syringe Service Programs
- ☐ Evidence-Based Data Collection & Research Analyzing the Effectiveness of Abatement Strategies w/in the State

Identify the Approved Use from Schedule B: (*see Exhibit E – List of Opioid Remediation Uses*)

- ☐ Treat Opioid Use Disorder (OUD)
- ☐ Support People in Treatment and Recovery
- ☐ Connect People Who Need Help to the Help They Need (Connections to Care)
- ☐ Address the Needs of Criminal Justice-Involved Persons
- ☐ Address Needs of Pregnant/Parenting Women & Their Families, Including Babies with Neonatal Abstinence Syndrome
- ☐ Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids
- ☒ Prevent Misuse of Opioids
- ☒ Prevent Overdose Deaths and Other Harm (Harm Reduction)
- ☐ First Responders
- ☐ Leadership, Planning and Coordination
- ☒ Training
- ☐ Research

List the Subcategory as Shown in Exhibit E:

Note: The Subcategories are the numbered items listed under the Core Strategies from Schedule A or the Approved Uses from Schedule B

- A.A. - Naloxone to reverse opioid overdoses;
 A.G. - Prevention Programs;
 B.G. - Prevent Misuse of Opioids;
 B.H. Prevent Overdose Deaths & Other Harms (Harm Reduction);
 B.K. Training

Description – Provide an explanation about what the program/project/training entails.

Focus will continue to be placed on educating a variety of individuals within the community to include those incarcerated, school personnel, professionals, and the general community members on the harms of opioids, current overdose trends, and how to recognize & respond to an overdose. We will continue to provide nasal Narcan as requested to all community members, along with supporting Narcan needs of all county schools (Overdose Aid Kits), YMCA, EMS, LE, mailing program, and through our Public Health Kiosk. Staff will continue to raise awareness about various local and national resources, prevention strategies, and stigma reduction; to include: media campaigns (Dose of Reality, Real Talks, etc.), community disposal programs (National RX Takeback Day), and participate in the Chippewa County Healthy Communities Voices in Prevention coalition, Overdose Fatality Review Team, National Public Health Vending Machine Round Table, and others as appropriate. Lastly, staff will participate in educational opportunities to increase knowledge of best practices and engage in networking opportunities to continually improve services. Trainings could include the Opioids, Stimulants, and Trauma State Summit, State Harm Reduction Conference, and others as they arise.

How does this program/project/training help with the Opioid use abatement efforts in Chippewa County?

This project aligns with the opioid abatement efforts in Chippewa County by strategically connecting many efforts related to opioid misuse prevention and harm reduction measures. Recommendations from the Overdose Fatality Review Team can be put into action in a coordinated fashion, which reduces duplication and increases efficiency. Barriers will be reduced, which makes accessing services more readily available and reduces potential harms.

Has this program/project/training utilized Opioid funds in the previous year? ☒ Yes ☐ No

If yes, then identify some of the measurable impacts the program/project/training has had on abatement efforts.

Since the launch of our Narcan distribution program in 2023, we have conducted 71 training sessions, training nearly 1,000 individuals, and distributed 1,539 boxes (3,078 doses) of nasal Narcan. We have invested in staff training to ensure best practices are being followed in overdose response, Narcan administration, and harm reduction counseling. With feedback from jail staff and inmates, staff were able to develop focus groups to improve the delivery of harm reduction trainings in the jail.

Estimated Annual Cost of Program/Project/Training: \$ 35,000

Amount of Annual Chippewa County Opioid Funds Requested: \$ 35,000

Will matching funds be used by another organization/municipality? ☐ Yes ☒ No

If yes, identify who and amount: _____

Is there a current program/service that will no longer be offered? ☐ Yes ☒ No

If yes, please identify the program, costs and revenue source of the current program.

Are you able to manage and implement this new program/project/training with existing staff within your department?

☒ Yes ☐ No

If yes, how many staffing hours annually are anticipated? 400 hours

If no, are you able to contract with an organization/individual to provide the service? ☐ Yes ☐ No

Return completed form to the County Administrator

Brittnay Fortuna

Signature of Project Requester/Department Head

04/08/2025

Date

SECTION 2 – To Be Completed by the County Administrator

- ☒ Approved for Committee Review and Feedback ☐ Denied ☐ More Information Needed
☐ Training Approved – Committee Review Not Needed

Total Amount of Chippewa County Opioid Funds Recommended by County Administrator: \$ 35,000.00

<u>Lori Zwiefelhofer (CA Vacancy)</u>	<u>4/9/2025</u>
County Administrator	Date

Comments:

This Opioid request can be forwarded to your policy committee. Remember this year is unique because the new County Administrator, Andy Albarado, will have final approval after your policy committee review of this request.

SECTION 3 – Additional Action and/or Comments from Committee

Note: It should be emphasized to the Policy Committee that not all programs/projects may be approved due to the limited funds available in the Opioid Abatement Account.

Committee Meeting Date: _____ ☐ Approved ☐ Denied ☐ More Information Needed

Department Head Recommended Ranking: _____ Committee Approved Ranking: _____

Total Amount of Chippewa County Opioid Funds Approved by Committee: \$_____

Comments:

- Submit completed form back to the County Administrator after policy committee has reviewed/approved by June 15th.

EXHIBIT E**List of Opioid Remediation Uses****Schedule A****Core Strategies**

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies (“Core Strategies”).¹⁴

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and
2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. **MEDICATION-ASSISTED TREATMENT (“MAT”) DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT**

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;
2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;
3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and
4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

¹⁴ As used in this Schedule A, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs.

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment (“*SBIRT*”) services to non-Medicaid eligible or uninsured pregnant women;
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder (“*OUD*”) and other Substance Use Disorder (“*SUD*”) / Mental Health disorders for uninsured individuals for up to 12 months postpartum; and
3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME (“*NAS*”)**

1. Expand comprehensive evidence-based and recovery support for NAS babies;
2. Expand services for better continuum of care with infant-need dyad; and
3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

E. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;
2. Expand warm hand-off services to transition to recovery services;
3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;
4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and
5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. TREATMENT FOR INCARCERATED POPULATION

1. Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and
2. Increase funding for jails to provide treatment to inmates with OUD.

G. PREVENTION PROGRAMS

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);
2. Funding for evidence-based prevention programs in schools;
3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);
4. Funding for community drug disposal programs; and
5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. EXPANDING SYRINGE SERVICE PROGRAMS

1. Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE

Schedule B
Approved Uses

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder (“OUD”) and any co-occurring Substance Use Disorder or Mental Health (“SUD/MH”) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:¹⁵

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (“MAT”) approved by the U.S. Food and Drug Administration.
2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (“ASAM”) continuum of care for OUD and any co-occurring SUD/MH conditions.
3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.
4. Improve oversight of Opioid Treatment Programs (“OTPs”) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.
5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.
6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.
7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

¹⁵ As used in this Schedule B, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs.

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.
9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.
10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.
12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (“DATA 2000”) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.
13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry’s Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.
14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry’s Provider Clinical Support Service for Medication–Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the programs or strategies that:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.
2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.
3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved medication with other support services.
5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.
6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.
7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.
8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.
9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.
10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.
11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.
12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.
13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.
14. Create and/or support recovery high schools.
15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED
(CONNECTIONS TO CARE)

Provide connections to care for people who have—or are at risk of developing—OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.
2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.
3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.
4. Purchase automated versions of SBIRT and support ongoing costs of the technology.
5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.
6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.
7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.
8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.
9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.
10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.
11. Expand warm hand-off services to transition to recovery services.
12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.
13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.
15. Engage non-profits and the faith community as a system to support outreach for treatment.
16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:
 1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (“*PAARI*”);
 2. Active outreach strategies such as the Drug Abuse Response Team (“*DART*”) model;
 3. “Naloxone Plus” strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;
 4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (“*LEAD*”) model;
 5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or
 6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.
2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.
3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.
5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.
6. Support critical time interventions (“CTI”), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.
7. Provide training on best practices for addressing the needs of criminal justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (“NAS”), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.
3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.
4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; and expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.
6. Provide child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.
7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.
8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.
9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.
10. Provide support for Children's Services—Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. **PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS**

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).
2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.
3. Continuing Medical Education (CME) on appropriate prescribing of opioids.
4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.
5. Supporting enhancements or improvements to Prescription Drug Monitoring Programs ("PDMPs"), including, but not limited to, improvements that:

1. Increase the number of prescribers using PDMPs;
2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or
3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.
6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.
7. Increasing electronic prescribing to prevent diversion or forgery.
8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding media campaigns to prevent opioid misuse.
2. Corrective advertising or affirmative public education campaigns based on evidence.
3. Public education relating to drug disposal.
4. Drug take-back disposal or destruction programs.
5. Funding community anti-drug coalitions that engage in drug prevention efforts.
6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (“SAMHSA”).
7. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.
9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.
10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.
11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.
12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.
2. Public health entities providing free naloxone to anyone in the community.
3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.
4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.
5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.
6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.
8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.
9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.
10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.
11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.
12. Providing training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.
13. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.
2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.
3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, those that:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.
2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.
2. Research non-opioid treatment of chronic pain.
3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.
5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.
6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (*e.g.*, Hawaii HOPE and Dakota 24/7).
7. Epidemiological surveillance of OUD-related behaviors in critical populations, including individuals entering the criminal justice system, including, but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (“ADAM”) system.
8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.
9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.



STATEMENT OF EXPLANATION
HUMAN SERVICES SUCCESS STORY - YOUTH JUSTICE - KYRA SECRAW

6.1

Youth Justice staff will briefly share a success story highlighting a young man who, by all indications, could have been easily slotted for jail or prison as a young adult. However, when extra effort and a little extra time is dedicated to a youth, the predicted trajectory of that youth can be changed.



**STATEMENT OF EXPLANATION
PUBLIC HEALTH POLICY, PRACTICE, AND PEOPLE – NUTRITION
DIVISION - STEPHANIE ABBE**

6.2

The Women, Infants and Children (WIC) Program is a nutrition program that helps families stay healthy by providing nutrition education, healthy foods, breastfeeding support and referrals to community resources. Stephanie Abbe, WIC Director, will give an overview of WIC, eligibility criteria, services, program outcomes, and the future of WIC.



Wisconsin WIC Program



WISCONSIN DEPARTMENT
of HEALTH SERVICES

2025

This institution is an equal
opportunity provider.

1

1

Outline

What is
WIC

WIC
Outcomes

Eligibility
Guidelines

WIC
Program
Services

Program
Highlights

Looking
Ahead

2

2

Meet our Staff



Pangya Thao
Program Assistant



Mary Rudd
LTE Program Assistant



April Krumenauer
Breastfeeding Peer Counselor



Amy Ralph, MS, RD, CLC
Nutritionist



Stephanie Abbe, RD
WIC Director, Nutritionist

Coming
soon

Vacant
LTE Nutritionist

3

3

WIC

The Special Supplemental Nutrition Program for **Women, Infants and Children** (WIC) serves to safeguard the health of low income pregnant, postpartum and breastfeeding women, infants, and children up to age 5.



4

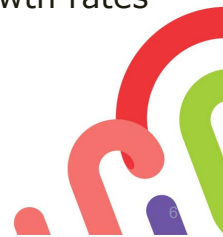


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WIC Works

- Better Birth Outcomes
- Increased Nutrients in Diet
- Improved Infant Feeding Practices
- Improved Cognitive Development and Academic Abilities Development
- Improved Preconceptual Nutritional Status
- Other Improved Outcomes: more likely to have regular medical provider, improved growth rates and immunization rates



6

Who Qualifies?

Individuals who are:

- Pregnant
- Up to 6 months postpartum
- Breastfeeding or providing their human milk to WIC enrolled infant up to 12 months old
- With pregnancy loss up to 6 months postpartum
- Under 5 years of age

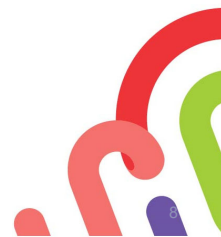


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7

Who Qualifies?

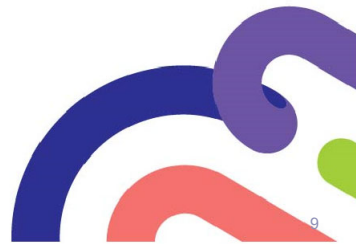
- Resident of Wisconsin
- Income eligible
 - Up to 185% of the federal poverty level
 - Enrolled in foster care, kinship care, or FoodShare
 - Many families enrolled in Medicaid/BadgerCare Plus
- Health or nutrition need



8

WIC Provides

1. Nutrition Education
2. Nutritious foods
3. Breastfeeding promotion and support
4. Referral Services



9

1. Nutrition Education

WIC works with families to address:

- Eating habits
- Dietary needs
- Meal planning
- Feeding concerns



10

10

2. Nutritious Foods



\$75-80/month for kids
\$100-125/month for women
\$115-200/month for infants

11

11

Shopping with WIC



4452 0000 0000 0000



WISCONSIN WOMEN, INFANTS & CHILDREN NUTRITION PROGRAM

SHOPPING GUIDE

EFFECTIVE NOV 1, 2022 TO OCT 31, 2025



BENEFIT PERIOD 5/18/2025 - 6/17/2025		
Quantity	Unit	Food Item
3		Milk, 1% or Skim, Gallon
1	CTR	15-16 oz cans Beans/Peas or 1 lb. dried Beans/Peas or 16-18 oz Peanut Butter
1		Cheese, 1 LB = one 16 oz. pkg or two 8 oz pkg
36	Ounce	WIC Cereal
2		Juice, 64 oz container
1		Dozen Eggs
32	Ounce	Whole Wheat Bread or Whole Grain Foods
26	Dollars	Fresh, frozen, or canned Fruits and Vegetables
1		Yogurt, Low Fat/Nonfat, 1 QT = one 32 oz or two 16 oz



Wisconsin MyWIC app

12

Farmers Market Nutrition Program (FMNP)

- Provides WIC participants the opportunity to purchase locally grown fruits, veggies and herbs at authorized farmers market and farm stands in Wisconsin
- In 2024, Chippewa County WIC enrolled families redeemed \$13,416 worth of checks
- In 2024, Farmers Market Nutrition Program generated about \$18,368 in revenue for our Chippewa County authorized farmers
- In 2024, WIC FMNP generated almost \$1.25 million for farmers



13

3. Breastfeeding Promotion



WIC helps families reach their breastfeeding goals.

14

14

Breastfeeding Peer Counselors



15

15

Infant Feeding

“One of the biggest challenges for me to overcome was asking for help.”

—Daili
WIC Participant



16

16

4. Health & Community Services Referrals

- Area food resources
- Children's Resource Center - West
- Mental health services
- Birth to 3
- Dental services
- Head Start
- Family Support Center
- Public health programs including prenatal care coordination, nurse family partnership, lead testing, well water testing, car seat, immunizations
- Housing
- Domestic abuse
- Economic Support Programs – energy assistance, childcare assistance, FoodShare, BadgerCare
- Primary care providers, lactation consultant
- Tobacco, alcohol, substance use cessation



17

17

A Typical WIC Visit

- Proof of identification, residency, income are collected (once/year)
- Weight, length/height and hemoglobin are collected (twice/year)
- The dietitian completes the nutrition assessment and counseling.
- WIC benefits are loaded and the next visit is scheduled.



18

18

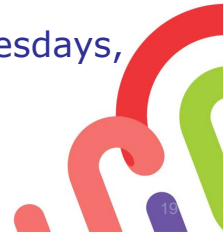
WIC Clinic Locations and Schedule

Satellite clinics:

Monthly: Bloomer - 2nd Thurs, Stanley - 3rd Thurs
Quarterly: 1st Thurs Cornell

Late clinics: 1st, 2nd and 3rd Mondays –
9:30am-6pm which also has some lunch hour
visits available

Chippewa Falls clinics: Mondays, Tuesdays,
Thursdays on non-satellite clinics



19

Connect Families to WIC

- Refer all potentially eligible families
- Word of mouth is the best referral source

Learn More and Apply Online!
www.dhs.wisconsin.gov/WIC



20

Exciting Changes Planned for 2025-2026

- Authorization of Kwik Trip
- 2-way communication within the WIC app
- WIC food package changes
 - addition of canned fish, adjustment of milk, juice, whole grains
 - increased whole grain options, dairy alternatives, possibly nut and seed butters
 - expansion and flexibility of package and container size



21

Program Highlights



Contracted
Monthly
Caseload: 907

1356
participants
served in 2024

\$816,542 revenue
to WIC vendors

83% of women give
breastmilk at birth

93% of participants
have BadgerCare
Plus

75% of
postpartum
women are on
WIC in pregnancy

Top 4 referral sources:
Friend/relative, the doctor's
office/clinic, social services and
HMO's

22

22

Questions?



23

23

Contact Information

Stephanie Abbe, RD, CD

Nutrition Division Manager, WIC Director
Chippewa County Department of Public Health
sabbe@chippewacountywi.gov
715-726-7870

To learn more about Wisconsin WIC, visit:
www.dhs.wisconsin.gov/wic



24

24



STATEMENT OF EXPLANATION
HUMAN SERVICES DIRECTOR'S PROGRAM AND FINANCIAL REPORT –
BOBBIE JAEGER

6.3

Human Services Director Bobbie Jaeger provides a department program and financial report for review and discussion.

Human Services Director's Report

Board Meeting Date: May 15, 2025

WCHSA Updates

Division of Children and Families (DCF) and CYF PAC

- DCF discussed childcare items in the governor's budget bill. PAC asked DCF to provide what statutory changes are needed for categorical eligibility for foster parents and kinship caregivers.
- CMS proposed rule on healthcare marketplaces would shorten the open enrollment period and limit special enrollment periods. PAC will submit comments on CMS proposed rule.

Division of Health Services (DHS)

- PAC discussed CLTS program issues including need for communication about DHS taking over provider contracts and program fiscal integrity issues. Northern Region had meeting with DHS in March about fiscal integrity issues.
- DHS provided feedback to PAC on proposal to use CCOP funds to eliminate CLTS MOE. DHS thinks CCOP services would be hurt if \$6 million was taken out to fully eliminate the CLTS MOE.
- DHS provided feedback on Birth to 3 sustainability recommendations. DHS suggested WCHSA present sustainability recommendations to the Birth to 3 Interagency Coordinating Council.

Behavioral Health PAC

- Board discussed legislation to authorize DHS to pursue new Medicaid waiver for children's behavioral health services. Board raised the following points:
 - Want more services for children with complex needs.
 - Not convinced of the need for new waiver program.
 - Should work with DHS to improve existing services
 - Don't rule any new service delivery structures like statewide MCO in or out yet before more discussion of services.
 - Building service provider capacity is the critical need.
 - Board approved option to support legislation that gives DHS authority to revise existing Medicaid services or develop new services working with counties and other stakeholders.



Department and Division Updates

Department Updates

Work Anniversary CONGRATS and THANKS to the following staff for their service and dedication:

- 2nd - Song Wu, Fiscal (3 Years)
- 3rd - Hannah LaBelle, CPS (4 Years)
- 15th - Ann Teuteberg, B3 (24 Years)
- 15th - Ashley Yang, CPS (2 Years)
- 20th - Jessica Gibson, ADRC (6 Years)
- 22nd - Serena Schultz, CWDA (8 Years)
- 27th - Sarah Hedlund, ADRC (11 Years)
- 30th - Amy Giani, CPS (2 Years)
- 30th - Kai Burakowski, CWDA (2 Years)

Division Updates

Aging & Disability Resource Center (ADRC)

- May is recognized as Aging and Disability Resource Center (ADRC) Month. We are grateful to the ADRC team for their dedicated service to our customers!
- This month also marks the nationwide observance of Older Americans Month. This year's theme, Flip the Script on Aging, encourages individuals and communities to challenge stereotypes and have meaningful conversations that can help dispel misconceptions about aging.
- Participation in our Café 60 program continues to increase, including 8 diners recently added, bringing the total number of participants to 36. Café 60, a modern model for senior dining, provides meals in a restaurant setting in rural areas too small to support a formal congregate meal site.

Children, Youth & Families (CYF) Division

Birth to Three (B-3)

- April 2025 was a very busy month for Birth-to-Three. Early in the month, two local community members came and provided a learning opportunity on lip and tongue ties and the impact it has on young children, for our program. We were able to open this opportunity up to collaborating community partners with the help of grant money that we received.
- Unfortunately, our contracted Physical Therapist retired at the end of April after serving the Chippewa County Birth-to-Three Program for thirty-three years; this is a huge loss. The position has been advertised by our contracted partner for the last month and a half with no responses. Our team is working on adapting to the loss of having a full team and picking up extra work. For now, we have limited access to virtual support to help fill the gap. This position will be difficult to fill due to changes in schooling and the compensation offered.
- As a team we are exploring a new ongoing assessment tool, with guidance from the state, who is providing a grant of \$500.00 to use towards the purchase of a state approved tool.
- Birth-to-Three continues to be busy with twenty-one new referrals for the month of April.



Children, Youth & Families (CYF) Division

Child Protective Services (CPS)

- In April 2025, the Child Abuse and/or Neglect Access line received seventy-five calls alleging abuse and/or neglect. Of those seventy-five calls, twelve were screened in to assess child safety.
- In April 2025, two children's cases were able to close due to Guardianship.
- In April 2025, two cases were set for Termination of Parental Rights Proceedings; unfortunately, one case has been delayed due to a new attorney needing to be found for the parent and the other case has been adjourned to May.
- One child was removed in May 2025 due to parents who were refusing to care for their child.
- As mentioned in the previous report, Anna Duske, an Ongoing Worker who has been with the Department for two and a half years, will be leaving in May 2025. Due to the unit's hard work in decreasing out-of-home placements, achieving permanency timely for children, and decreasing caseloads overall, this open position will now be a Youth Justice Position to lower their caseloads and hopefully decrease their out-of-home placements.

Children, Youth & Families (CYF) Division

Children with Differing Abilities (CWDA)

- We are fully staffed and currently onboarding 4 new staff to the unit.
- Referrals to Children's CCS and CLTS continue to be steady.
- We continue to work on action steps set forth in our CAP with the state regarding the timeliness of CLTS enrollment. Our first meeting with the State regarding our CAP is scheduled for this month.

Children, Youth & Families (CYF) Division

Youth Justice (YJ)

- We were informed that a social worker position in CPS is being reallocated to YJ to assist in supporting the youth of Chippewa County and addressing the long-standing understaffing challenges we have been juggling over the past decade.
- Interviews are being conducted for an LTE (Admin III) Grant Coordinator to assist in facilitating our initiatives with the Community Innovations grant we were awarded for this year.

Economic Support (ES) Division

- May 12-16 Economic Support Week. We want to thank all our leads, specialists, fraud, and reception staff for their hard work serving our customers!
- GRCC removed "all-in" call center days. Typically, we schedule an "all-in day" the day after a closure to anticipate higher call volumes. However, based on data from previous "all-in" days, we've identified the need to find a greater balance between call center and task processing on those days.



- Ericka Zillmer was promoted to Economic Support Coordinator and began her new role on April 28. Ericka has worked in Economic Support for 12 years in various roles including Energy Assistance, Family team, Child Care team, Fraud, and part of our Elderly Blind and Disabled team.
- Leah Luther will be starting on May 12 as Administrative Assistant.
- Recruitment to replace Ericka's Economic Support Specialist position will begin May 7

Recovery & Wellness Consortium (RWC) Division

- May is identified as Mental health Awareness Month. This year's theme is "Turn Awareness into Action" This theme encourages individuals and communities to take meaningful steps toward positive change, through advocacy, education and action. There has been proposed cuts to the 988 Suicide and Crisis Lifeline. Specifically funding to specialized services for the LGBTQ+ youth. While anyone in a mental health crisis can call or text 988 and be connected to a trained counselor, the line has specially trained counselors, often with similar life experiences, for high-risk groups like veterans and LGBTQ+ youth. What they get with that specialized services line is they get somebody who cares, somebody who's been there with them, who has shared experiences, who can understand where they're coming from, and who has been specially trained to address the situations that they are dealing with. Please reach out to your representatives to voice your concerns about this action.
- David Pfeffer has begun his transition into the role of Mental Health Clinician. Mental health clinicians are an essential component of all the Medicaid programs provided by the RWC. Clinical supervision of staff members includes direct service, assessment, and feedback regarding each member's delivery of mental health services. David joins Michelle Phelps, Lisa Hudson and Jennifer VanSleet as the other mental health clinicians from RWC.
- Rita Fehr has transferred from Comprehensive Community Service (CCS) to Community Support Program (CSP) as a service facilitator. This looks to be a "good fit" for Rita as this will draw upon her strength of developing an alliance with consumers.
- Adult Protective Services (APS) needs to prioritize their time to ensure that the mandated services are performed in accordance to statute. Power of Health Care and Finances are valuable services offered to citizens to avoid more intensive and costly guardianship proceedings. RWC is looking to collaborate with ADRC in ways to provide these services to community members that have health barriers to leaving their homes.



2025 Monthly Fiscal Information

Through Month of: April 2025

2025 Budget (Total is \$37,539,226): \$12,513,075 Prorated – 4 months

Expenses Paid (Through April 30): 7,823,934

Variance to Budget: \$4,689,141

Note: The April Over/(Under) amounts are an estimated annualized amount for each placement category. Prior months estimated amounts are shown to indicate if expense variances are trending up, down, or remaining the same.

2025 Kinship Placement with a Relative

Month	Kinship	Projected Cost	2025 Grant Amount*	Over/(Under)
January	80	\$351,072	\$454,500	(\$103,428)
February	77	340,536	454,500	(113,964)
March	77	347,772	454,500	(106,728)
April	75	338,960	454,500	(115,540)

2025 Children and Youth in Out-of-Home Placements

Month	Out of Home*	Out of Home**	Projected Cost	2025 Budget	Over/(Under)
January	29	0	\$1,365,828	\$1,046,000	\$319,828
February	31	0		1,046,000	
March	31	0	1,785,004	1,046,000	739,004
April	28	3	2,106,305	1,046,000	1,060,305

*Children and Youth in Placement: Foster Care, Treatment Foster Care, Group Home, Residential Care

**Additional children placed with relatives (unpaid)

2025 Adult Mental Health CBRF Out-of-Home Placements

Month	Out of Home	Projected Cost	2025 Budget	Over/(Under)
January	13	\$281,328	\$479,041	(\$197,713)
February	15	399,708	479,041	(79,333)
March	12	474,756	479,041	(4,285)
April	15	457,618	479,041	(21,423)

2025 Institute for Mental Disease (IMD) Placements

Month	Inpatient Days	Projected Cost*	2025 Budget	Over/(Under)
January	161	\$1,090,296	\$878,000	\$212,296
February	100	751,591	878,000	(126,409)
March*	146	852,716	878,000	(24,284)

*March IMD is the most recent invoice received



Note: The following reports show monthly disbursement amounts for each placement category. The month shown is the month the invoice was paid (not the month the charge was incurred).

2025 Kinship

Month	Amount Paid	Monthly Grant Amount
January	0	\$37,875
February	28,058	37,875
March	28,734	37,875
April	27,902	37,875
Total	\$84,694	\$454,500

2025 Children & Youth Placements

Month	Amount Paid	Monthly Budget
January	0	\$87,167
February	134,373	87,167
March	82,173	87,167
April	189,086	87,167
Total	\$405,632	\$1,046,000

2025 Adults in CBRF Placement

Month	Amount Paid	Monthly Budget
January	0	\$39,920
February	17,553	39,920
March	49,898	39,920
April	24,651	39,920
Total	\$92,102	\$479,041

2025 IMD

Month	Amount Paid	Monthly Budget
January	0	\$73,166
February	37,179	73,166
March	135,141	73,166
Total	\$251,724	\$878,000



WELCOME to our latest NEW Human Services Employees

Jacob Kueler
CWDA 3/3/25



Before working at Chippewa County, what is the most unusual or interesting job you've had?

There was a year and a half period earlier in my life in which I worked as an Insurance Sales representative. I learned lots of valuable information about auto/home/life insurance and got to meet lots of great people in the community.

If you could learn to do anything, what would it be?

Astrophysics! Some of my favorite non-core classes in college were related to universal physics and astronomy.

What's a fun fact about you many people may not know?

Having worked at MAC's at the beginning of college, I can make mean homemade mac and cheese!

Courtney Krug
CWDA 4/14

If you could be any fictional character, who would you choose?

Hermoine Granger

What's a fun fact about you many people may not know? I spent a month in Germany the summer after I graduated from high school.

If you could have any superpower, what would it be?

Teleportation



DHS SPOTLIGHT CONTINUED

Lexi Hollmann
CWDA 4/14

Where's your favorite place in the world?

My family's cabin Up North on Big Arbor Vitae Lake. I have amazing memories with my family there and love to spend time on the water!

What chore do you absolutely like/dislike?

Dishes, I love to cook and bake but absolutely hate doing the dishes!

What would you do for a career if you weren't doing this?

My dream would be to open a coffee shop and bakery!



Kelly Hazelton
CWDA 4/14



Where's your favorite place in the world?

Florida; Fort Myers to be specific. I love the beach, ocean, and sand.

What would you do for a career if you weren't doing this?

I have wanted to become a therapist specializing in PTSD specifically with a focus on battered women and our military veterans.

What's a fun fact about you many people may not know?

I love BIG dogs! I love all dogs, but the bigger the better. I have a 173-pound male English Mastiff named 'Hank' who is my everything.

Child Protective Services (CPS) Screened-in CPS Reports Yearly Comparison

Year	Screened in CPS Reports January-April	Number of IA Workers	End of Year
2025	61	4	N/A
2024	62	4	180
2023	51	4	167
2022	84	4	189
2021	86	4	199

WCHSA Caseload Recommendations

Initial Assessments: 11 cases per worker with no more than 6 new assessments per worker per month

Ongoing: 10 cases per worker with no more than 15 children per worker

Current CPS Family Caseloads (05-07-25)

Caseload Type	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1FTE	1 FTE	1 FTE	1 FTE
Initial Assessment	9	8	9	9						
Ongoing					6	9	5	4	6	7

Total Families/Cases Open: Initial Assessment = 35; Ongoing = 37; equals 72 Total

Out-of-Home Placement Yearly Comparison

Total Children/Youth Served January - April for each year listed below (includes Kinship)

2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015
99	57	120	150	156	143	168	178	148	73	48

Children/Youth Opened in CCS and/or CLTS (May 2025)

Children/Youth Opened in April	17
Children Waiting to be Screened to Determine Eligibility	10
Waiting to be enrolled - CCS	12
Waiting to be enrolled - CLTS	10

Current IMD Expenditures (Mar-May 2025)

Children/Youth – IMD*	\$18,289
Adults – IMD	\$194,889
Total	\$213,178

Yearly Comparison Crisis: Jan – March

	Adults	Children
2025	149	37
2024	188	31
2023	216	42
2022	219	67
2021	168	60

Yearly Comparison Youth Justice Referrals

Year	Jan-Feb	End of Year
2025	38	N/A
2024	38	277
2023	56	243
2022	44	263
2021	34	236



STATEMENT OF EXPLANATION
PUBLIC HEALTH DIRECTOR'S PROGRAM AND FINANCIAL REPORT –
BRITTNAY FORTUNA

6.4

Public Health Director Brittnay Fortuna provides a department program and financial report for review and discussion.



Administration Division

The Doris Vennard Scholarship Committee met and selected one recipient for this year's \$2,500 scholarship. A total of six applicants applied. The Committee chose Sorik Spangler, a Cornell High School senior. Sorik is pursuing a Doctor of Nursing Practice Degree, with a focus on surgical nursing, through the University of Wisconsin – Eau Claire.

Although Doris Vennard was not a nurse herself, she was deeply moved by the compassionate care she received from the nursing profession. In her Will, she designated funds to establish scholarships for deserving and financially limited high-school graduates from Chippewa County who plan to pursue a one- to four-year degree in nursing.

Recipients are selected based on financial need, specifically, students who do not have access to other scholarships and whose parents are unable to contribute financially to tuition and textbook expenses.



Committee-left to right:
Pam Guthman, Brittnay Fortuna, Kristen Kelm, April Krumenauer, Carol Lendle



April and Audra participated in the Healthy Kids Day event at the YMCA on April 12, where they promoted car seat safety as well as Public Health programs and services.

The Fiscal Administration Team attended the Learn Grow Lead Conference at CVTC in celebration of Administrative Professionals Day. The event provided a valuable day of professional development.

Sarah and Christina continue to follow up on outstanding TN Water payments.

Community Health Division

Community Update: Rabies and Animal Bite Follow-Up in Chippewa County

Chippewa County Public Health follows up on all animal bites reported to law enforcement. This is an important part of protecting our community from rabies, a communicable disease.

Rabies is a virus that affects the brain and nervous system. It is most commonly spread through the

bite or scratch of an infected animal. Without timely treatment, rabies is almost always fatal, but it is also preventable.

In our area, bats are the most common carriers of rabies. However, other animals such as dogs, cats, foxes, raccoons, and even livestock can also become infected. Humans can become infected as well, typically through contact with the saliva of a rabid animal via a bite or scratch.

Bat bites can go unnoticed due to their small size. If you find a bat in your home, especially in a bedroom or near someone sleeping, please contact the health department. We can help determine whether the bat should be tested for rabies.

Chippewa County Public Health can send animals for rabies testing when appropriate. It is important to note that the animal must be deceased for testing, and it must be euthanized humanely. The portion tested is located at the base of the skull, so care must be taken not to damage this area.

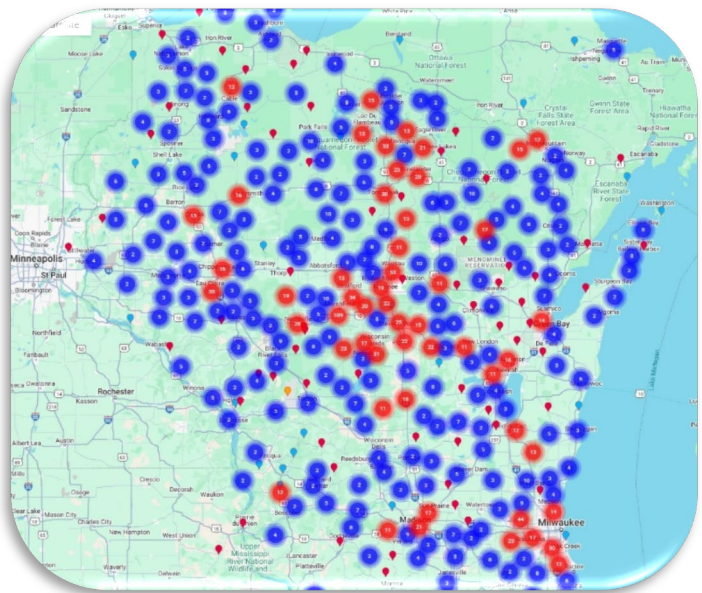
It is also important to keep cats and dogs up to date on their rabies vaccinations. This significantly reduces their risk of contracting the virus. Animals that are not vaccinated must be quarantined if they are exposed to a potentially rabid animal. Under Wisconsin State Statute 95.21, all pet owners are required to vaccinate their dogs and cats against rabies.

Tickborne Disease Prevention and Research Partnership

Tickborne illnesses like Lyme disease, anaplasmosis, and ehrlichiosis are a growing concern in Wisconsin. Many people in our state get sick each year, and tick season is now underway. To help prevent these illnesses and better understand where tick bites are happening, Chippewa County Public Health is partnering with Marshfield Clinic Research Institute on their Tick Inventory via Citizen Science (TICS) project.

This project asks people across Wisconsin to send in ticks they find, along with where the tick was picked up. Last year, more than 6,000 ticks were submitted, helping researchers map out high-risk areas. This year, the study also includes follow-up surveys to learn more about what puts people at risk and how tickborne diseases affect them.

Through our partnership with the Western Wisconsin Public Health Readiness Consortium, we are offering free tick removal kits to help community members safely remove ticks and access practical tips for preventing tickborne illnesses. Together, these resources support both individual protection and broader public health efforts to better understand and prevent tick-related diseases in our region.



To stay safe this tick season, we encourage everyone to:

- Wear long sleeves and pants when outside
- Use bug spray with DEET or another EPA-approved repellent
- Check your body and clothes for ticks after being outdoors
- Remove ticks right away using tweezers

This partnership gives our community easy access to tools and information that support early prevention and helps public health experts better understand tickborne disease in our region.

To view this year's tick tracking map, visit: [Tick Dashboard – Marshfield Clinic Research Institute](#)

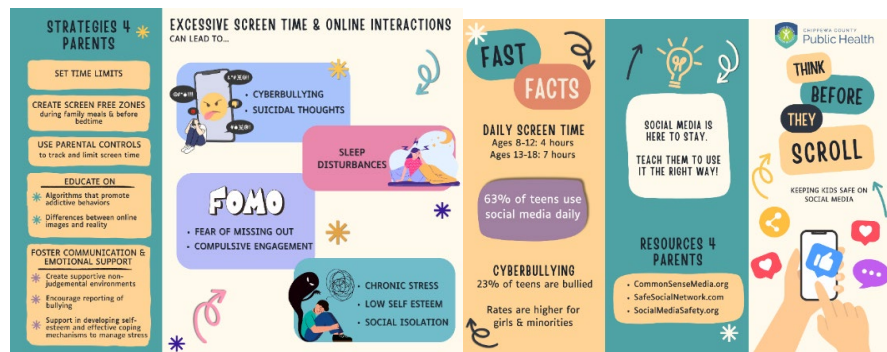
Tick kits can be picked up at the Chippewa County Health Department or requested directly by emailing tics@marshfieldclinic.org or calling 715-221-6462.

UW-Eau Claire Master of Science in Nursing Administration (MSN) Program Partnership:

The Chippewa County Department of Public Health (CCDPH) continues to benefit from strong academic partnerships that enhance our capacity to advance community health while supporting workforce development.

For the 2024–2025 academic year, CCDPH partnered with the University of Wisconsin–Eau Claire's Master of Science in Nursing (MSN) Administration program. From September through May, Mik Devereaux, a graduate nursing student, completed a practicum placement with our team. During this time, Mik made meaningful contributions to several high-priority initiatives, including our reaccreditation preparation, internal Just Culture efforts, and an analysis of the impact of social media on adolescent mental health. Just Culture, an approach that promotes a fair and supportive environment for learning from mistakes, emphasizes accountability while encouraging open discussions of errors without fear of punitive action. Mik's work in this area has been instrumental in advancing our efforts to foster a culture of continuous improvement within the department. Mik's contributions helped inform future planning and underscored the importance of continued collaboration between academia and public health practice.

These partnerships not only provide valuable learning experiences for nursing students but also strengthen CCDPH's efforts to promote health equity, improve access to care, and build a healthier Chippewa County.



Social Media Resource created by Mik Devereaux, UWEC-MSN Student

Communicable Disease

The Health Officer is required by Wisconsin State Statute 252.05 to report information on current communicable disease reporting and follow-up to the Health and Human Services Board. In April, we received 105 new reports: 33 confirmed (6 Coronavirus-Associated Hospitalizations, 10 Chlamydia, and 4 Lead-Blood Levels-Adult-BLL 10); 5 probable cases (3 Lyme Laboratory Reports, 1 Hepatitis B, and 1 Syphilis); and 47 that did not meet the definition of a case (13 Lead-Blood Levels-Adults, 9 Hepatitis A, and 5 Lyme Laboratory Reports). See the attached report for further breakdown by disease type.

Environmental Health Division (EH)

The Environmental Health team completed 40 routine food safety and recreational licensing inspections and 26 pre-inspections for new businesses. A pre-inspection is a preliminary check conducted before a business (such as a restaurant, food truck, swimming pool, or recreational facility) receives its official operating license. This inspection ensures that the facility complies with all relevant health and safety codes before it opens to the public. The team received three complaints: two food safety complaints that required onsite visits, and one human health hazard, which is going to require a placard.

Each spring, our EH staff complete a food safety document review with all of Chippewa County's schools. This review of school food service operation is to ensure it follows a Hazard Analysis and Critical Control Point (HACCP) plan, a food safety system designed to prevent foodborne illness. HACCP is required for all school programs that participate in federally funded child nutrition programs. These second visits help prevent foodborne illnesses in our communities' children, ensure regulatory compliance with USDA and local health department standards, and promote a culture of food safety in educational settings. Chippewa County has a total of 26 schools.

Fifteen TN bacteria/nitrate samples were collected, and 16 private well-owner bacteria samples were processed. Four sanitary surveys were completed for the DNR.

April showers bring May campers! April is always a summer preparation month, as many of our campground and seasonal operators are starting to prepare their facilities for summer. All campgrounds participating in the Department of Natural Resources (DNR) program are required to notify the DNR of the date they will re-pressurize their well and perform system chlorination as part of seasonal reopening procedures. This is a critical step to ensure the campground's water system is safe, compliant, and ready for public use.

Following this notification, Environmental Health (EH) staff must conduct a timely site visit to collect water samples. These samples are tested for:

- Total coliform bacteria
- Escherichia coli (E. coli)
- Nitrate levels

Water system start-up and testing are mandatory steps to prevent waterborne illnesses and ensure compliance with Safe Drinking Water Act (SDWA) requirements and local health regulations. Currently, 24 of 52 facilities have submitted the required documents and are serving water to the public after being turned off for the winter.

Nutrition Division

Women, Infants and Children (WIC) Program

WIC Farmers Market Nutrition Program (FMNP) update

The WIC Farmers Market Nutrition Program (FMNP) provides WIC participants with fresh, locally grown produce while supporting Wisconsin farmers, markets, and farmstands. These benefits are in addition to their regular monthly WIC benefits. In 2024, over one million dollars' worth of produce was purchased from Wisconsin farmers through WIC FMNP, and almost \$1.8 million worth of produce was purchased between both WIC and Senior FMNP. Historically, FMNP check issuance begins in June and expires on October 31. However, in April, we learned that WIC FMNP check issuance will be delayed because of funding uncertainty. This has resulted in WIC staff needing to cancel our planned Fun at the Farmers Market class with FoodWise in June, as well as canceling planned in-person check pick up. We are hopeful funding will come through to start FMNP issuance in July. Learn more about the impact of WIC FMNP here:

<https://www.dhs.wisconsin.gov/publications/p03561b-2024.pdf>

Red Cross Blood Drive

Please join us for the Chippewa County Courthouse Blood Drive. Each donation will ensure patients in need have lifesaving resources in the weeks to come. One hour, one donation can help save up to 3 lives. As an added thank you, each donor will receive a Red Cross solar lantern for donating in the month of May. [Sign Up Today for the Chippewa County Courthouse Blood Drive](#) or call the Red Cross at 1-800-733-2767 or Stephanie Abbe at 715-726-7870. THANK YOU!



Blood Drive **Chippewa County Courthouse**

Room 001
711 N Bridge St
Tuesday, May 27, 2025
10:00 a.m. to 4:00 p.m.



Planning and Strategy Division

Prom Positive Campaign - Bloomer High School

During the week of April 21–26, we worked with Chippewa County Healthy Communities to launch "Prom Positive" at Bloomer High School to support safe and healthy celebrations during prom season. The initiative emphasizes that most students are already making healthy, substance-free choices, helping to reinforce positive norms and reduce risk behaviors. The campaign included daily

announcements, social media content, an interactive classroom game, and a two-day lunch booth offering education and resources. A highlight of the week was a panel of local leaders and individuals with lived experience who shared personal stories and discussed the real-life consequences of substance use.



YMCA Healthy Kids Day

On Saturday, April 12, our coalition team participated in Healthy Kids Day at the YMCA, engaging with 500 to 700 families from across the county. In collaboration with the Chippewa County Healthy Communities coalition, we hosted tables focused on substance use prevention, positive mental health, and healthy lifestyle choices.

Additional outreach from the Chippewa County Department of Public Health featured information on car seat safety, immunizations, WIC services, and supports available through the Children's Resource Center – West. This event continues to be a valuable opportunity to build relationships with families and promote community-wide wellness.

National Drug Take Back Day

On Saturday, April 26, we partnered with local law enforcement and the Chippewa County Healthy Communities coalition to host three Drug Take Back events in Lake Hallie, Chippewa Falls, and Bloomer. These events provided residents with the opportunity to safely dispose of unused or expired medications and sharps, helping to prevent misuse and protect public health. The events were made possible through collaboration with the Lake Hallie Police Department, Chippewa Falls Police Department, Bloomer Police Department, and the Chippewa County Healthy Communities coalition. Offering sharps disposal for free at each site supported ongoing harm reduction goals while promoting public awareness of safe medication practices.

Children's Resource Center - West

The Children's Resource Center – West (CRC-West) is enhancing support for families of children and youth with special health care needs. Based on insights from recent focus groups where parents shared the pressures of caregiving on their health, CRC-West is hosting two compassion resilience events titled "Caring for Yourself While Caring for Your Child." These sessions, led by a trusted community partner, will provide essential training in resilience and self-care, with free meals and childcare offered for accessibility. This effort aligns closely with the recent advisory from U.S. Surgeon General Dr. Vivek Murthy, which highlights the urgent need to support the mental health and well-being of parents and caregivers for the benefit of children and society. These workshops provide practical tools for managing caregiver stress, preventing compassion fatigue, and creating space for personal well-being.

The next session will take place on Saturday, June 14, from 1 to 4 p.m. at Cross Lutheran Church in Roberts. This free event includes lunch, and support for respite and transportation is available to reduce barriers to attendance. A second workshop is also planned for the La Crosse area in June, with more details to be announced soon. This ongoing series continues to be a valuable way for CRC-West to connect with caregivers, offering real-world strategies and support for families across western Wisconsin. More information will be available at www.crcwest.org.

CARING FOR YOURSELF WHILE CARING FOR YOUR CHILD
A path to balance for parents of children with special needs

Date & Time
 Saturday, June 14, 2025, 1-4 p.m.

Location
 Cross Lutheran Church
 1246 County Road TT
 Roberts, WI 54023

To Register:
<https://redcap.link/crcw.stcroix>
 Call: 715-726-7907
 Email: crcwest@chippewacountywi.gov
 Respite & Transportation assistance available!
 Registration Required

IN THIS WORKSHOP YOU'LL:

- Learn what compassion fatigue is and how to avoid it.
- Experience simple practices to build resilience and recharge.
- Discover ways to sneak these practices into your busy days.
- Create a personal plan to ensure you have energy left for you!

FREE EVENT!
 Lunch and Take-Home Tools Provided!

HOSTED BY: Children's Resource Center-West
 SESSIONS FACILITATED BY: EPIC

In addition, CRC-West has launched the Essential Resource Purchase Program, allowing regional organizations to request critical items for serving children and youth with special health care needs, with CRC-West managing purchasing. This program streamlines access to needed resources and supports our partners' efficiency.

Our recent outreach season has concluded, and we are excited to share that several new community partnerships have been established to expand our collaborative impact. Information and referral services remain at peak levels, underscoring the strong, ongoing need for resources and support in our community.

Children's Resource Center-West: April is Autism Acceptance Month

Autism is one of the most common reasons families reach out to us—whether they're processing a new diagnosis, exploring school support options, or trying to access services like the Children's Long-Term Support (CLTS) waiver. Behind each call is a caregiver working hard to ensure their child has what they need to thrive.

On April 15, 2025, the CDC released new estimates: 1 in 31 children in the U.S. is now identified as having autism. That number represents thousands of families in our region—families juggling appointments, paperwork, school meetings, and daily life across systems that often don't communicate well with each other. Our role is to help make that path clearer, whether a family is just beginning or facing new challenges after years of navigating.

Throughout the year, we:

- Share information about services, sensory supports, and local events via our newsletter and Facebook.
- Provide personalized information and referrals.
- Offer guidance on challenges like long diagnostic waitlists, insurance denials, and special education issues.
- Host learning sessions on care coordination and the transition to adult services.

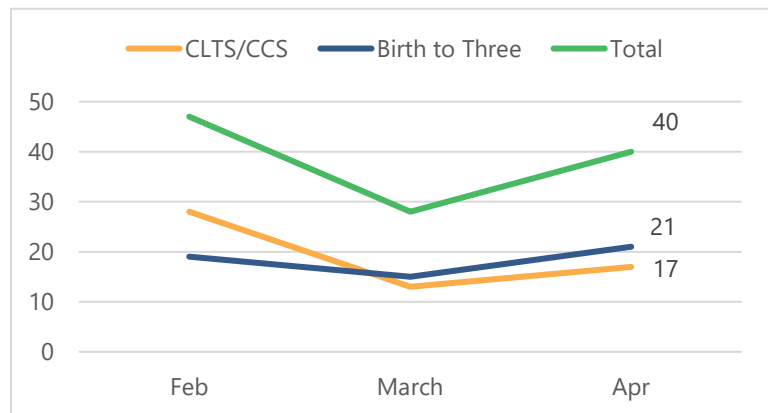
Each day, we see how families show up with determination, love, and care to support their children. Caregivers are resourceful, persistent, and deeply committed. Children and youth with autism bring creativity, focus, honesty, and unique perspectives that challenge us to build better, more responsive systems.

As Autism Acceptance Month comes to a close, we honor the families who inspire us every day—and the children and youth with autism whose strengths push us to think differently, act better, and build systems that truly support them.

Single Point of Entry: Centralized Support for Families of Children with Special Needs in Chippewa County

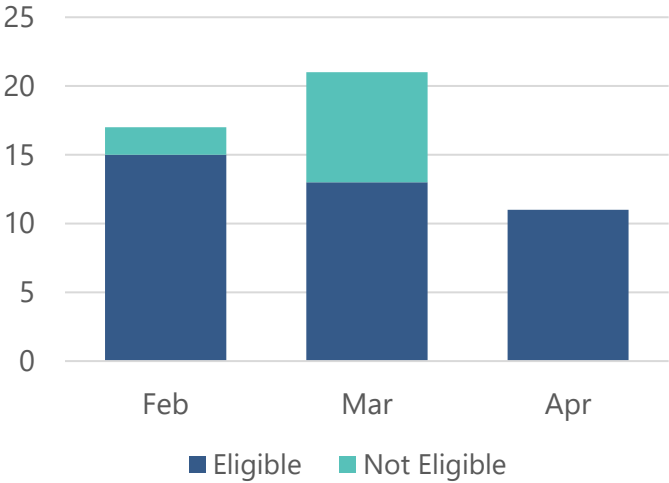
The CRC-West serves as the Single Point of Entry for families in Chippewa County seeking support for children with special needs. This means families can contact CRC-West as a central place to access a variety of services without needing to reach out to multiple organizations. Under a contract with the Department of Human Services, CRC-West connects families to programs like Birth to Three, Children's Comprehensive Community Services (CCS), and the Children's Long-Term Support (CLTS) Waiver and assists with functional screenings for these services.

April saw a rise in referral numbers, with 40 referrals this month.



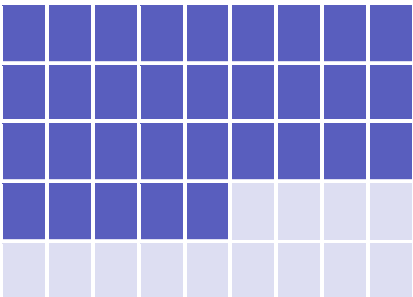
To ensure that children receive timely assistance, Wisconsin's Department of Health Services has established a **45-day standard for determining eligibility following a referral**. Meeting this standard is crucial, as it reflects our commitment to connecting families with essential resources efficiently.

Completed Functional Screens



Over the last 6 months, the Average Number of **Days from Referral to Eligibility** is

32 days



Years of Service

CONGRATULATIONS to the following staff for their hard work and dedication to providing excellent customer service to the citizens of Chippewa County.



- ❖ Brittney Fortuna, Public Health Director – 2 years
- ❖ Maryn Bengs, Children’s Resource Center-West Program Coordinator – 2 years



**Wisconsin Department of Health Services
Division of Public Health
PHA VR - WEDSS**

County Board of Health Report

Jurisdiction: Chippewa County

Received Date: 4/1/2025 to 4/30/2025

Disease	Confirmed	Probable	Suspect	Not A Case	Total
LEAD-BLOOD LEVELS - ADULT	0	0	0	13	13
CHLAMYDIA TRACHOMATIS INFECTION	10	0	0	0	10
HEPATITIS A	0	0	0	9	9
LYME LABORATORY REPORT	0	3	0	5	8
STREPTOCOCCUS PNEUMONIAE, INVASIVE DISEASE	2	0	2	3	7
CORONAVIRUS, NOVEL 2019 (COVID-19) - ASSOCIATED HOSPITALIZATION	6	0	0	0	6
HEPATITIS C, CHRONIC	0	0	2	3	5
RESPIRATORY SYNCYTIAL VIRUS (RSV) - ASSOCIATED HOSPITALIZATION	0	0	5	0	5
HAEMOPHILUS INFLUENZAE, INVASIVE DISEASE	0	0	0	4	4
LEAD-BLOOD LEVELS - ADULT - BLL 10	4	0	0	0	4
STREPTOCOCCAL DISEASE, INVASIVE, GROUP B	0	0	3	1	4
MYCOBACTERIAL DISEASE (NON-TUBERCULOUS)	3	0	0	0	3
PERTUSSIS (WHOOPING COUGH)	1	0	0	2	3
E-COLI, ENTEROPATHOGENIC (EPEC)	0	0	2	0	2
INFLUENZA-ASSOCIATED HOSPITALIZATION	2	0	0	0	2
SYPHILIS REACTOR	0	0	0	2	2
TOXOPLASMOSIS	0	0	1	1	2

Executed: 5/2/2025 9:43:27 AM

Page 1 of 2

Attachment: April CD Report (8952 : Public Health Director's Program and Financial Report – Brittney Fortuna)

Disease	Confirmed	Probable	Suspect	Not A Case	Total
AFB SMEAR	0	0	1	0	1
ANAPLASMOSIS, A. phagocytophilum	0	0	0	1	1
CAMPYLOBACTERIOSIS	0	0	1	0	1
CANDIDA AURIS, UNSPECIFIED	1	0	0	0	1
CARBAPENEMASE PRODUCING ORGANISM (CPO)	0	0	0	1	1
CORONAVIRUS, NOVEL 2019 (COVID-19)	1	0	0	0	1
E-COLI, ENTEROTOXIGENIC (ETEC)	0	0	1	0	1
GIARDIASIS	0	0	1	0	1
HEPATITIS B, CHRONIC	0	1	0	0	1
HEPATITIS C, ACUTE	1	0	0	0	1
MEASLES (RUBEOLA)	0	0	0	1	1
RESPIRATORY SYNCYTIAL VIRUS (RSV)	1	0	0	0	1
SALMONELLOSIS	1	0	0	0	1
SYPHILIS, UNKNOWN DURATION OR LATE	0	1	0	0	1
TUBERCULOSIS, LTBI - LABORATORY RESULTS ONLY	0	0	1	0	1
VARICELLA (CHICKENPOX)	0	0	0	1	1
Total	33	5	20	47	105

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Public Health Financial Results

April 2025

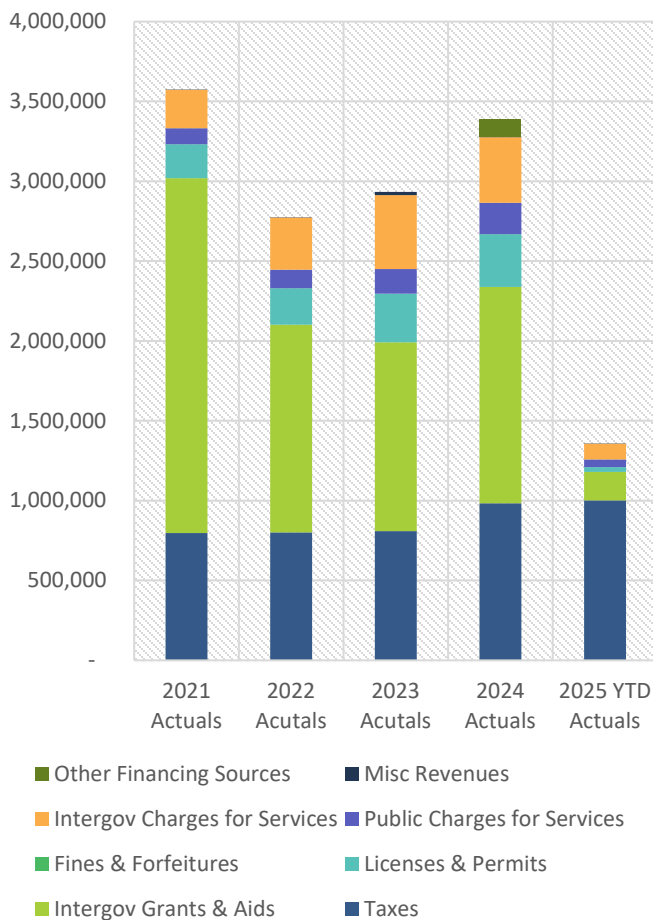
Fund	Description	Revenue			Expense		
		Budget	Actual	% Collected	Budget	Actual	% Spent
54100	Community Health	\$ (593,947.00)	\$ (529,163.05)	89.1%	\$ 593,947.00	\$ 167,118.77	28.1%
54121	Nurse Family Partnership	(123,650.00)	(30,644.73)	24.8%	123,650.00	30,381.05	24.6%
54123	Farmers Market	(3,930.00)	(92.56)	2.4%	3,930.00	128.76	3.3%
54125	Prenatal Care Coordination	(27,536.00)	(4,859.80)	17.6%	27,536.00	9,664.06	35.1%
54127	Healthy U	(31,393.00)	(19,979.84)	63.6%	31,393.00	1,062.28	3.4%
54128	Public Health Preparedness	(47,943.00)	(12,119.84)	25.3%	47,943.00	14,595.69	30.4%
54129	TN Program	(56,587.00)	(31,486.35)	55.6%	56,587.00	12,674.92	22.4%
54130	CHIP Coalition	(4,500.00)	-	0.0%	4,500.00	58.17	1.3%
54132	Drug Free Community Grant	(139,083.00)	(18,431.57)	13.3%	139,083.00	23,218.46	16.7%
54133	Iron Will Endowment Fund	(1,881.00)	(2,190.73)	116.5%	1,881.00	19.16	1.0%
54135	Bright Start River Source	(10,997.00)	(10,233.40)	93.1%	10,997.00	2,033.02	18.5%
54138	Planning & Strategy	(325,662.00)	(300,745.20)	92.3%	325,662.00	98,925.95	30.4%
54140	WIC	(433,809.00)	(130,551.88)	30.1%	433,809.00	124,047.08	28.6%
54142	Maternal & Child Health Program	(32,143.00)	(5,314.56)	16.5%	32,143.00	5,172.73	16.1%
54144	Wisconsin Wins	(5,065.00)	(525.12)	10.4%	5,065.00	924.35	18.2%
54149	Pre-Venture	(20,747.00)	(718.86)	3.5%	20,747.00	1,758.97	8.5%
54150	Prevention	(9,346.00)	(5,746.20)	61.5%	9,346.00	5,720.36	61.2%
54151	Equipment Loan Closet	(2,997.00)	(319.52)	10.7%	2,997.00	693.17	23.1%
54152	Childrens Resource Center	(242,490.00)	(58,491.28)	24.1%	242,490.00	69,522.73	28.7%
54153	WIC Endowment	-	(2,547.62)	#DIV/0!	-	1,445.48	#DIV/0!
54154	Title X Reproductive Health	(6,000.00)	(7,859.72)	131.0%	6,000.00	7,913.19	131.9%
54156	FIT WIC	(41,447.00)	(2,934.76)	7.1%	41,447.00	11,682.82	28.2%
54157	Reproductive Health	(55,193.00)	(10,321.59)	18.7%	55,193.00	9,363.82	17.0%
54158	WIC BF Peer Counseling	(19,995.00)	(518.40)	2.6%	19,995.00	10,581.25	52.9%
54161	Health Clinics	(32,652.00)	(1,408.71)	4.3%	32,652.00	2,690.01	8.2%
54162	COVID Vaccine	(23,032.00)	(2,105.56)	9.1%	23,032.00	1,910.82	8.3%
54163	Overdose Fatality Review	(27,347.00)	(4,468.24)	16.3%	27,347.00	6,432.98	23.5%
54164	COVID Contact Tracing	-	-	#DIV/0!	-	11,021.23	#DIV/0!
54165	GYT - Get Yourself Tested	(2,195.00)	(45.68)	2.1%	2,195.00	63.55	2.9%
54166	Water Lab	(3,627.00)	(2,339.84)		3,627.00	12,239.22	
54171	Food Safety Recreation License	(357,141.00)	(38,008.84)	10.6%	357,141.00	93,089.76	26.1%
54172	Infant Immunization Grant	(16,794.00)	(4,071.64)	24.2%	16,794.00	4,626.49	27.5%
54173	Opioid Abatement	(1,694.00)	(396.44)		1,694.00	628.72	
54174	Forward Health Outreach	(33,744.00)	(4,313.24)	12.8%	33,744.00	5,229.85	15.5%
54176	Environmental Health	(79,337.00)	(76,568.03)	96.5%	79,337.00	13,178.79	16.6%
54178	Public Health Infrastructure	(72,867.00)	(2,799.48)		72,867.00	6,240.73	
54180	DHS Agreement	(173,446.00)	(31,445.84)	18.1%	173,446.00	40,792.32	23.5%
54182	Environmental Tracking	-	(1,508.00)		-	1,908.80	
54184	Childhood Lead Poisoning Prev.	(9,927.00)	(2,420.16)	24.4%	9,927.00	2,262.41	22.8%
54186	Charity Outreach Program	(250.00)	-	0.0%	250.00	-	0.0%
54188	WI Wayfinder	(81,987.00)	(1,292.84)		81,987.00	4,330.49	
54189	Sensory Friendly Vaccination	-	-		-	-	
54190	Public Health Donation Expendi	(1,000.00)	(418.72)	41.9%	1,000.00	-	0.0%
		\$ 3,153,381.00	\$ 1,359,407.84	43.1%	\$ 3,153,381.00	\$ 814,732.25	25.8%



Public Health Revenue vs Expenses

Variance Year-to-Date through April 2025

Total Revenues for All Years



Total Expenses for All Years

